Licentiate thesis
Work-integrated learning
2026 No. 55

UNIVERSITY WEST

ILLUSTRATION: ELIN BEHRNS

Strengthening Parenthood through Specialised Nursing and self-awareness

A Work-Integrated Learning Approach within Child Health Services

Veronica Bohlin

Tryck: Stema Specialtryck AB, Oktober 2026

Licentiate thesis
Work-integrated learning
2026 No. 55

UNIVERSITY WEST

Strengthening Parenthood through Specialised Nursing and self-awareness

A Work-Integrated Learning Approach within Child Health Services

Veronica Bohlin

University West
SE-46186 Trollhättan
Sweden
+46 520 22 30 00
www.hv.se

© Veronica Bohlin 2026
ISBN 978-91-89969-46-9 (printed)
ISBN 978-91-89969-45-2 (electronic)

Cover image; Elin Behrns

Acknowledgements

This challenging and developing journey required support, and I am grateful to many people. In particular, I thank my supervisors, *Professor Elisabeth Dahlborg* and *Associate Professor Katarina Patriksson,* for valuable insights and helping me turn an idea for a thesis into reality. I much appreciated your time; thank you for making yourselves available to me.

For the nurses in child health services who works for all children´s rights and best interests, so that they will have best possible healthy outcome. You are the reason for this licentiate thesis, and some of you also made it come true as participants within the study, my thank you and gratitude!

More people to appreciate; Hrafnhildur Gunnarsdottir and Susanna Höglund Arveklev. Anna Wilner, Astrid Olsson and Elin Behrns, thank you!

To Åse Boman, former head of department, thank you for giving me valuable support, guidance, and the opportunity to start my journey of research.

Professor and Study Director of PhD studies, Fredrik Sunnemark, for your support: my thanks.

For all the inspiration you have given me, Professor of Public Health, Bengt Lindström; being your student at the former Nordic School of Public Health gave me a passion and opened my eyes to salutogenes, thank you so much! To Professor of Public Health, Monica Eriksson, thank you for the inspiration and for generously sharing your written texts and articles! More inspiration came from Professor Jan Gustafsson Nyckel, thank you for sharing perspectives for learning and understanding. One more source of inspiration, keeping my eyes on health promotion in child health services is Antonia Reuter: my gratitude! One more health promotion practitioner to keep in mind, Mona Bryggman, much love for you!

For insightful contributions during my progression seminars, my thanks go to Professor Anette Ekström- Bergström and Professor Kristina Areskoug Josefsson.

I am much grateful to all my PhD colleagues and the WIL PhD community; Anh, Anneli.T., Alma, Carina.F., Claudia.P., Ivan, Linda.F., Kristina.M., Ksenija,

Maria.H., Mia.B., Olivia Serbin, Pernilla.B., and dear Jessica Persson Kylén for valuable discussions and support during courses and writing processes.

To the Residency Grant of Villa Martinson in Jonsered, thank you for support and inspiration with new insights.

I feel fortunate to have supportive and dear friends like Ester F., Bashar, Sara 'rara', and Sofia W in my life. To the community of 'sisters', Anna-Stina, Ulrika, Maria, and Ingela, and to each and every one of you in various communities, especially the 'climbing tree members' of the Red Cross University of former 'sisters', Alexandra, Minea, and Mojgan. Thank you for wanting to climb trees together, knowing anything is possible. You are all precious to me!

To my dear sisters and brother, always present and loving.

Mam and Dad, thank you for giving me unconditional support and constant love.

The most important people in my life, Marcus and Aron,

for constantly reminding me of what truly matters.

Above all,

for sharing, caring and learning, thanks unto You!

/ Veronica Bohlin

'Ge barnen kärlek, mera kärlek och ännu mera kärlek, så kommer folkvettet av sig själv.'

'Give the children love, more love and still more love, and the common sense will come by itself.'

Astrid Lindgren, 1948.

Veronica Bohlin

Göteborg 19th of May 2026

Populärvetenskaplig Sammanfattning

Titel: Att stärka föräldraskapet genom specialiserad omvårdnad och självkännedom:
-Ett arbetsintegrerat lärande inom barnhälsovården

Nyckelord: Barnhälsovårdssjuksköterska; Barnets bästa; Hälsofrämjande; Professionella kompetens; Föräldrastöd; Arbetsintegrerat lärande

Inom barnhälsovården har barnhälsovårdssjuksköterskan (BHV- sjuksköterskan) en avgörande roll för att främja barns och familjers hälsa. Denna licentiatavhandling beskriver hur BHV-sjuksköterskorna använder sin professionella kompetens som ett personligt verktyg i mötet med familjen för att främja hälsa. I den första delen av arbetet lyfts samspelet mellan sjuksköterskan, barnet och familjen fram som en dynamisk process. Denna process består av tre sammanlänkade begrepp; omsorg (caring), kunskapsdelning (knowledge sharing) och lärande (learning). De tre begreppen består av olika lager och nivåer som är beroende av varandra och blir till en hälsofrämjande process, *healthy learning*. Det nybildade begreppet *interactioning,* används för att beskriva denna process samt BHV-sjuksköterskans arbete med att aktivt delta i den och påverka att hälsa och lärande växer fram i mötet med barnet och familjen.

Genom att vara lyhörda, flexibla och anpassningsbara kan barnhälsovårdssjuksköterskor ge skräddarsytt stöd utifrån varje barns och familjs unika behov. Förmågan att ”ställa in sig” utifrån olika situationer ökar chanserna till goda hälsoresultat samt bildandet av en ”känsla av sammanhang” (KASAM) för både barnet och BHV-sjuksköterskan.

Studien bygger på kvalitativ metod utifrån deltagande observationer med informella samtal samt enskilda intervjuer.

Artikel A beskriver den dynamiska interaktionen mellan BHV-sjuksköterskan, barnet och familjen med temat *”Hälsofrämjande som professionell kompetens är ett hantverk av interaktion för omtanke och ömsesidigt lärande”.* Arbetsintegrerat lärande (AIL) lyfts fram som en pedagogisk modell för att förstå den hälsofrämjande interaktionsprocessen vilket integrerar teori med praktik.

Resultaten i artikel B lyfter fram det övergripande temat ”*Att lyssna in och anpassa stödet till familjen för barnets bästa”* beroende på varje enskild familjs unika situation och behov. BHV-sjuksköterskornas personliga resurser som tålamod, takt och kunskap stärker barnens och familjernas egna förmågor. Genom att lyhört lyssna in och skräddarsy stödet utifrån familjens behov främjas barnens hälsa vilket ökar chansen till ett mer hälsosamt utfall. Att vara medveten om sina egna förmågor

kan liknas vid instrument, att lyssna in och stämma av sin kompetens blir grunden för ett kontinuerligt och anpassningsbart lärande.

AIL lyfts fram som en pedagogisk modell där teori och praktik möts och möjliggörandet av reflektionstid blir nyckeln till ett kontinuerligt lärande. Utveckling av den professionella samt kliniska kompetensen i det dagliga arbetet utgörs av såväl praktisk och erfarenhetsbaserad kunskap som teoretisk. Behovet av reflektionstid är centralt.

Sammanfattningsvis visar avhandlingen att interaktionsprocessen i BHV-sjuksköterskans arbete inom barnhälsovården blir till ett hälsofrämjande lärande.

Genom att använda sin professionella kompetens som ett verktyg för ett hälsosamt resultat kan BHV-sjuksköterskan använda AIL för sina specifika resurser från sin professionella kompetens som hon behöver i varje unik situation för barnens bästa.

Abstract

Title: Strengthening Parenthood through Specialised Nursing and self-awareness: A Work-Integrated Learning Approach within Child Health Services

Keywords: Child healthcare nurse: Child´s best interest; Health promotion; Professional competence; Support of parenthood; Work-integrated learning

ISBN: 978-91-89969-46-9 (printed)

ISBN: 978-91-89969-45-2 (electronic)

This licentiate thesis explores how child healthcare (CHC) nurses use their professional competence to promote health. A qualitative design is adopted using data from participant observations and interviews. The findings in Paper I emphasise the interaction between the CHC nurse, the child, and the family as a dynamic process that builds different layers of three '-ing' concepts: caring, knowledge-sharing, and learning. The concepts are dependent on each other as well as on the process of interaction between health promotion and healthy learning. To indicate this process, the neologism *interactioning* is used for the dynamic interaction process containing the three '-ing' concepts. Paper A highlight the theme *Health promotion as a professional competence is a craft of interaction for caring and mutual learning* and positions work-integrated learning (WIL) as a pedagogical model. In the context of CHC practice, it offers a framework for understanding health promotion and the interaction process. WIL supports the development of knowledge in everyday practice, emphasising the integration of theory and practice.

Paper B highlights the overarching theme *Tuning in and adapting support for the family in the best interests of the child,* reflecting the CHC nurses' attitudes to each family's unique situation. The personal resources of these nurses, perceived as skills in patience, tact, and tacit knowledge, strengthened both the children's and the families' own resources and were attuned to the needs of the families. The chance of a healthy outcome increased when CHC nurses were adaptable, giving tailored support for individual needs. Awareness of how CHC nurses utilise themselves as instruments of their own competence, through their skills and abilities, serves as a foundation for continuous and adaptable learning. This self-awareness enables the development of clinical competence, enhances the potential for positive health outcomes, and contributes to the strengthening of a sense of coherence (SOC) for both the nurse and the child.

WIL integrates theory with practice, and reflective practice enables nurses to gain perspective both in and on their CHC practice. Therefore, it is crucial to ensure CHC nurses have reflection time to promote continuous learning and develop competence.

In summary, the thesis describes that CHC nurses' interaction process with children and families promotes health and learning. Moreover, by using themselves as tools to bring healthy outcomes, CHC nurses can use WIL to choose specific resources from the professional competencies needed in each unique situation to ensure that the children's best interests are met. Reflection as a resource for decision-making, as well as the self-awareness of using themselves as a tool of their own competencies, enables the development of CHC nurses' professional competence, leading to continuous and adaptable learning that enhances healthy outcomes and contributes to the feeling of SOC for both the nurse and family.

Abbreviations

CHC	child healthcare
CHC centre	child healthcare centre
CHC nurse	child healthcare nurse
CHS	child health service
CoP	community of practice
GRR	general resistance resources
SOC	sense of coherence
WIL	work-integrated learning

Table of Contents

Acknowledgements iii
Populärvetenskaplig Sammanfattning v
Abstract vii
Abbreviations ix
Table of Contents xi
1 Introduction 13
2 Background 14
2.1 Swedish Child Health Service 14
2.2 Child- and family-centred perspective 16
2.3 Professional competence and learning of nurses in Child Health Service 17
3 Previous research 18
3.2 Problem formulation 20
3.3 Overarching aim 21
3.3.1 Aim of Paper A 21
3.3.2 Aim of Paper B 21
4 Conceptual frameworks 23
4.1 Work- Integrated Learning within Child Health Service 23
4.1.1 Sociocultural perspective 24
4.2 Health and learning 27
5 Methodology 31
5.1 Design 31
5.2 Data collection and participants 32
5.3 Data analysis 36
6 Ethical considerations 41
7 Results 43
7.1 Paper A 43

7.2 Paper B 46
7.3 Synthesis of results..... 49
8 Discussion 51
8.1 Understanding health promotion and the interaction process ……..51
8.2 A community of practice as learning environment 55
8.3 Self-awareness and development of clinical competence . 58
8.3.1 Model of epistemology and Work-integrated learning 61
9 Methodological considerations..... 67
9.1 Paper A 68
9.2 Paper B 69
9.2.1 Limitations 70
10 Conclusion..... 71
10.1 Implications and further research..... 72
11 References 73

Appendices

Appendix 1 2022-09-21 Interview guide

Appended Papers

Paper A The nurse in child healthcare as a craftsman to use professional competence and build a health promotive relationship- an observation study

Paper B Tuning in to provide tailored and adjustable health promotion support in children's best interest – an interview study with child healthcare nurses

1 Introduction

This licentiate thesis explores child healthcare (CHC) centres through the lens of health promotion and the professional development of nurses within the framework of work-integrated learning (WIL).

The Swedish national child health service programme with continuous health visits for newborns up to six years of age supports an ongoing relationship among nurses, children and families. The positive outcomes of children's health are partly dependent on nurses´ work at centres, which serve as an important arena for public health; therefore, understanding their work is crucial. Existing relationships with children and families form the foundation for, and are essential to, meaningful learning encounters. Learning derived from these encounters is necessary for the development of nurses' competence, highlighting the need to understand how health promotion work is conducted in practice, including what occurs in these encounters as well as when and why. To understand how this work is shaped in encounters, WIL is explored as a framework for examining the relationship between theory and practice. This project provides valuable perspectives on the use of nurses´ competence and the development of their learning competence. More specifically, it can contribute to a deeper understanding of WIL in the clinical practice of centres and how it functions in relation to interaction processes, the learning environment and the development of nurses´ competence. By studying nurses´ work and their experiences of health promotion and learning in centres, the focus is placed on how learning is shaped by the nurses themselves.

Nurses with the necessary competencies to work in a setting are specialised in either paediatric nursing or public health nursing. The term 'nurses' will be used throughout to refer to all such specialist nurses. Although some male nurses work

in practice, the number is small, and no male nurses participated in this research project.

2 Background

2.1 Swedish Child Health Service

The overarching public health policy goals in Sweden include eight different and very important target areas. The first concerns early-life conditions, making an important actor in supporting parenthood. Supporting parenthood and creating favourable conditions for children's development are therefore central components of the public health policy goals (Folkhälsomyndigheten, 2025).

To achieve the goals and aims of the Swedish child health service, various legislative acts and a national programme at three different levels provide guidance and establish the framework for ensuring the best possible and equitable health outcomes. These include the United Nations Convention on the Rights of the Child (SFS 2018:1197), Agenda 2030 (United Nations, n.d.) and the Swedish Health and Medical Services Act (SFS 2017:30) (Socialstyrelsen, 2014). The goal of CHC is to promote children's physical, mental and social health; support children´s health and development; prevent ill health and identify and initiate interventions at an early stage (Reuter, 2023). Achieving these aims contributes to fulfilling overarching public health policy goals of creating societal conditions for good and equitable health and reducing existing health inequalities within a generation (Folkhälsomyndigheten, 2025; Socialstyrelsen, 2014).

The Swedish child health service is publicly funded and provided free of charge (Wallby & Hjern, 2011). Its mandate is to identify risks and initiate appropriate measures at an early stage when concerns arise regarding children´s health,

development or the environment in which they are being raised (Reuter, 2023; Socialstyrelsen, 2014).

The first level of the national programme concerns initiatives extended to every child, such as health monitoring. The second level involves initiatives offered to every child with a need, while the third level comprises initiatives designed for children and families whose needs require support from professionals other than nurses. All three levels of interventions are incorporated into the health visits offered nationally by the (Socialstyrelsen, 2014) and correspond to the Swedish public health approach of universal, selective and indicated initiatives.

Working at a centre involves viewing each child and family within the framework of goals and routines, guided by relevant legislation and regulations. The Swedish child health service programme states that all children have the right to be equally treated (Reuter, 2023; Socialstyrelsen, 2014).

Nurses need to offer individual and tailored assistance to all children and parents. This includes paying attention to the conditions within children´s environments and identifying factors that promote health in order to ensure continuity of care and support (Reuter, 2023; Socialstyrelsen, 2014).

Providing parental support constitutes an important aspect of health promotion. Accordingly, the Swedish National Board of Health and Welfare highlights the importance of promoting healthy relationships within child health services as a means of promoting a more holistic perspective and creating social conditions for equitable care in the best interests of the child (Reuter, 2023; Socialstyrelsen, 2014). Consequently, a family-centred approach is required (Socialstyrelsen, 2014).

2.2 Child- and family-centred perspective

The family should be seen as a unit, as the development and well-being of a child are influenced by the parents (Shorey, 2021). Therefore, healthcare should be planned based on the needs of the entire family (Benzein et al., 2008b; Jolley & Shields, 2009). Benzein et al. (2023) argued that a reciprocal approach is optimal, whereby nurses invite the entire family into the healthcare system while the family, in turn, invites the nurse into the family system. Such collaboration is necessary to establish a partnership that identifies factors promoting the health and well-being of both the child and the family (Benzein et al., 2008a, 2023). Since a family perspective must be based on the child's view of what constitutes a family (Coyne et al., 2018), adopting a family-centred approach is essential for achieving child-centred care.

A child-centred approach within a family-centred framework involves a commitment to active listening and the development of a trusting relationship among the child, family and nurse, enabling care to be tailored to the child´s needs (Coyne et al., 2016, 2018). A concept analysis defined child- and family-centred care as an approach that recognises the child as an individual and an active collaborator alongside their family. The authors highlighted that, as concepts evolve and meanings shift in response to societal change, periodic concept analyses are required to ensure that definitions remain up to date (Zgambo et al., 2025).

To achieve the goals of child health service, support for children and families is essential. The provision of this support depends on nurses´ competencies.

2.3 Professional competence and learning of nurses in Child Health Service

Nurses require broad competencies across different types of knowledge in order to work in accordance with child health service goals and routines from a holistic perspective (Socialstyrelsen, 2014). To fulfil the aims of promoting children´s development and preventing ill health, nurses must provide support to all parents by encouraging and empowering them in their parenting role, thereby creating favourable conditions for their children (Socialstyrelsen, 2014).

A specialised nurse at a centre must make decisions during routine visits, which requires certain competencies. Ellström (1992) described competence as an individual's ability to act in relation to a certain task, situation or context. Furthermore, competence is something that all individuals develop within their learning environment and through learning processes (Ellström et al., 2008; Illeris, 2009). Billett, 2016, argued that learning within healthcare work is shaped by everyday practices, routines and social interactions within the clinical environment. He further emphasised that clinical practice provides structured opportunities for continuous learning and the development of both individual and collective competencies through established routines. Work in healthcare is characterised by continual change and ongoing challenges, highlighting the importance of workplace learning as a foundation for lifelong learning, a point already emphasised by Tynjälä (2008).

Making decisions to achieve certain aims and the ability to act on specific concerns are aligned with Ellström's (1992) and Schön's (1983) descriptions of the development of competence as dynamic and derived from learning in social practice (Ellström et al., 2008; Schön, 1983).

Providing support to parents based on the family's situation and working to ensure equitable health outcomes require specialised nurses to have relevant knowledge and skills to promote health to support parenthood for the child's

benefit (Ekström-Bergström et al., 2022; Langeland et al., 2022; SFS 2018:1197; Shorey, 2021; Socialstyrelsen, 2014). Supporting parenthood includes the competence to identify factors and resources surrounding the child and family (Langeland et al., 2022), which aligns with the concept of professional competence as the ability to integrate theory and practice to solve problems (Schön, 1987).

For nurses, learning is a vital means to develop competence in promoting health, identifying factors surrounding the child and family and supporting the child's well-being based on available resources.

3 Previous research

Previous research has highlighted the importance of interaction, as it is through this that relationships are formed—a prerequisite for nurses' daily work in child healthcare centres (Bohlin et al., 2022; Eklund et al., 2022), more specifically for identifying resources around the child (Langeland et al., 2022). Eklund et al. (2022), in an interview study with child healthcare nurses, found that a primary task was to promote responsive interaction between parents and children, which is essential for future relationships. A key finding of this study was that nurses interpret signals in parent and child behaviours, reinforce parents in their role and, at times, experience feelings of professional inadequacy. This underscores the importance of nurses' communication knowledge and skills.

The holistic perspective involves providing professional support and adopting an approach in which the nurse is responsive to the family's unique needs (Ekström-Bergström et al., 2022; Gilmer et al., 2016). Moreover, certain knowledge and skills are needed to strengthen social support and identify factors that influence health outcomes (Ekström-Bergström et al., 2022). Supporting parenthood

through clinical practice is time-consuming, and recent research has highlighted that lack of time is perceived as a major barrier for nurses in child healthcare settings in daily practice (Ersson et al., 2021).

Knowledge and skills are required to ensure children's right to good health and equitable care within child health services. Promoting responsive interactions between parents and children is therefore a fundamental aspect of nurses' work. However, this has been described as challenging and may lead to feelings of inadequacy, partly due to obstacles such as insufficient knowledge to promote responsive interactions (Eklund et al., 2022).

Regarding nurses' learning in encounters with children and families, their practice must be grounded in reflection on experience in order to support the development of professional competence. A systematic review examining the use of reflection and reflective practice in health profession education found that reflection is widely valued for supporting professional growth, clinical reasoning and lifelong learning; however, the field lacks consistency (Mann et al., 2009).

As concerns nurses´ competencies in clinical child healthcare settings, there is a research gap regarding both their attitudes towards helping families in need and their ability to enhance accessibility (Engström et al., 2021). Moreover, research shows a need for nurses to be more aware of their supporting abilities in order to become more available and inclusive for both parents (Hrybanova et al., 2019).

To better understand how nurses in child healthcare centres apply their experience, skills and competence, there is a need to examine their clinical practice. Research further underscores the importance of supporting nurses in developing interactional skills that promote child participation and suggests that further research is needed to explore how healthcare can better support child-centred practice (Harder et al., 2017).

Children's health is affected in diverse ways and can be seen from various perspectives, which underscores the importance of exploring how nurses use their competence in child healthcare centres.

3.2 Problem formulation

Since certain knowledge and skills are needed to achieve the best possible health outcomes and uphold the rights of the child, nurses in clinical child healthcare settings must be aware of learning processes within interactions and encounters. The foundation of nurses´ work in a child healthcare setting lies in establishing a collaborative relationship among the child, family and nurse. This partnership is essential for identifying health-promoting factors and requires time for understanding the child's unique needs, as well as to sustain learning and develop competence to ensure best possible health outcomes. As health promotion enables people to increase control over their own health, the early stages of life are particularly crucial for the well-being of both the child and the parents. Consequently, child healthcare settings play a vital role in health promotion efforts.

Promoting an equitable child health service that supports good and sustainable health outcomes is a core responsibility of nurses. To maintain and further develop a health-promoting approach, it is essential to explore how nurses perceive health promotion and how it is expressed in their work with children and families.

Previous research has shown that nurses need to be aware of their supporting capacities, and that studying encounters among the nurse, child and family offers valuable insights that can address a significant gap in current knowledge. Awareness of one´s own competence signifies an ongoing process of self-directed learning and professional development. This reflective understanding enables

individuals to identify areas of strength and development, thereby fostering continuous improvement and adaptability in practice.

In nurses' learning processes, competence is constructed through the integration of theoretical knowledge and practical experience, as well as through interactions with others, such as colleagues and families. Understanding nurses' learning processes through encounters and interactions can make an important contribution to explaining how the unique needs of both the child and the family are met. Understanding the conditions under which nurses carry out health promotion, and how their learning and competence can be enhanced through work integrated learning (WIL)—which values theory and practice equally—is a vital component of professional development.

The results of this study are expected to provide knowledge about how child healthcare nurses in use learning processes for maintaining and developing competence during health promotion encounters. The thesis further problematises the potential of WIL as a tool for facilitating learning within child healthcare centres.

3.3 Overarching aim

The overall aim of this thesis is to explore how health promotion and professional competence are enacted and developed in relational encounters between child healthcare nurses and the families they engage with.

3.3.1 Aim of Paper A

Paper A aims to explore how child healthcare nurses use their professional competence to promote health in families with children.

3.3.2 Aim of Paper B

Paper B aims to describe nurses' experiences of health promotion in child healthcare.

4 Conceptual frameworks

4.1 Work- Integrated Learning within Child Health Service

WIL constitutes a distinct research field that focuses on the study of learning processes in various professional and educational contexts (Truong, 2024). Theories that enable an understanding of WIL within child health service are presented below.

Patrick et al. (2008) described WIL as an umbrella term encompassing various approaches and multidimensional learning strategies that integrate theory with workplace practice. Within child health service, WIL can be framed as the professional learning of specialised nurses and is closely aligned with the notion of a 'real-world learning experience'. This perspective emphasises the practical dimension of WIL, where learning is embedded in authentic clinical contexts (Patrick et al., 2008), and supports lifelong learning through the integration of theoretical and practical knowledge in the workplace. This thesis thus explores health promotion practices within child health service, paying particular attention to nurses' learning processes and competence development. It examines how WIL contributes to these practices by bridging theoretical frameworks with hands-on experience in clinical settings.

Learning that arises through social interaction (Billett & Choy, 2011; Ellström, 1996; Lave & Wenger, 2005; Lindström & Eriksson, 2011; Nilsson & Lindström, 1998; Pennbrant & Svensson, 2018; Säljö, 2014; Vygotskij, 1978), particularly within the everyday encounters of CHC centres, can be understood as a foundation for exploring how theory and practice are integrated. This offers a

meaningful lens for understanding WIL as experienced and perceived by nurses in their professional context.

WIL encompasses work-based learning experiences that promote diverse forms of knowledge and encourage reflective practice, continuous development of learning and professional competence (Mann et al., 2009). For child healthcare nurses, this approach strengthens both individual learning and professional competence, as well as deepening the understanding of the complexities involved in promoting children´s health.

To enable and enhance a deeper understanding, reflective practice is needed. Schön (1983) described the stages of reflective learning as reflection-in-action and reflection-on-action. Reflection-in-action refers to the practitioner´s ability to think critically and adapt during a professional activity, while reflection-on-action occurs when the practitioner translates the practical experience into future practice. The reflective process is central to the development of professional competence (Schön, 1983) and enables professionals' experiences to become learning opportunities.

To understand the context of the prevailing learning environment at a child healthcare centre, the sociocultural perspective has been used as a guiding framework.

4.1.1 Sociocultural perspective

Säljö (2005, 2014) stated that human existence is sociocultural and must be understood based on social practices, which provides a comprehensive perspective. In this work, WIL is conceptualised as a dynamic learning process in which knowledge is co-constructed by individuals within their social contexts and through interaction with others. From a sociocultural and socioconstructivist standpoint, knowledge is understood to develop through active social engagement and the exchange of ideas (Säljö, 2014).

The concept of 'community of practice' (CoP) is chosen to illustrate the collaborative dynamics within child healthcare practice, where professionals collectively address shared concerns. This interpretation resonates with both Patrick et al. (2008) and Wenger (1998), who conceptualised learning as a socially situated process that occurs through active participation in a community in which members engage in shared practices, mutual engagement and the development of a shared repertoire (Wenger, 1998; Wenger-Trayner & Wenger-Trayner, 2015).

Interdisciplinary collaboration in child health service involves individuals sharing and drawing on each other's experiences for learning (Dewey, 1938; Kolb, 1984), forming a CoP that enables the development of resources (Patrick et al., 2008) such as reflective practice (Schön, 1983). Lave and Wenger (1991, 2005) described CoP within the context of situated learning, where learning occurs through interactions and collaborations and is situated in or alongside the workplace and professional practice (see also Wenger, 1998). A situated activity involves individuals participating in specific tasks as well as broader social communities (Lave & Wenger, 2005). The interactions represent a co-constructed process between the individual and the surrounding environment (Ellström, 1992; Säljö, 2005, 2014) and are important because learning emerges through the development of insights, knowledge and skills. These are subsequently retained at the individual level as personal experiences and embodied competence. To understand how learning occurs, it is important to identify skills and competencies within the workplace, as organisations can facilitate knowledge-sharing, skill development and adaptation to new challenges (Säljö, 2005, 2014).

Illeris (2018) stated that all learning takes place within a process of interaction. Although Illeris is not typically regarded as a strictly sociocultural theorist, his theorisation of learning adopts an integrative perspective in which sociocultural dimensions constitute a central component, alongside psychological and content-related dimensions. Understanding the foundations of reciprocal and negotiated interactions requires consideration of the degree of alignment between the

individual´s learning, values and beliefs and the workplace´s cultural norms and values (Billett, 2002). Therefore, for a specialised nurse in child health service, the development of skills grounded in theoretical knowledge could provide what Yardley (2012) described as a learning experience.

Although Ellström (1992,1996,2008) did not explicitly position his work within a sociocultural theoretical tradition, his theorisation of learning and competence development aligns with sociocultural perspectives in important respects, notably in recognising learning as situated in social practice and shaped by the dynamic interplay between individual agency and contextual conditions. According to Ellström (1996), lifelong learning is underpinned by two principles: that learning is an ongoing process that continues throughout life, and that it occurs across various educational contexts, including formal learning as well as informal learning in working life and everyday life. These forms of learning are complementary and contribute to the development of both the individual and the organisation. Therefore, a balanced approach that focuses on both adaptation and development is desirable (Ellström et al., 1996).

Whether learning develops from experience depends on the opportunities for observation, interpretation and reflection in a specific context (Ellström, 1992), as learning is closely linked to the individual´s scope for action. Opportunities to reflect on and evaluate actions in relation to goals and tasks create conditions for facilitating learning (Ellström et al., 1996).

In 2008, Ellström et al. distinguished between *enabling environments,* which promote dialogue, autonomy and innovation, and *constraining environments*, which emphasise control, standardisation and compliance. These two types of learning environment are shaped by the structure and culture of the workplace and the extent to which conditions for developmental learning can be created (Ellström et al., 2008).

Experiential learning is significant because it emerges through individuals' actions within complex and context-dependent situations. These experiences are shaped by multidimensional interactions and deepened through collaborative participation in a CoP, where learning becomes a socially mediated and shared process (Lave & Wenger, 2005). Experiences in child healthcare centres arise from interactions among the nurse, child and family, where the aim is to provide the individualised support required to promote parenthood and achieve good health outcomes.

4.2 Health and learning

Health promotion was defined in the Ottawa Charter as a process that enables people to increase control over and improve their health (WHO, 1986). Since children´s health is dependent on their parents´ living conditions, socioeconomic circumstances play a significant role in shaping health outcomes (Marmot, 2010; SOU 2017:47). This underscores the importance of equity, both in socioeconomic conditions and in the provision of child health service. To attain good and equitable health, all individuals must have equal opportunities for health, positioning health as an outcome of the interaction between the individuals and society (Dahlgren & Whitehead, 2007). Health can be weakened or strengthened depending on how individuals' resources are used; therefore, nurses' professional competence must be both broad and specific in order to identify health-promoting factors (Ekström-Bergström et al., 2022; Langeland et al., 2022; Shorey, 2021). Health promotion interventions depend on nurses' competence and how evidence-based knowledge is implemented at the workplace (Langeland et al., 2022).

Providing support in parenting aimed at strengthening parents' abilities is a core component of health promotion and disease prevention work of child health service (Reuter, 2023; SOU 2021:78; Socialstyrelsen, 2014).

Antonovsky (1979) introduced the concept of generalised resistance resources (GRRs), which enables individuals´ resources to develop their sense of coherence. When nurses identify these resources, they can be strengthened and supported as required by each child and family. In this way, the promotion of healthy relationships is based on a salutogenic perspective, while the identification of risk factors reflects a more preventive and pathogenic approach.

The salutogenic and pathogenic approaches complement each other in working with families with children and are aligned with child health service and the mission to promote health and prevent disease. Prevention involves knowledge of the cause of illness, prevention of risk conditions and the early identification of situations in which children may need support (Socialstyrelsen, 2014).

The determinants of health in the rainbow model (Figure 1) illustrates the different layers of structural factors, such as socioeconomic, cultural and environmental conditions, which are commonly referred to as living conditions and lifestyles (Dahlgren & Whitehead, 1991). Therefore, the model is highly relevant to use in child healthcare settings, as they operate within the societal domain of 'living and working conditions'.

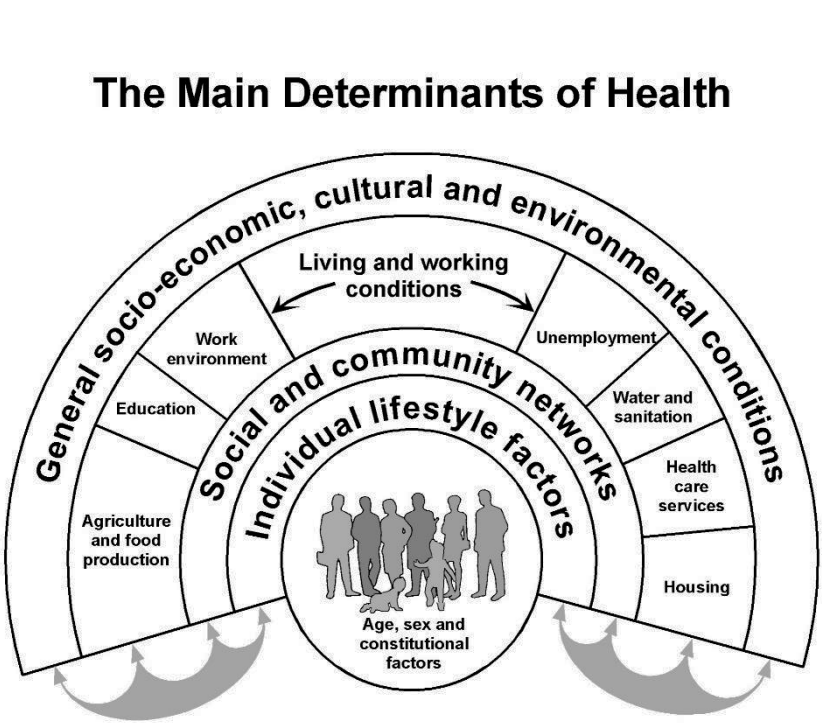

Figure 1. Dahlgren G, Whitehead M (1993). Tackling inequalities in health: what can we learn from what has been tried? Working paper, London: King's Fund, 1993, accessible in: Dahlgren G, Whitehead M. (2007) European strategies for tackling social inequities in health: Levelling up Part 2. Copenhagen: WHO Regional Office for Europe. Printed and published with permission from the author.

The Commission on Social Determinants of Health (WHO, 2008) defines social determinants as structural elements within society, producing health inequalities, advocating for proportional universalism. Growing inequalities comes from "drivers", such as racism or poverty. The Rainbow model, see Figure 1, can support identification in the child health service, especially if the main determinant of health involves a salutogenic perspective where health is seen as a resource (Antonovsky, 1979).

Both the Ottawa Charter (WHO, 2008) and general resistant resources (GRRs) can be seen as learning processes since people interact, and learning is the result

of experiences (Nilsson & Lindström, 1998). Interaction with others enables learning as a development process (Billett, 2016; Dahlborg, 2010; Pennbrant & Svensson, 2018), while promoting health is described as a process of healthy learning (Lindström & Eriksson, 2011; Nilsson & Lindström, 1998). The process of engaging in relational interactions with others fosters learning, which expands the space for knowledge through insights gained in practice (Pennbrant & Svensson, 2018).

5 Methodology

5.1 Design

This licentiate thesis is based on one study and two datasets (see Table 1). The selection of research designs and methods for data collection was strategically guided by the overall aim of the study, ensuring alignment between the methodological approach and the intended analytical focus.

The research project has an explorative and qualitative design because of the aims to explore health promotion work and learning in health-promoting encounters between nurses, children, and families.

The study was inspired by ethnographic research as a process of learning about people by learning from them (Roper & Shapira, 2000). The use of participant observations with informal conversations and individual interviews can give information about the studied field and the participants' different actions.

Table 1. Overview of Papers I and II.

Paper	**I**	**II**
Aim	To explore how child healthcare nurses use their professional competence to promote health in families with children	To describe nurses' experiences of health promotion work in child healthcare
Design	Exploratory qualitative	Exploratory qualitative

Context	Five CHC centres in areas with different contexts in the west of Sweden.	Five CHC centres in areas with different contexts, in the west of Sweden.
Data collection	Participant observations and informal conversations Fieldnotes 12 CHC nurses	Individual interviews 14 CHC nurses
Data analysis	Qualitative content analysis	Qualitative content analysis

5.2 Data collection and participants

Data collection was first carried out through participant observations of the work of the nurses. The participant observations were conducted first to prevent any possible influence from the interviews on the nurses' actions in practice. After the observations at different workplaces, individual interviews with the nurses were conducted

Purposeful sampling of five child healthcare centres in the west of Sweden was carried out in areas with different contexts. The aim was to obtain as broad a selection as possible to ensure variation within primary healthcare, both private and public. The child healthcare centres were situated in either urban or rural areas and in both socioeconomically vulnerable and wealthy contexts. The number of nurses in the child healthcare workplaces varied from two to six. Eight child healthcare centres were invited to join the project, but three of their managers were not reachable. Five agreed to be part of the study project.

Data collection **for Paper A** was conducted from 5 October 2022 to 9 February 2023. Fourteen nurses were invited by the observer via telephone or e-mail, and

12 agreed to participate in the observational study. The inclusion criteria were that participants should be registered nurses specialised in either paediatric nursing or in public health nursing. Table 2 presents an overview of the participants' characteristics. Informed consent was obtained from all participating nurses prior to data collection. The mean length of experience working with children and families in child healthcare practice was 8.17 years. The participants were aged between 36 and 60 years, with a mean age of 49 years. All 12 participants were pseudonymised.

Table 2. Overview of the participants, Paper A.

Participant	Specialisation	Years of experience
Alice	Public health	11
Brita	Public health	12
Cornelia	Public health	6 months
Dagny	Public health	20
Ebba	Public health	13
Fredrika	Public health	18
Gudrun	Paediatric nurse	5 months
Hildur	Paediatric nurse	2
Ida	Public health	3½
Jessica	Paediatric nurse	4
Kajsa	Public health	4½
Lovis	Paediatric nurse	10

Each observation was conducted in the nurses' consultation rooms for children and families. The nurses' work tools, such as a desk computer and telephone,

were present in the room. During telephone calls, it was not possible to observe interactions directly; only the nurses' responses could be observed.

All families received verbal information about the study from both the nurse and the observer. They were also provided with written information explaining the study's purpose and informing them that they could withdraw at any time. The written information also stated that the results would be published in a scientific journal and that no individuals would be identified.

The observer sat on a chair, mostly positioned in a corner behind the child and family, to remain discreet and minimise disruption to the encounter. Each observation began with the nurse, after which the observer sought permission from the families to continue observing the encounter. The observations included 23 health visits, 17 phone calls and 9 team visits involving both a physician and a nurse, giving a total of 49 observations within 31.5 hours (Table 3).

When necessary, informal conversations were held after the observation to clarify unclear situations (Polit & Beck, 2021), supporting a better understanding of the context. Handwritten field notes were used as aide-memoires and were written at rather high speed during the encounters and observations.

Table 3. Overview of the observations, Paper A.

Type of observation	**Number of observations**	**Hours of observation (h)**
Health visit Nurse	23	20
Phone calls Nurse	17	4.5
Team visits made by nurse with physician	9	7

For **Paper B**, individual interviews were conducted between 5 October 2022 and 9 February 2023 at the same five child healthcare centres that participated in the observation study. Fourteen nurses were invited to be part of the study, and all agreed both verbally and in writing, compared to the 12 nurses who participated in the observations. The participants had between 5 months and 20 years of experience working in child healthcare practice, with a mean of 7 years and 10 months. They were aged between 36 and 60 years, with a mean of 49 years and 10 months. To maintain anonymity, all participants were given different pseudonyms from those used in the observation study (see Table 4). The first author interviewed all participating nurses. An interview guide was followed, and the interview questions were created and discussed by all authors. The first question was open: 'What does health mean to you?' The next was 'What does it mean to you as a nurse to work with children and families to promote health?' Each interview took place at the nurses' workplace in a private room to ensure confidentiality. The interviews lasted between 24 minutes and 1 hour and 8 minutes, giving a total of 8 hours and 47 minutes (mean 37 minutes).

Table 4. Overview of the interviewees, Paper B.

Participant	Specialisation	Years of experience
Amanda	Public health	11
Betty	Public health	12
Clary	Public health	6 months
Dorothy	Public health	20
Ellen	Public health	13
Felicia	Public health	18
Ruth	Paediatric nurse	5 months
Helena	Paediatric nurse	2
Ingela	Public health	3½
Jennifer	Paediatric nurse	4
Kristina	Public health	4½
Lilly	Paediatric nurse	10
Madeleine	Public health	7
Vera	Paediatric nurse	4

5.3 Data analysis

The nurses' health promotion work was observed during encounters with children and families. The nurse, the child, and the family were present during the participatory observations. Fieldnotes with pre-prepared headings, such as the observer's own emotions during the observation and the appearance of the room, were used to document the situations and various actions that occurred during the encounter. Follow-up informal conversations were conducted after the observation (Lindgren et al., 2020) when necessary to clarify aspects of the

observed situation (Pilhammar & Skyvell Nilsson, 2017). Qualitative content analysis, following Graneheim et al. (2017) and Graneheim and Lundman (2004), was used to analyse data from the participatory observations, field notes and transcribed informal conversations, as well as data from the individual interviews. This method was chosen as it highlights differences in communication and facilitates the identification of patterns and themes (Graneheim & Lundman, 2004; Graneheim et al., 2017; Lindgren et al., 2020).

The analytical process began in the same way for both **Papers A and B**. The first step involved becoming familiar with the text and gaining an overall understanding. The next step was to divide the text into meaning units related to both the aim and the context. Then, codes were created from these meaning units while retaining the manifest content. The codes were discussed within the author group and subsequently organised into subcategories and categories (see Table 5 for Paper A and Table 6 for Paper B). The categories were abstracted from the manifest content in relation to the study aim, after which an overarching theme emerged, aligned with the steps described by Graneheim and Lundman (2004).

Table 5. Example of the analysis process, Paper A.

Meaning units	Condensed meaning units	Code	Subcategory	Category
"The child should receive treatment with a laxative for as long as she needs it." *(Alice)*	The child should receive treatment for as long as she needs it	Information about treatment	Sharing to learn	Decision-making

Table 6. Example of the analysis process, Paper B.

Units of meaning	Condensed units of meaning	Code	Subcategory	Category
"To make visible whether the parents are annoyed with each other, what is behind it, that you take and tell what you see and hear". *(Amanda)*	Making visible from what you see and hear whether the parents are annoyed with each other	Making visible what you see and hear	Identifying the needs of the family	Finding opportunities to influence and promote health

6 Ethical considerations

The study obtained ethical approval from the Research Ethics Committee in Sweden (registration number 2022-03858-01). Both Papers A and B followed the ethical principles of the World Medical Association Declaration of Helsinki (2024). Potential risks and consequences of participating in the project included possible feelings of discomfort. The observer was prepared to intervene and stop the interview if discomfort occurred.

Regarding data collection in **Paper A,** visiting families were given verbal information about the study, offered written information about the study and informed that they could withdraw at any time. Although families were part of the observation, the focus was on the participating nurses. As the observer, I was positioned in a corner behind the child and family, which allowed me to remain unobtrusive while taking field notes during the observation. In preparation for the participant observations, I developed awareness of the potential ethical dilemmas in this setting, and before the study started, I was mentally prepared to stop any observation that seemed to harm the observed child. During one observation, a situation arose in which there was a potential risk of unnecessary harm to the child. At that point, I had the choice to continue observing or stop the observation. I also had time to reflect, as it was initially unclear whether the nurse would proceed with the procedure prescribed by the physician, despite some hesitation. The nurse subsequently informed the parent that the procedure needed to be carried out due to the physician's prescription and prepared to proceed. Given the perceived risk of unnecessary harm, I chose to stop both the procedure and the observation. The nurse responded immediately, stepped back and informed the parent that the procedure would not be continued. I informed the nurse that we would speak after the encounter had concluded, which we did.

During our conversation, I clarified that the observation was not part of the data collection process.

For **Paper B,** the participants received both verbal and written information about the study and provided written consent. Two more nurses agreed to be interviewed rather than to participating in the observations. The interviews were conducted individually in a private room with the participant nurse, where the door could be closed to maintain privacy and create a feeling of security. At times, it was apparent that the participants had a tight schedule; nevertheless, they seemed motivated to be interviewed and eager to answer the questions, suggesting that it was important for them to have their voices heard. Their tight schedules, however, might have affected the interview duration. After the interviews had been conducted and transcribed, one participant's response was found to be unclear, whom I contacted by phone for clarification. We had a conversation about the answer and shared understanding of its meaning. To gain a deeper understanding during the interviews, I also relied on my own preunderstanding as a former nurse in child health service when formulating follow-up questions, particularly in situations where the participants' responses required further clarification.

7 Results

The result of Paper A showed that health promotion, as a professional competence, is a craft of interaction for caring and mutual learning. The contribution of Paper B was to highlight the importance of nurses having time for reflection in order to maintain self-awareness and support professional growth for continuous learning.

7.1 Paper A

The results are described under one overarching theme: *health promotion as a professional competence is a craft of interaction for caring and mutual learning.*

The description proceeds from the categories identified in the findings. The first category, *creating trust and support*, describes how nurses use their competence to build relationships with the child's family. The nurses paid attention to each family to establish and maintain trust. The observations showed that nurses welcomed families from their very first meeting in the waiting room, helping them feel seen and heard, with a focus on their well-being. The process of obtaining information often started in the waiting room itself. When the nurses escorted families to the visiting room, they occasionally encountered challenges in establishing meaningful relationships. In certain situations, barriers emerged that hindered these interactions, such as a lack of mutual understanding or ineffective communication between the nurse and parent. For instance, the absence of active listening on either side could disrupt the relationship. Additionally, a mother's postnatal condition could affect her ability to engage, making her less receptive to the nurse's guidance. This, combined with time constraints in the nurses' schedules, often led to heightened stress levels.

The second category, the *nurses' decision-making processes*, was shaped by their insights and the information gathered through interactions with families. Engaging the child and gaining their attention were essential for establishing the foundation for effective communication and cooperation. This initial engagement was crucial for beginning the assessment process in a manner that felt safe and respectful for the child. The nurses' skill and ability to cooperate with the child were important for achieving reliable and assessed outcomes. Sometimes, parents needed to be involved in the interaction by helping the child. Once interaction between the nurse and child had been established, it went at a fast pace to sustain the child's full attention. Nurses used various strategies to engage the child, such as role-play or toys, such as a doll or a car. Engaging with the child was essential, as it enabled meaningful observation of their behaviour. Through this connection, nurses could gain valuable insights into the child's emotional state, responses and overall well-being, information that was vital for guiding further assessment and support. The observations also showed that interaction with babies required different approaches from those used when interacting with older children. The nurses often stood in front of the baby at the changing table, making eye contact when speaking to them. They received a response and a smile almost every time. The parents frequently began talking to the baby in the same way as the nurse, using a positive tone of voice. This outcome showed a positive side-effect whereby nurses' individual interaction skills not only supported professional assessment but also promoted empowered parenting. The phone calls seemed to follow a similar pattern of knowledge exchange as health visits, as the nurses' questions about well-being came directly after the greeting. It was easier for the nurses to get to the core of the problem during telephone conversations, where the parents' description of the problem led to the nurse supporting them on how to handle the problem.

Both the nurses' professional knowledge of children's health and development and the parents' knowledge of the child's unique needs were considered valuable

and needed to be shared. The outcome of this sharing emerged from communication and a mutual understanding. In a reciprocal relationship, the parties listened to each other and shared their knowledge and experiences. A further finding was that the nurses seemed to be self-aware when they lacked knowledge, since they always seemed to have a plan for how to obtain it. Collaboration with colleagues was also important in forming a plan for further action to support the child's well-being.

The third category, g*uiding parents*, reflected the creation of a trusting relationship for empowering parenthood. Setting boundaries was one way in which the nurses guiding the parents. For example, during a phone call, a parent might request medication for a child's symptoms that the nurse considered inappropriate, requiring the nurse to decline the request. Another situation could concern setting boundaries for a sibling who took attention away from the child to be examined. In this way, the nurse showed the parent that it was acceptable to set boundaries when needed.

One way to maintain relationships with families was to give them a summary of the encounter and a plan of further action to move forward. Often, the parents were given choices so they could decide for themselves, such as whether further contact was needed, and if so, when. Considering local guidelines, such as when a mother did not feel well after giving birth, the nurses used their professional competence to follow guidelines and provide the needed support.

In summary, the findings showed that the participating nurses used their professional competence to promote health in encounters with the children and their families, as the process of interaction drove health promotion. The process of interaction itself was a healthy learning process through which the nurses continuously developed competence through their engagement in dynamic, healthy learning processes. Moreover, they learned how to carry out these

processes better because of regular interactions, which further highlights the existence of a CoP.

7.2 Paper B

The results are captured in one overarching theme: *tuning in and adapting the support for the family in the best interests of the child.*

The first category, *finding opportunities to influence and promote health,* reflected the profound opportunity to be part of shaping the children's healthy future. It highlights how nurses viewed their work as meaningful and saw themselves as having the ability to affect children's development in their best interests as well as for a healthy outcome. The nurses experienced the encounters as times when they could use skills such as active listening and showing patience to ensure the child and family gained a sense of security and trust. A relationship and open communication were necessary to include all the members of the family, make the family feel comfortable enough to ask questions, even about difficulties, and identify the child's needs.

Among the challenges that the nurses faced during the encounters were parents who did not want any advice at all, which some nurses understood as insecurity in parenthood. In such cases, it was harder for the nurses to identify risk factors, but they had several strategies to handle this, such as sharing the information that all vaccinations are important. The nurses' tight schedules were another obstacle to handle; when time was tight, the younger children were prioritised, and sometimes, the nurses forgot to take a break.

The nurses are skilled in providing tailored health promotion advice and encouraging parenthood to make the parents feel secure and believe in their own parenting skills, thus strengthening their own resources, confidence, and decision-making.

The second category, *growing in your work*, highlighted that the nurses believed that they could rely on their own professional experience as a way to grow in their work. They used their professional experience to share knowledge and learn from their experiences. It was important to have reflection time during and after encounters for learning.

The nurses' own professional experience contributed to a sense of confidence, even in situations where they lacked specific knowledge. They recognised that their experiential learning expanded through encounters with diverse family constellations. At times, previous professional experiences could evoke emotional responses, especially when situations mirrored past challenges. This emotional awareness, combined with intuition, such as a gut feeling that something was not quite right, played a crucial role in their assessments. The ability to draw on and adapt their experience to the unique circumstances of each child and family was seen as essential in providing sensitive and effective care.

The adaptation of the knowledge came from sharing information in the interactions that occurred during the encounters. On some occasions, the parents could not receive all the knowledge at the same time, so the nurses needed to share it in small doses over several encounters. Body language was also important during the sharing. Some nurses talked about considering parents' emotions during the encounter so they could relieve them of a burden through active listening.

The third category, *The need for organisational support,* was about the need of the manager´s engagement of the environment such as the importance of reflection time as a resource and tool was significant. An example showed that when the nurses kept their emotions to themselves, there was a risk that these emotions returned after work. Therefore, organised reflection time was necessary. When the nurses had time for reflection before encountering a family, they felt that they both remembered and learned more. Another reason for organised reflection time

was that it allowed the nurses to share knowledge with colleagues to enable mutual learning. The lack of time for reflection led to their grabbing a colleague if they needed to talk about difficulties. The nurses also believed that reflection time and its outcome, namely, growing together with colleagues, could lead to necessary changes in the workplace.

The need for managers to be engaged reflected the need for organisational support. In some situations, the nurses needed to feel the manager's support for them as nurses. One way to offer such support was to give the nurses regular reflection time.

Help could be needed from an external service due to worries about a child. When no help was received from external services, such as social services, the nurses felt frustrated. External support could also come from the Central Child Health Service Unit, which offers training and regular encounters for nurses in the west of Sweden and which the nurses considered a support for the nurses working in Child Health Service.

The results show that networking for the best interests of the child concerned collaborating with others to strengthen health promotion work around the child and family. Preschool was considered a collaboration partner to understand and see the child's needs from different perspectives.

In summary, paper B demonstrates that using learning processes to promote a more positive and healthier outcome that is in the child's best interests involves a commitment to continuous personal and professional growth. By reflecting on experiences, integrating new knowledge, and actively addressing challenges in everyday practice, nurses strengthen their ability to meet the needs of children in a supportive and health-promoting way. This process requires self-awareness and collaboration, where learning not only benefits the child but also contributes to a sustainable and evolving work environment for staff. Working in child healthcare

practice means constantly adapting to change, managing complex situations, and maintaining a clear focus on the child's best interest – a journey of ongoing learning.

7.3 Synthesis of results

Becoming aware of their own learning processes increases nurses' opportunities to develop professional competence, since they are continuously engaged in healthy learning through interactions. The process itself was viewed as a form of health promotion emerging during encounters at the child healthcare centre, where WIL served as a pedagogical tool. By integrating theoretical knowledge with practical experience, the nurses needed to use both skill and ability in certain situations, for example, when cooperating with a young child to achieve a reliable assessment of the child´s development and behaviour. In such situations, the nurses drew upon theoretical knowledge while simultaneously relying on experiential knowledge developed through practice. Through interactional processes involving communication, shared understanding and care for the relationships, the nurses sought appropriate ways to respond to the child´s behaviour. In this way, learning became possible, emerging as a healthy learning out of the interaction process. The findings showed that engaging the child and gaining their attention were essential. In this way, WIL facilitated meaningful learning within everyday practice.

The outcome of mutual learning through regular interactions also underscored the importance of establishing a CoP, which fosters shared reflection, collective competence and continuous development. This reinforces the value of collaborative learning in promoting both professional growth and child well-being. If the nurses were unable to integrate theoretical knowledge and practical experiences as equally important components of practice, there was a risk of children's unique needs and rights to support being overlooked. A lack of external support for nurses proved frustrating, particularly in situations where a child

needed additional assistance. The absence of timely help from other services often left nurses feeling constrained, especially when their own tight schedules limited the time available for meaningful interactions. These time pressures became a barrier to achieving positive outcomes during encounters, highlighting systemic challenges that hinder holistic and responsive care. For example, the nurses sometimes forgot to take breaks, and lack of time for reflection was described as very common. If reflection opportunities were available, they typically involved sharing experiences with a colleague, either immediately when needed or within a group setting. The nurses described reflection time as contributing both to improvements in workplace practice and the development of their own learning from experiences such as relieving emotions.

The nurses' experiences of child health promotion work reflected their use of competence and learning to attune to the child's and the family's needs in an adaptable manner. Awareness of one's own competence signifies an ongoing process of self-directed learning and professional development. This reflective understanding enables individuals to identify areas of strength and growth, thereby fostering continuous improvement and adaptability within their practice. These findings demonstrate the integration of theory with practice, that is, WIL, which is an important tool used in both the learning process and the development of continuous learning.

8 Discussion

WIL within child health service in a child healthcare setting reflects the principles of Wenger's (1998) CoP, where learning is situated, social and embedded in everyday professional activity. Nurses engage in meaningful interactions with children and families, applying their clinical competence and using communication as a central tool to identify contextual factors and tailor support to individual needs. These encounters become more than routine; they serve as opportunities for experiential learning and knowledge exchange.

According to Wenger (1998), a CoP is formed through mutual engagement, a joint enterprise and a shared repertoire. In this context, nurses collectively develop and refine their professional knowledge through shared experiences, reflective dialogue and collaborative problem-solving. WIL thus becomes a dynamic and reciprocal pedagogical process in which theory and practice continuously inform one another, and professional development is sustained through participation in a learning community.

8.1 Understanding health promotion and the interaction process

The results of paper A indicate that the overarching theme of *health promotion as a professional competence is a craft of interaction for caring and mutual learning* conceptualises health promotion as both the work and craft of nurses. Interaction is important in encounters, as it is through interactions that relationships are established, which form a prerequisite for nurses' daily work in child healthcare centres (Bohlin et al., 2022; Eklund et al., 2022; Langeland et al., 2022).

The categories from the participatory observations show that learning and the positive outcomes of encounters are dependent on the interactions among the nurse, child and family which indicates that the process involves a form of healthy learning emerging from health-promoting work. Learning requires a reciprocal relationship where both parties listen to each other, since collaboration with parents is a prerequisite for integrating practical and theoretical knowledge and for making a professional assessment of the child.

Barriers to maintaining a child-centred focus included limited time and tight schedules, which made it difficult for the nurses to treat theoretical and practical knowledge as equally important components in the creation of new understanding and learning—an approach emphasised within the concept of WIL. When these forms of knowledge were not given equal consideration, there was a risk that the child's right to appropriate support could be overlooked.

In such circumstances, the aim of the child health services framework—including relevant legislation, guidelines and routines, namely that all children have the right to equal treatment—cannot be fulfilled (Reuter, 2023; SFS 2017:30; Socialstyrelsen, 2014). The finding that there is an increased risk of failing to achieve these aims, or to ensure equal treatment within child health service, shows the importance of reflective practice, both in action and on action (Schön, 1983), to avoid situations where children's needs and rights may be neglected (SFS 2017:30; SFS 2018:1197). Therefore, the finding that a pedagogic tool such as WIL is needed is important for child healthcare nurses' continuous learning, to safeguard children's needs and rights and to ensure the use of experience-based knowledge in practice.

The importance of the interaction process within learning is reflected in the theme as a *craft*, as the nurses build interaction through the establishment of trusting relationships. Health promotion, understood as a shared learning and interaction process, is in line with the Ottawa Charter (WHO, 1986), which states that health

promotion is both a resource and a process to improve health (WHO, 2008). Shared learning is dependent on a healthy learning process (Lindström & Eriksson, 2011), and WIL is seen as a pedagogic tool to understand health promotion work (Pennbrant & Svensson, 2018).

In child healthcare centre as practice, the meaning of *child health promotion care* would improve and strengthen the outcomes of health promotion work of nurses´ daily work.

Support for parents as health promotion care could concern empowering parenthood (Socialstyrelsen, 2014). Often, the parents were allowed to decide for themselves, such as when a new contact was needed. Leaving such decisions to the parents showed confidence and trust in their parenting, which increased the chances of empowering them.

The observations indicated that nurses are dependent on parents' knowledge of their children and on their collaboration during the assessments. Being proactive as nurses, inviting the family as valuable partners (Benzein et al., 2023; Benzein et al., 2008b), and empowering parental confidence to be active in shared decision-making as collaborative partners reflect an increasing chance of changing the traditionally hierarchical power dynamics between nurses and parents. In child healthcare centres, the nurses' professional expertise has often positioned them as dominant figures in the encounter, potentially limiting parental agency and participation. However, as shown in research by Delmar (2012) and Reeder and Morris (2021), there is an increasing emphasis on relational approaches that promote mutual respect, shared decision-making, and collaborative care.

By fostering open communication and recognising parents as knowledgeable partners in their child's well-being, the power order begins to flatten. This evolving dynamic supports a more inclusive and empowering model of care,

where expertise is not imposed but shared, enhancing trust, engagement, and ultimately, health outcomes.

The child-centred focus was shown in health promotion since parents were empowered to improve outcomes for the child, and active listening and building trust and relationships were part of providing tailored care and support as well as ways to use the nurses´effective communication competence, which aligns with the performed knowledge, hence the knowledge is not static but performed and enacted through actions and interactions (Fenwick, 2006). The skill of communication was used to build trust during encounters and can thus be seen as what Säljö (2014) calls a resource of mediation: a tool to use for knowledge and learning. An example could be when the nurse needed to normalise some concerns such as when the child wore dirty clothes coming from preschool to the centre or developmental issues such as no visible teeth – were not a cause of worry and took the focus off the child.

Therefore, the outcome of Paper A positions WIL as a pedagogical work-integrated learning tool that aligns with the perspectives of Pennbrant and Svensson (2018) that offers a framework for understanding health promotion and the interaction process in child health service as forms of *healthy learning,* where learning itself becomes a vehicle for well-being. Within this context, WIL supports the development of knowledge grounded in everyday practice, emphasising the integration of theory and experience. For child healthcare nurses, this approach becomes a means to enhance both individual learning and professional competence (Björck & Willermark, 2024; Högskolan Väst, 2023). It encourages reflective practice (Schön, 1983), continuous development, and a deeper understanding of the complexities involved in promoting child and family health.

8.2 A community of practice as learning environment

The results of paper B highlighted the overarching theme *tuning in and adapting the support for the family in the best interests of the child,* reflecting the nurses' inclusive attitude to each family's unique situation. Using their inclusive skills, the nurses practised active listening through the interactions. Their personal resources, that is, patience, tact, and tacit knowledge, strengthened both the children's and the families' own resources. The chance of a healthy outcome thus increased since the nurses' way of listening (tuning in to the needs of the families) enabled them to adjust and give tailored support. The nurses used themselves as tools in their health promotion work to meet the aims of child health service. The findings also highlighted that workplace conditions can strengthen or weaken sense of coherence due to the ability to tune in to the unique needs of the child and family. Inadequate knowledge-sharing may lead to a failure to adapt support in the child's best interests. To maintain awareness of competencies, reflection time is needed for continuous professional development. The results also show the importance of becoming aware of one's own competences and the possibilities of learning to achieve healthier outcomes for children. The development of effective learning strategies requires ongoing learning, as the underlying prerequisites are in constant flux (Hutchings & Jarvis, 2012; Tynjälä, 2008).

The need for organisational support was about the managers engagement as well as the access to external resources, such as social services, were expected to support children when the nurses asked for help. When they could not give the expected support, the nurses felt frustrated. Another risk of ethical stress for the nurses occurred in encounters with non-receptive parents or when there was no time for breaks, which made it hard to develop learning, as there was no time for reflection. Lack of time in their schedules was also an important factor in nurses' clinical work, since it could lead to their neglecting the rights of children. An

important reason that children should not be neglected is that they will experience future visits in child healthcare centre in a positive way (Sahlberg et al., 2020).

Since the factors of developing a sense of coherence as a general resistance resource, seem crucial for nurses in child health service to avoid ethical stress and the risk of missing a child's needs, every child healthcare practice should be responsible for creating a learning environment for developing a sense of coherence. According to Article 3 of the UN on the "Rights of the Child", all children have the right to be treated as the primary concern in their best interest (SFS 2018:1197).

Therefore, tight schedules must be avoided so that nurses can develop and feel a sense of coherence and have the time needed for reflection on their experience. Not having the opportunity to reflect on experiences could also lead to supposed good intentions to treat parents the way a nurse expressed she wanted to be treated herself, which shows a normative way of encountering the families. Instead of tuning in the unique needs of the families, the nurse tuned them out which highlights the importance of being aware of nurses´own norms and values as given norms may exclude instead of including. This finding aligns with the study of parent groups in child health service and the reasons for not being part of them (Forslund Frykedal et al., 2019).

There was awareness of the nurses' need to reflect to develop their professional growth. Instead of missing reflection time, they spontaneously grabbed a colleague when the need for reflection arose. Reflection to develop competences and professional skills is very important for both experiences in-and on-action (Schön, 2003). This situation reflects the nurses' flexibility as regards handling concerns and solutions by themselves, but also the need for time in their schedules so they can safeguard the rights and interests of children, as found by a previous study (Sahlberg et al., 2020).

The capacity to learn is closely linked to health development and the strengthening of an individual's sense of coherence as a general resistance resource (Nilsson & Lindström, 1998). In this context, the learning process itself is viewed as health-promoting and is conceptualised as *healthy learning* (Lindström & Eriksson, 2011).

The sense of coherence consists of *comprehensibility*, which, in a child–parent relationship, includes responsive interaction between the young child and parents and serves to make reality understandable. *Manageability* refers to life as constraining stressors and difficulties that humans must learn to handle. *Meaningfulness* concerns feeling part of a social community, understanding our surroundings and being understood, which aligns with the results that the nurses feeling meaningfulness of their health promoting work and also part of a CoP. The ability to mobilise one's GRRs is closely connected to the development and preservation of a sense of coherence, which supports the maintenance and enhancement of health (Antonovsky, 1979, 1987).

WIL could serve as both a tool and a pedagogical approach to prepare nurses for health promotion work in child health service. The results indicated that nurses require collaboration with other professionals to complement and further develop their competence and expertise. A group of people who share common concerns and deepen knowledge through interaction, understood as a community of practice (Lave & Wenger, 2005), increases the likelihood that nurses in child healthcare centres will develop and maintain their professional expertise. WIL could therefore serve as a pedagogical tool in preparing nurses for health promotion work in child health service.

8.3 Self-awareness and development of clinical competence

The project reflects WIL as a pedagogic tool used in learning processes. The process itself was considered a health promotion, with WIL functioning as the pedagogical tool within the interactive learning process.

The importance of the interaction process, mentioned in the theme as a *craft,* includes different layers of the three '-ing' concepts, namely caring, knowledge-sharing and learning, all of which are interdependent and shaped through the interaction process. To emphasise the significance of interaction and the health promotion process as healthy learning, the neologism *interactioning* could be used. This term explains how a healthy outcome of interactions within child healthcare centres leads to the development of caring, knowledge-sharing and learning. Nurses develop their competence while engaging in these healthy learning processes, sharing concerns through *interactioning* and continuously improving their practice through interaction. The findings from Paper A indicate that learning through interaction is contingent upon treating practical and theoretical knowledge as equally important. When this balance is not maintained, the process is disrupted and does not develop into genuine interaction-based learning. The findings from Papers A and B further highlight that decision-making decisions both in and on action requires reflective thinking, and that in such moments, nurse may turn to colleagues to exchange knowledge when needed.

These findings highlight the importance of working within a community of practice, as described by Lave and Wenger (2005), where learning emerges through mutual engagement and interaction around a shared domain of interest.

The results in Paper B also show that despite a lack of time, the nurses understood the value of reflection time for sharing knowledge and learning together (Lave & Wenger, 2005; Schön, 1983). The concept of a CoP, as reflected in the findings, illustrates the collaborative dynamics within child healthcare centres, where

professionals collectively address shared concerns. This interpretation resonates with the work of Patrick et al. (2008) and aligns with Wenger's theoretical framework, which conceptualises learning as a socially situated process. According to this view, learning emerges through active participation in a community, where members engage in shared practices, foster mutual engagement and develop a common repertoire of knowledge and tools (Wenger, 1998; Wenger-Trayner & Wenger-Trayner, 2015). Although time constraints were common and few nurses reported having established routines for reflection, those who did described them positively and valued managerial support and engagement in their work. From a sociocultural and socioconstructivist standpoint, the findings show that knowledge is developed through active social engagement and the exchange of ideas (Säljö, 2014).

Lave and Wenger (2005) described learning as a process of situated activity in which people interact, which involves individuals in both specific activities and social communities. The interactions are understood as a co-constructed process between the individual and the environmental context (Ellström, 1992; Säljö, 2005, 2014). The interaction between the individual and the societal collective is important, as learning emerges through the development of insights, knowledge and skills. These are shaped through interactions and, as such, retained at the individual level as personal experiences that constitute competence. To understand how learning occurs, it is important to identify skills and competences within a workplace, as the organisation can facilitate knowledge-sharing, skills development and adaptation to new challenges (Säljö, 2005, 2014).

Nurses' clinical practice and awareness of how their *child health promotion care* works in the interactional process of encounters increase the likelihood of positive outcomes for the child, the family and the nurse. Awareness of how nurses use themselves as instruments of their own competence, through skills, abilities and professional judgement, serves as a foundation for continuous and adaptable learning. This self-awareness fosters the development of clinical competence and

enhances the potential for positive health outcomes. Moreover, it strengthens a sense of coherence for both the nurse and the child, supporting general resistance resources as resilience and well-being within the caring relationship.

A crucial prerequisite for this process is the availability of time for reflection. As this issue seems to be linked to a sense of coherence, it is important for managers of healthcare centres to understand its significance. With organisational support, such as protected time for reflection, nurses in child healthcare centres can strengthen their sense of coherence, while their general resistance resources for managing demanding schedules may be enhanced, thereby contributing to a more meaningful workplace and improved outcomes for children's health. Reflective practice enables nurses to gain perspective on clinical situations, refine their approach and respond more effectively to the unique needs of each family. The quality of interaction and the ability to attune to the family's context are central to delivering tailored health promotion in the child's best interest. For learning to remain dynamic and responsive, structured opportunities for reflection must be embedded in practice, ensuring that professional development is both sustainable and aligned with the evolving demands of child healthcare settings. The need for reflection time should therefore be viewed as a requirement for adaptable learning that supports continuous development of competence (Ellström et al., 2008).

A healthy outcome is more likely when a sense of coherence is developed among the nurse, child and family. Nurses' awareness of their own developmental competence and learning processes reflects continuous professional learning. The nurses experienced their work in child healthcare centres as meaningful, as it provided opportunities to influence healthy outcomes in the best interests of children and families. They highlighted the importance of meaningful engagement, which enhanced the potential for developing a sense of coherence within their work in child health service. This, in turn, contributed to improved health outcomes and fostered a sense of coherence for both the child and the family, in line with previous research (Antonovsky, 1987; Lindström & Eriksson,

2006; Vinje & Mittelmark, 2006). Experiencing meaningful work may also strengthen nurses' own sense of coherence, which can function as a protective factor against stress. This strengthened sense of coherence may contribute to resilience and support nurses in remaining in the profession, even in the context of demanding workloads and the risk of ethical stress.

8.3.1 Model of epistemology and Work-integrated learning

Figure 2. Epistemology in child healthcare (CHC) centres according to Veronica Bohlin.

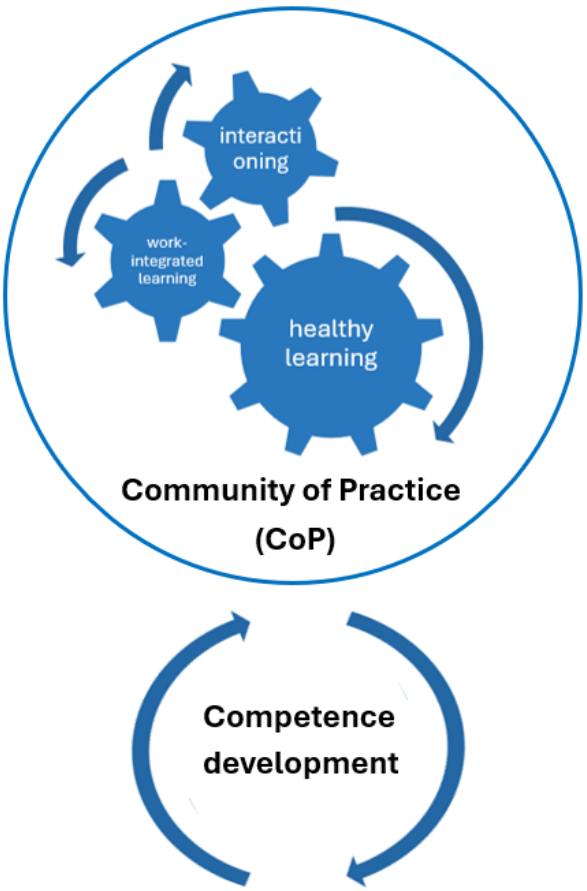

Figure 2 illustrates the epistemology within child healthcare centres, highlighting the dynamic process through which new knowledge is created for learning, according to the findings of the research project.

A ***community of practice*** functions as a framework for nurses within child health service. What individuals know and how they learn are shaped by the context of the CoP, where the environment and organisational culture act as learning resources. The child healthcare centre, as a practice setting, comprises a group of people who share a common concern and engage in situated activities through interaction around a common subject.

A way of relating to others – interactioning

– describes an encounter as a concrete experience, in action, and includes the development of different layers of caring, knowledge-sharing and learning; that is, the ***craft of being a child healthcare nurse***. Nurses use their professional competence to make decisions that involve reflection-in-action as a resource.

Health promotion – healthy learning. Healthy learning, as an outcome, emerges from the process itself becoming a form of health promotion. The process involves the creation of meaningfulness and the development of a sense of coherence through *comprehensibility, manageability and meaningfulness.*

WIL – is used to understand the learning process as a pedagogic tool that describes the integration of theory and practice. This integration enables adaptability and the development of competence towards a higher level of knowledge, thereby increasing the likelihood of positive healthy outcomes.

Competence development – Knowledge involves the skills and professional abilities that specialised child healthcare nurses use as resources to identify and make sense of learning opportunities. Reflection-on-action regarding experiences

enables the adaptable, adjustable and tailored support necessary for professional competence development, understood as a dynamic, mutual and continuous process emerging learning.

The model, presented in Figure 2, explains the learning process involved in creating new knowledge and conceptualises this process as dynamic and dependent on WIL as a resource, tool and pedagogical model. WIL, grounded in experience, theories and practical knowledge, together with nurses' professional competence in promoting health and well-being, is used within child health service to engage with children and families respectfully and to regard them as valuable partners, in line with the work of Benzein et al. (2008a). WIL is used to understand learning as the integration of theory and practice (Pennbrant & Svensson, 2018), thereby enabling positive health outcomes. A non-hierarchical and collaborative relationship must be established with the family (Benzein et al., 2008a), as it is necessary to understand and explore conditions and environments in as equitable manner as possible. Knowledge in this thesis is understood as being constructed by individuals within social contexts and in relation to others. Säljö (2014) described knowledge not only as shared but also as created through social contexts. This idea is in line with the CoP, where Lave and Wenger (2005) described groups of people sharing a common concern and where learning occurs through situated activity, interaction and participation in social communities. This process resembles the interactional activity observed during encounters within child healthcare centres. The encounter process itself could be understood as *interactioning*, through which caring and knowledge-sharing are constructed within a dynamic process of healthy learning.

Making decisions in action within child healthcare centres requires the competence to follow established aims, legislation and guidelines. Schön (2003) explained reflection-in-action as an interplay between concrete action and an interpretation of what is occurring within that action. Reflection can be integrated into the action itself and does not always occur consciously (Schön, 2003).

Individuals develop understanding through interaction with others and the use of communication as a tool. The use of language is central to Säljö's (2014) perspective, which shifts the focus from individual cognition towards the role of interaction and societal structures in shaping learning.

Ellström (1992) described competence development as emerging through learning (see also Ellström et al., 2008), where reflection is viewed as important and necessary for continuous learning. Ellström et al. (1996) indicated two forms of learning that contribute to lifelong learning: learning as an ongoing process that continues throughout life and learning that occurs within formal education as well as in working life through informal learning. Ellström (1996) regarded these two principles as complementary and essential for the development of both the individual and the organisation. A balanced approach that incorporates both adaptation and development is therefore considered necessary (Ellström et al., 1996).

The nurses' identification of factors surrounding the child and family is important for health promotion work from a salutogenic perspective. Health, understood as a spectrum ranging from complete health to ill health, moves continuously between these extremes throughout life as part of a dynamic process (Antonovsky, 1979; Lindström & Eriksson, 2010). According to Schön (2003), competence is also a dynamic and ongoing process, and nurses' continuous identification of factors provides an example of this.

The pathogenic perspective concerns advice and interventions aimed at disease prevention. Antonovsky (1987) argued that the salutogenic and pathogenic perspectives are complementary and both are necessary. The development of a sense of coherence comes from *comprehensibility, manageability, meaningfulness* and how to use one's GRRs to maintain or improve health (Antonovsky, 1979, 1987). The stronger the sense of coherence, the better the health (Eriksson, 2022; Eriksson & Lindström, 2006).

Child healthcare nurses' learning during encounters with children and families needs to involve reflection-in-action and decision-making, enabling the adaptable development of professional competence through tailored knowledge derived from experience.

9 Methodological considerations

My preunderstanding, as a nurse, includes a background specialising in paediatric nursing and a master's degree in nursing. A master's degree in public health is also worth mentioning, as understanding requires consideration of the whole context, and interpretation of findings is continually evolving throughout the analytical process, in line with Larsson (1993). Therefore, quotation was used in both parts of the study, as along with examples from the analytical process (Elo et al., 2014; Graneheim & Lundman, 2004; Graneheim et al., 2017), to strengthen credibility and demonstrate the steps taken to reach the findings (Elo et al., 2014; Graneheim & Lundman, 2004). My clinical experience includes approximately 17 years of work in child health service.

Both papers in this licentiate thesis were inspired by ethnographic research, understood as a process of learning *about* people by learning *from* them, in line with Roper and Shapira (2000). Ethnonursing research is described by Polit and Beck's (2021) as the study of human cultures, with a focus on the beliefs and practices of a group that relates to nursing care and health behaviours. The worldview underpinning the study adopts an ontological stance that can be described as constructivist, as knowledge is generated through interaction and through the meanings emerging through these encounters. This perspective reflects the two papers included in the research project (Brewer, 2000; Clark et al., 2021; Säljö, 2014).

Explorative, qualitative designs were chosen to explore how nurses in child health service use their professional competence to promote health in families with children and to describe their experiences of their health promotion work.

9.1 Paper A

The validity of paper A rests on the method chosen, namely participant observations, since this method reduces distance to the observed situations, which can hamper validity. Ethnographic tradition places great importance on sustained presence within the context being studied (Hammersley & Atkinson, 2019; Larsson, 1993). Since familiarity with everyday practice is necessary to support claims to validity, my preunderstanding as a nurse, together with my knowledge of how to interpret different situations, enabled me to be present and engaged during the participant observations (Larsson, 1993).

The participant observations were carried out at five child healthcare centres in western Sweden. The nurses' professional competence was examined during health visits, phone calls and team visits. Field notes were taken throughout each observation, following Pilhammar and Skyvell Nilsson (2017), and were structured using headings aligned with the study aim. When informal conservations were necessary, a recording device was used to capture all spoken information.

As a participant observer, I wore staff clothes and a name tag. I sat in a corner behind the child and family to avoid confusion caused by my presence. The focus and perspective were on the nurses' work, and my preunderstanding, shaped by many years of experience as a child healthcare nurse, could be a limitation in terms of the risk of non-intervention. However, the fast pace of the observations facilitated a focus on taking field notes rather than active participation during the encounters. On one occasion, I used my preunderstanding as a strength in relation to ethical principles, as I needed to stop an encounter to prevent a procedure that was not in the best interests of the child and could have caused discomfort. The nurse understood the reason for my intervention and informed the parent that the procedure would not be continued. However, this situation was not included in the data collection.

The study results are transferable to other contexts in child health service and can be used in both academic research and clinical practice by illustrating how nurses use their professional competence in health promotion work within child healthcare centres, as well as the importance of awareness of their professional competence.

9.2 Paper B

Qualitative interviews were chosen for paper B in line with the aim of exploring the participating nurses' experiences and perspectives on health-promoting work. All interviews were conducted in accordance with Kvale and Brinkmann´s (2014) description of the interview process as a craft involving different stages, in which knowledge is co-constructed through interaction between the interviewer and participant, as the interview represents an active form of knowledge production. The interviews were carried out at five child healthcare centres in western Sweden. The participants were informed about the interviewer's preunderstanding, and the interview questions were developed collaboratively by all authors of the study.

Since I was the interviewer and have specialised in both paediatric nursing and public health, there was a risk of conflating my perspectives with those of the participants during data collection. Despite this, my preunderstanding could also be seen as a strength since more specific questions could be asked. Therefore, it was important to discuss the different stages of the analysis process—moving from text to codes, subcategories and categories—with my supervisors.

An interview guide increases the credibility of the study, as the questions were developed with an awareness of my preunderstanding and were designed to elicit responses aligned with the study's aim, in line with Elo et al. (2014). A strength of preunderstanding is that the questions can be more detailed. However, the participants' responses may be interpreted too quickly, which can lead to

subsequent questions being marginalised or prematurely influenced (Graneheim et al., 2017; Sandelowski & Leeman, 2012).

All the interviews were recorded digitally since transcribing interviews verbatim confers greater credibility.

9.2.1 Limitations

In this study, only females were observed and interviewed, as only female nurses were employed in the selected child healthcare centres. The centres were chosen because of the need for as broad a sample as possible and to ensure variation, rather than based on the sex of the nurses. Another limitation is that both the observation and interview data were collected during the same period. The interviews could have been influenced by the observations that had already been conducted; however, to minimise the risk, the decision was made to carry out observations first.

10 Conclusion

The overall aim of this licentiate thesis was to explore how health promotion and professional competence are enacted and developed within the relational encounters between nurses and the families they engage with. The findings show that nurses maintain and develop competence at health promotion encounters through a dynamic process of interaction and *interactioning*, which includes different layers of '-ing': caring, knowledge-sharing, and learning, which are dependent on each other as well as on the process of interaction. WIL can then be considered a model pedagogical tool to use in learning processes, as the example of the *interactioning* process itself was considered health promotion. This WIL perspective fosters the integration of theoretical knowledge with practical experience to enable lifelong learning.

The development of nurses' professional competence highlights a community of practice, that is, they are engaging with interactions and sharing concerns from interactioning with each other. Learning from interactioning was dependent on regarding practical knowledge as equal to theoretical knowledge and needed reflection in-action and on-action for decision-making. The availability of time for reflection was crucial for the process, both for decision-making and for adaptable learning for developmental competence. Being aware of the learning processes will enhance the chances of continuous learning for nurses.

Becoming aware of how nurses improve themselves as instruments of their own competence is a foundation of continuous and adaptable learning. This awareness enhances the possibilities of healthier outcomes that serve a child's best interests, after which the chances of developing a sense of coherence increase for both the nurse and the child. Sense of coherence, as a general resistance resource for nurses, could improve staff retention in the face of ethical stress from tight

schedules. All managers should be aware of the importance of feeling that work is meaningful in child health service and strive to retain nurses' sense of coherence.

10.1 Implications and further research

As regards practical implications, the awareness of nurses' own health promotion work in child healthcare centre is important. *Interactioning* could be used to understand the process of what happens in *health promotion care* as a craft, that is, building caring, knowledge-sharing, and learning. Using WIL as a pedagogic model to understand the dynamic, mutual, and reciprocal process of *interactioning* shows a need for continuous learning about tuning in and adapting to the child's unique needs for adjustable support to ensure their best interests are met. It is hoped that the model of WIL shown in Figure 2 could contribute to a shared understanding of the *health promotion care* process as a learning process.

In future research, it would be interesting to see whether similar findings are made in regard to male nurses in child healthcare setting and their perspectives on how their professional competencies are used in health promotion work and how their learning is achieved. Can WIL *interactioning* and the mutual knowledge-sharing, understanding, and caring be seen differently from a male perspective? To my knowledge, no previous research has addressed this subject, so there seems to be a knowledge gap.

11 References

Antonovsky, A. (1979). *Health, stress, and coping*. Jossey-Bass.

Antonovsky, A. (1987). *Unraveling the mystery of health: How people manage stress and stay well*. Jossey-Bass.

Benzein, E., Hagberg, M., Persson, C., Saveman, B.-I., & Syrén, S. (2023). *Att möta familjer inom vård och omsorg: en samtalsmodell på systemisk grund* [Meeting families in health and social care: A conversation model based on systematic principles]. Studentlitteratur.

Benzein, E., Johansson, P., Arestedt, K. F., & Saveman, B. I. (2008b). Nurses' attitudes about the importance of families in nursing care: A survey of Swedish nurses. *Journal of Family Nursing*, *14*(2), 162–180. https://doi.org/10.1177/1074840708317058

Benzein, E. G., Hagberg, M., & Saveman, B.-I. (2008a). 'Being appropriately unusual': A challenge for nurses in health-promoting conversations with families. *Nursing Inquiry*, *15*(2), 106–115. https://doi.org/https://doi.org/10.1111/j.1440-1800.2008.00401.x

Billett, S. (2002). Workplace pedagogic practices: Co-participation and learning. *British Journal of Educational Studies,* 50(4), 457-481. https://doi.org/10.1111/1467-8527.t01-2-00214

Billett, S. (2016). Learning through health care work: Premises, contributions and practices. *Medical Education*, *50*(1), 124–131. https://doi.org/10.1111/medu.12848

Billett, S., & Choy, S. (2011). Cooperative and work-integrated learning as a pedagogy for lifelong learning. In R. K. Coll & K. Zegwaard (Eds.), *International handbook for cooperative and work-integrated education: International perspectives of theory, research and practice* (2nd ed., pp. 25–30). World Association for Cooperative Education.

Björck, V., & Willermark, S. (2024). Where is the 'WIL' in work-integrated learning research? *Studies in Continuing Education* 1-15. https://doi.org/10.1080/0158037X.2024.2378718

Bohlin, V., Nolbris, M. J., & Wigert, H. (2022). Child health care nurses' experiences of language barriers during home visits. *Public Health Nursing*, *39*(1), 146–152. https://doi.org/10.1111/phn.12977

Brewer, J. D. (2000). *Ethnography*. Open University Press.

Clark, T., Foster, L., Sloan, L., & Bryman, A. (2021). *Bryman's social research methods*. Oxford University Press.

Coyne, I., Hallström, I., & Söderbäck, M. (2016). Reframing the focus from a family-centered to a child-centred care approach for children´s healthcare. *Journal of Child Health Care,* 20(4), 494-502.

Coyne, I., Holmström, I., & Söderbäck, M. (2018). Centeredness in healthcare: A concept synthesis of family-centered care, person-centered care and

child-centered care. *Journal of Pediatric Nursing*, *42*, 45–56. https://doi.org/https://doi.org/10.1016/j.pedn.2018.07.001

Dahlborg, E. (2010). Praxis i vårdvetenskap [Praxis in Caring Science]. In S. Lagrosen, U. Lundh Snis, & E. Nehls (Eds.), *Lärande i och för det nya arbetslivet* [Learning in and for the new working life] (pp. 139–154). Studentlitteratur.

Dahlgren, G., & Whitehead, D. (2007). *European strategies for tackling social inequities in health: Levelling up Part 2*. https://iris.who.int/bitstream/handle/10665/107791/E89384.pdf?sequence=1&isAllowed=y

Dahlgren, G., & Whitehead, M. (1993). *Tackling inequalities in health: What can we learn from what has been tried?* [Working paper, London: King´s Fund, 1993] Accessible in: Dahlgren. G., Whitehead. M. (2007). European strategies for tackling social inequities in health: Levelling up Part 2. Copenhagen: WHO Regional Office for Europe.

Dahlgren, G., & Whitehead, M. (1991). *Policies and Strategies to Promote Social Equity in Health*. Stockholm, Sweden: Institute for Future Studies.

Delmar, C. (2012). The excesses of care: a matter of understanding the asymmetry of power. *Nursing Philosophy,* 13(4), 236-243. https: //doi.org/10.1111/j.1466-769X.2012.00537.x

Dewey, J. (1938). *Experience and education.* Macmillan.

Eklund, A. L., Jangsten, E., & Gunnarsdóttir, H. (2022). Assessing and promoting responsive interaction between parents and children – a qualitative study of the experiences of child health care nurses in Sweden. *Journal of Pediatric Nursing*, *63*, e95-e101. https://doi.org/10.1016/j.pedn.2021.10.006

Ekström-Bergström, A., Thorstensson, S., & Bäckström, C. (2022). The concept, importance and values of support during childbearing and breastfeeding – a discourse paper. *Nursing Open*, *9*(1), 156–167. https://doi.org/https://doi.org/10.1002/nop2.1108

Ellström, E., Ekholm, B., & Ellström, P.-E. (2008). Two types of learning environment: Enabling and constraining a study of care work. *Journal of Workplace Learning*, *20*, 84–97. https://doi.org/10.1108/13665620810852250

Ellström, P.-E. (1992). *Kompetens, utbildning och lärande i arbetslivet: problem, begrepp och teoretiska perspektiv*. Publica.

Ellström, P.-E., Gustavsson, B., & Larsson, S. (1996). *Livslångt lärande*. Studentlitteratur Lund.

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open*, *4*(1), 2158244014522633. https://doi.org/10.1177/2158244014522633

Engström, M., Hiltunen, J., Wallby, T., & Lucas, S. (2021). Child health nurses' experiences of addressing psychosocial risk factors with the families they meet. *Acta Paediatrica*, *110*(2), 574–583. https://doi.org/10.1111/apa.15492

Ersson, M., Henström, M., Almquist-Tangen, G., Hesketh, K. D., & Delisle Nyström, C. (2021). How to support child healthcare nurses in Sweden to promote healthy lifestyle behaviors from the start of life. *Children*, *8*(8), 696. https://doi.org/10.3390/children8080696

Fenwick, T. (2006). Learning as grounding and flying: Knowledge, skill and transformation in changing work contexts. *Journal of Industrial Relations*, *48*(5), 691–706. https://doi.org/10.1177/0022185606070112

Folkhälsomyndigheten. (2025). *The Public Health Agency of Sweden.* https://www.folkhalsomyndigheten.se/the-public-health-agency-of-sweden/

Forslund Frykedal, K., Barimani, M., Rosander, M., & Berlin, A. (2019). Parents' reasons for not attending parental education groups in antenatal and child health care: A qualitative study. *Journal of Clinical Nursing*, *28*(17–18), 3330–3338. https://doi.org/https://doi.org/10.1111/jocn.14912

Gilmer, C., Buchan, J. L., Letourneau, N., Bennett, C. T., Shanker, S. G., Fenwick, A., & Smith-Chant, B. (2016). Parent education interventions designed to support the transition to parenthood: A realist review.

International Journal of Nursing Studies, *59*, 118–133. https://doi.org/10.1016/j.ijnurstu.2016.03.015

Graneheim, U. H., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today*, *56*, 29–34. https://doi.org/https://doi.org/10.1016/j.nedt.2017.06.002

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Hammersley, M., & Atkinson, P. (2019). *Ethnography: Principles in practice*. Routledge.

Harder, M., Enskär, K., & Golsäter, M (2017). Nurses´use of pliable and directed strategies when encountering children in child and school healthcare. *Journal of Child Health Care* 21:55-64.

Hrybanova, Y., Ekström, A., & Thorstensson, S. (2019). First-time fathers' experiences of professional support from child health nurses. *Scandinavian Journal of Caring Sciences*, *33*(4), 921–930. https://doi.org/https://doi.org/10.1111/scs.12690

Hutchings, M., & Jarvis, P. (2012). The relationship between practice, theory and research. In J. Higgs, R. Barnett, S. Billett, M. Hutchings, & F.

Trede (Eds.), *Practice-based education: Perspectives and strategies* (pp. 175–186). SensePublishers. https://doi.org/10.1007/978-94-6209-128-3_13

Högskolan Väst. (2023). *De tre dimensionerna av AIL* [The three dimensions of work-integrated learning]. https://www.hv.se/arbetsintegrerat-larande/om-arbetsintegrerat-larande/tre-dimensioner-av-ail/

Illeris, K. (2009). Kompetence, læring og uddannelse – Hvordan læres kompetencer, og hvordan kan de udvikles gennem formaliseret uddannelse? [Competence, learning and education – How are competences learned, and how can they be developed through formal education?] *Nordic Studies in Education*, *29*(2), 194–209. https://doi.org/10.18261/ISSN1891-5949-2009-02-03

Illeris, K. (2018). An overview of the history of learning theory. *European Journal of Education,* 53(1), 52-65. https://doi.org// 10.1186/s12960-020-00491-x

Jolley, J., & Shields, L. (2009). The evolution of family-centered care. *Journal of Pediatric Nursing*, *24*, 164–170. https://doi.org/10.1016/j.pedn.2008.03.010

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development.* Prentice-Hall.

Kvale, S., & Brinkmann, S. (2014). *Den kvalitativa forskningsintervjun (Tredje upplagan).* Lund: Studentlitteratur.

Langeland, E., Ausland, L. H., Gunnarsdottir, H., Arveklev, S. H., & Vinje, H. F. (2022). Promoting salutogenic capacity in health professionals. In M. B. Mittelmark, G. F. Bauer, L. Vaandrager, J. M. Pelikan, S. Sagy, M. Eriksson, B. Lindström, & C. Meier Magistretti (Eds.), *The handbook of salutogenesis* (pp. 611–624). Springer.

Larsson, S. (1993). Om kvalitet i kvalitativa studier [On quality in qualitative studies]. *Nordisk Pedagogik*, *13*(4), 194–211. urn:nbn:se:liu:diva-32338

Lave, J., & Wenger, E. (1991). *Situated learning : legitimate peripheral participation*. Cambridge University Press.

Lave, J., & Wenger, E. (2005). *Situated learning: Legitimate peripheral participation*. Cambridge University Press.

Lindgren, B.-M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *International Journal of Nursing Studies, 108*, Article 103632. https://doi.org/10.1016/j.ijnurstu.2020.103632

Lindström, B., & Eriksson, M. (2006). Contextualizing salutogenesis and Antonovsky in public health development. *Health Promotion International*, *21*(3), 238–244. https://doi.org/10.1093/heapro/dal016

Lindström, B., & Eriksson, M. (2010). *The hitchhiker's guide to salutogenesis: Salutogenic pathways to health promotion*. Folkhälsan Research Centre.

Lindström, B., & Eriksson, M. (2011). From health education to healthy learning: Implementing salutogenesis in educational science. *Scandinavian*

Journal of Public Health, *39*(6_suppl), 85–92. https://doi.org/10.1177/1403494810393560

Mann, K., Gordon, J., & Macleod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Medical Education, 43(7)*, 595-621. https://doi.org/10.1111/j.1365-2923.2009.03344.x

Marmot, M. (2010). *Fair society, healthy lives: The Marmot Review*. T. M. Review.

Nilsson, L., & Lindström, B. (1998). Learning as a health promoting process, the salutogenic interpretation of the Swedish curricula. *Internet Journal of Health Promotion*, 14. URL:http://rhpeo.net/ijhp-articles/1998/14/index.htm.

Patrick, C. J., Peach, D., Pocknee, C., Webb, F., Fletcher, M., & Pretto, G. (2008). *The WIL (Work Integrated Learning) report: A national scoping study*. Queensland University of Technology.

Pennbrant, S., & Svensson, L. (2018). Nursing and learning – healthcare pedagogics and work-integrated learning. *Higher Education, Skills and Work-Based Learning*, *8*(2), 179–194. https://doi.org/10.1108/HESWBL-08-2017-0048

Pilhammar, E., & Skyvell Nilsson, M. (2017). Etnografi. [Ethnography]. In B. Höglund-Nielsen & M. Granskär (Eds.), *Tillämpad kvalitativ forskning inom hälso- och sjukvård* (3rd ed., pp. 65–83). Lund; Studentlitteratur.

Polit, D. F., & Beck, C. T. (2021). *Nursing research: Generating and assessing evidence for nursing practice*. Wolters Kluwer.

Reeder, J., & Morris, J. (2021). Becoming an empowered parent. How do parents successfully take up their role as a collaborative partner in their child´s specialist care? *Journal of Child Health Care,* 25(1), 110-125. https://doi.org/10.1177/136749520910832

Reuter., A. (2023). *Barnhälsovårdens nationella program* [The national child health care program]. https://www.rikshandboken-bhv.se/verksamhetsriktlinjer/barnhalsovardens-nationella-program/

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Sage.

Sahlberg, S., Karlsson, K., & Darcy, L. (2020). Children's rights as law in Sweden–every health-care encounter needs to meet the child's needs. *Health Expectations*, *23*(4), 860–869. https://doi.org/https://doi.org/10.1111/hex.13060

Sandelowski, M., & Leeman, J. (2012). Writing usable qualitative health research findings. *Qualitative Health Research*, *22*(10), 1404–1413. doi:10.1177/1049732312450368

Schön, D. A. (1983). *The reflective practitioner: how professionals think in action.* Basic Books.

Schön, D. A. (2003). *The reflective practitioner: how professionals think in action.* Arena.

SFS 2017:30. *Hälso- och sjukvårdslag* [Swedish Health and Medical Services Act]. https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag_sfs-2017-30

SFS 2018:1197. *Förenta nationernas konvention om barnets rättigheter* [Swedish law on United Nations Convention on the Rights of the Child]. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-20181197-om-forenta-nationernas-konvention_sfs-2018-1197/

Shorey, S. (2021). Health promotion among families having a newborn baby. In G. Haugan & M. Eriksson (Eds.), *Health promotion in health care – Vital theories and research* (pp. 173–184). Springer. https://doi.org/10.1007/978-3-030-63135-2_14

Socialstyrelsen. (2014). *Vägledning för barnhälsovården* [Guidance for child health care]. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/vagledning/2014-4-5.pdf

Socialstyrelen. (2025). *Nationell kartläggning av barnhälsovården- En jämlik och tillgänglig barnhälsovård* [National mapping of child health care – An equitable and accessible child health care].

SOU 2017:47. *Nästa steg på vägen mot en mer jämlik hälsa – slutbetänkande av Kommissionen för jämlik hälsa* [Another step towards an equal health]. https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2017/06/sou-201747/

SOU 2021:78. *Börja med barnen!: Följa upp hälsa och dela information för en god och nära vård* [Starting with the children]. https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2021/10/sou-202178/

Säljö, R. (2005). *Lärande och kulturella redskap: om lärprocesser och det kollektiva minnet* [Learning and cultural tools: On learning processes and the collective memory]. Norstedts Akademiska Förlag.

Säljö, R. (2014). *Lärande i praktiken: ett sociokulturellt perspektiv* [Learning in practice: A sociocultural perspective]. (3rd ed.) Studentlitteratur.

Truong, A. (2024). *Developing an educational intervention to support work-integrated learning among professionals in health and social care for individuals with intellectual disabilities* (Publication Number 65) [Doctoral thesis, comprehensive summary, University West] DIVA Trollhättan

Tynjälä, P. (2008). Perspectives into learning at the workplace. *Educational Research Review*, *3*(2), 130–154. https://doi.org/https://doi.org/10.1016/j.edurev.2007.12.001

United Nations (n.d.). *Transforming our world: The 2030 Agenda for Sustainable Development*. https://sdgs.un.org/2030agenda

Vinje, H., & Mittelmark, M. (2006). Deflecting the path to burn-out among community health nurses: How the effective practice of self-tuning renews job engagement. *The International Journal of Mental Health Promotion*, *8*, 36–47. https://doi.org/10.1080/14623730.2006.9721750

Vygotskij, L. S. (1978). *Mind in society: The development of higher psychological processes*. Harvard University Press.

Wallby, T., & Hjern, A. (2011). Child health care uptake among low-income and immigrant families in a Swedish county. *Acta Paediatrica*, *100*(11), 1495–1503. https://doi.org/10.1111/j.1651-2227.2011.02344.x

Wenger-Trayner, E. & Wenger-Trayner, B.(2015). *Communities of practice: A brief introduction.* https://www.wenger-trayner.com/introduction-to-communities-of-practice/

Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*. Cambridge University Press.

Whitehead, D. (2006). Health promotion in the practice setting: Findings from a review of clinical issues. *Worldviews Evidence-Based Nursing*, *3*(4), 165–184. https://doi.org/10.1111/j.1741-6787.2006.00068.x

World Health Organization. (1986). *Ottawa Charter for Health Promotion, 1986*. https://iris.who.int/handle/10665/349652

World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health, WHO.* http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

WMA. (2024). Declaration of Helsinki: Ethical principles for medical research involving human subjects. World Medical Association

Yardley, S., Teunissen, PW., & Dornan, T. (2012). Experiential learning: AMEE guide No 63. *Medical Teacher.* 34 (e), 102-115

Zgambo, M., Blamires, J., Foster, M., Al.Motlaq, M., O´Sullivan, T. A., Houghton, D., & Mörelius, E. (2025). Child and family centred care: A three-phased principle-based concept analysis. *Journal of Advanced Nursing,* 81(8), 4542-4565 https://doi.org//10.1111/jan.16846

Appendices

Appendix 1 2022-09-21Interview guide

Appendix 1

2022-09-21

Interview guide

The overall aim is to explore how health promotion and professional competence are enacted and developed within the relational encounters between Child healthcare (CHC) nurses and the families they engage with.

About health and health promotion work

- What does health mean to you?
- What does it mean for you, as a CHC nurse, to work with families in a health-promoting way?
- How do you promote health at your child healthcare (CHC) centre?
- Does your CHC centre have its own development projects to promote health?

Concrete examples

- Can you describe a visit/situation that had truly health-promoting content in which you were able to focus/prioritize health promotion work?
- Can you describe a visit/situation in which the health-promoting content did not work well?

  Based on the above examples:
- What was the core health-promoting content when you visited the family?
- Can you identify any obstacles to including health-promoting content?

About the family

- How can you make every family member feel seen?
- Do you see the family as a unit, or can you identify the different needs of the parents?
- Based on your experiences, can you determine which parent needs the most support?

- What could be the reasons for that?
- Can you describe how you provide concrete support to parents?
- Do you work in the same way with same-sex parents as with heterosexual parents?
- How do you work with single parents—do you think that they have special needs?

About learning and collaboration

- In what ways do you learn in encounters with children and parents?
- How do you relate to the knowledge shared during the encounter? Have you acquired any learning strategies from parents?
- Do you receive support in your health-promoting work in child health service (CHS)?
- In what ways and with whom do you collaborate regarding health promotion work at your CHC centre?
- What do you consider to be the benefits of working with families in a health-promoting way?
- Have I missed asking anything that you would like to add?

- Demographic data
- First and last name
- Age
- Are you a nurse specialised in public health or pediatric nursing?
- Year of graduation?
- Professional experience in child health service (CHS) as a specialised nurse?
- Private healthcare
- Public healthcare

Appended Papers

Paper A

Title

The nurse in child healthcare as a craftsman to use professional competence and build a health promotive relationship – an observation study

A

Veronica Bohlin, Hrafnhildur Gunnarsdottir, Katarina Patriksson & Elisabeth Dahlborg

Published: ***International Journal of Qualitative Studies in Health and Well-being*****, 20(1), 2025**

CC-BY 4.

INTERNATIONAL JOURNAL OF QUALITATIVE STUDIES ON HEALTH AND WELL-BEING
2025, VOL. 20, 2527146
https://doi.org/10.1080/17482631.2025.2527146

Taylor & Francis
Taylor & Francis Group

RESEARCH ARTICLE

OPEN ACCESS Check for updates

The nurse in child healthcare as a craftsman to use professional competence and build a health promotive relationship- an observation study

Veronica Bohlin [a], Hrafnhildur Gunnarsdottir [a], Katarina Patriksson [a,b] and Elisabeth Dahlborg [a]

[a]Department of Health Sciences, University West, Trollhättan, Sweden; [b]Department of Pediatrics/Neonatology, NU-Hospital Group, Trollhättan, Sweden

ABSTRACT

Purpose: To explore how child healthcare (CHC) nurses use their professional competence to promote health in families with children.

Method: An explorative qualitative study was conducted based on data from participant observations and informal conversations. The sample comprised 12 CHC nurses who were observed for 31.5 hours during 23 health visits, 17 phone calls, and 9 team visits, totalling 49 observations. The results were analysed using a qualitative content analysis.

Results: The analysis resulted in one theme: Health promotion as a professional competence is a craft of interaction for caring and mutual learning. The theme describes how CHC nurses use professional competence as a health promotion approach to create trust, where the decision-making and guidance of parents are skills that depend on interaction, which is an ongoing process. The shared learning outcome of the encounter was dependent on a healthy learning process.

Conclusion: A health promotion approach was a part of CHC nurses' professional competence, which involves interaction for caring and sharing mutual learning. The ongoing process of healthy learning occurs through interactions between nurses, children, and families. This process can be considered as a pedagogical work-integrated learning tool.

ARTICLE HISTORY
Received 7 January 2025
Accepted 26 June 2025

KEYWORDS
Collaborative partnership; community of practice; health promotion in child healthcare; interaction; participant observations; professional competence; salutogenesis; work-integrated learning

Introduction

Swedish child health care (CHC) support refers to the unique needs of every child and family, where the nurse´s competence is a prerequisite for identifying factors that promote a child´s healthy development (Ekström-Bergström et al., 2022; Langeland et al., 2022; Shorey, 2021). To identify these factors, a relationship with the family is desirable, where both parties are seen as collaborative partners (Benzein et al., 2008). Previous research highlights the importance of establishing mutual and trustful relationships between the nurse and the family. Such relationships serve as a bridge, enabling encounters that provide individualized support tailored to the family's needs (Bohlin et al., 2022; Eklund et al., 2022). Health promotion interventions are not only dependent on the competence of nurses, but also on how evidence-based knowledge is implemented in the workplace (Langeland et al., 2022). Nursing is a profession in which a combination of different types of knowledge is needed such as generative, transformative and experience-based knowledge. Experience-based knowledge is developed in an ongoing process, created through experience and reflective observations (Benner, 1984; Kolb & Kolb, 2017; Schön, 1992). Specialized nurses in CHC use their experiences as part of their competence at their expert level for health promotion and it is important to understand how they use this competence in their work.

Background

The transition into parenthood can give rise to stress for both parents and children (Gilmer et al., 2016) and being able to respond to the child´s early signals through responsive interaction is fundamental for the child´s development (Bowlby, 1956). Therefore, supporting parents with focus on their ability and empowerment to enable their participation as well as the participation of their children (RHB, 2023; Swedish National Board of Health and Welfare, 2014). Strengthening and empowering parents aligns with the World Health Organization which explains health promotion as a process of making it possible for people to increase control over and improve their health according to the 1986 Ottawa Charter (WHO, 2008).

Swedish CHC is publicly funded, free of charge and voluntary, reaching almost every child from birth up to the age of six years; hence, it is an important arena for promoting the health of young children and their

CONTACT Veronica Bohlin veronica.bohlin@hv.se Department of Health Sciences, University West, Gustava Melins gata 1, Trollhättan SE-46186, Sweden

© 2025 University west, department of health sciences. Published by Informa UK Limited, trading as Taylor & Francis Group.
This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

families (Wallby & Hjern, 2011; Wettergren et al., 2016).

The Swedish act on United Nation Convention on the Rights of the child (SFS, 2018, p. 1197) should serve as a guide for all Swedish CHC. Nurses in CHC are specialized in paediatric nursing or public health and the teams at a CHC centre consist of nurses and physicians, where the nurses organize and lead the work as healthcare providers for the child and family. The child and family are referred to experts such as psychologists and nutritional specialists when necessary (Swedish National Board of Health and Welfare, 2014). Each area of a county or region has a Central Child Health Service Unit that is responsible for the quality of the CHC and the managers of the CHC centres are responsible for the tasks of CHC (RHB, 2023; Swedish National Board of Health and Welfare, 2014). The specialized nurse must possess comprehensive knowledge of child development, including the emotional, physical, and mental needs that children may have. Additionally, the nurse should be well-versed in strategies and interventions aimed at promoting children's health and preventing ill health (RHB, 2023; Swedish National Board of Health and Welfare).

The nurse's role in CHC focuses on fostering the necessary conditions for effective health promotion, while actively working to reduce social inequalities in health (Sandberg, 2022). The expanded home visiting programmes are examples of proportional universalism in targeted areas of vulnerability in Sweden (Marttila et al., 2017) as part of a more equal CHC system/service. Adopting a health promotion focus involves supporting each individual's unique prerequisites, while also shaping environmental conditions that influence health outcomes (Lundström et al., 2020).

As parents are expected to be involved in the health promotion approach (RHB, 2023; Swedish National Board of Health and Welfare, 2014), a more collaborative partnership between nurses and parents is required, in which the parent is invited into the care and the nurse is invited to the family (Benzein et al., 2008, 2023).

Nurses' competence is both practical and theoretical. To handle theory and practice as equally valid components of nursing competence, it is important to assign the same level of relevance to both generative and transformative forms of knowledge (Oberle & Allen, 2001).

In this study, a workplace in a CHC setting is seen as a community of practice formed by people engaged in a process of collective learning. Nurses in CHC have regular interaction with each other which teaches them how to share problems so that collective learning emerges.

Vygotskij (1978) described the central idea that learning happens when human activities take place in a social and cultural context, where shared social activities are transformed into new knowledge that continues to interact with and be transformed within a reciprocal relationship within the internal process (Vygotskij, 1978).

A salutogenic umbrella framework can serve as a fertile environment for optimal health and well-being during the first period of a child´s life (Shorey, 2021). Hence, for a balanced approach to health, it is important that both salutogenic and pathogenic approaches complement each other (Antonovsky, 2005; Langeland et al., 2022; Lindström & Eriksson, 2005).

Both parents' commitment and participation are important for children's development, and CHC nurses need to be aware of their own supportive abilities. Organizing supportive activities enables parents to perceive their own unique needs (Hrybanova et al., 2019) and since the importance of sufficient time to support parenthood in clinical practice has been highlighted in previous research, lack of time was perceived as a major barrier in daily work by CHC nurses (Ersson et al., 2021).

Salutogenesis presents an individual's resources such as determinants that enable people to develop a sense of coherence (Antonovsky, 1979). According to Nilsson and Lindström (1998), both the Ottawa Charter and the determinants can be seen as learning processes in which people interact with each other and learn through experiences. The ability to learn will develop health, a sense of coherence (Nilsson & Lindström, 1998) and also promotes health by describing learning as a process of healthy learning (Lindström & Eriksson, 2011). The process of relating to others creates learning, and the knowledge gained from practice expands the space for knowledge (Pennbrant & Svensson, 2018).

Ongoing learning throughout work life has become more important for many professions because of occupational challenges and requirements. Rapid changes in society and working life require learning in the workplace as a prerequisite for lifelong learning (Tynjälä, 2008). For lifelong learning in the workplace, it is important that professionals have opportunities for learning at work, which can be seen as a manifestation of work-integrated learning (WIL) (Billett & Choy, 2011; Björck & Willermark, 2024). WIL includes work-based learning experiences that can lead to the development of different types of knowledge and enable learning from both theory and practice (Björck & Willermark, 2024).

Nurses in Swedish CHC are asked to contribute evidence-based practice based on experience and knowledge of the national child health service programme. One of the tasks is to use health promotion

and identify the unique needs of each child and family to promote physical health and support a healthy lifestyle (RHB, 2023; Sandberg, 2022; Swedish National Board of Health and Welfare, 2014).

The task for specialized CHC nurses is to promote the health and well-being of the child and family, for which a collaborative partnership between nurses and parents is required. Studies of CHC show that competence is a prerequisite when promoting health and identifying factors to support the child and family. However, there is a gap in the body of knowledge on how nurses use their competence and professional judgement in their health promotion work. Observing how health promotion emerges in the encounter between the nurse and family makes it possible to highlight this.

This study aimed to explore how CHC nurses use their professional competence to promote health in families with children.

Materials and methods

Design

The study had an exploratory qualitative design, using participant observations and informal conversations (Polit & Beck, 2021) with nurses at their workplace in CHC centres. The participant observations were inspired by the ethnographic research approach, the process of learning about people by learning from them (Roper & Shapira, 2000). In participant observations, the observer engages with a group for a period in a natural setting in order to develop an understanding of the group (Foster et al., 2021).

Study setting

The five CHC centres were in areas with different contexts to obtain as broad a selection as possible for purposive sampling and to ensure variation. Inclusion criteria for CHC centres were being located in either vulnerable or well-functioning/affluent socio-economic areas, suburban or urban areas, as well as smaller and larger workplaces, with two to six nurses employed at each CHCC. In Sweden, all CHC nurses are registered nurses specializing in public health or paediatric nursing. Their work, which is covered by the national child health service/CHS programme, involves regular growth and development check-ups, health counselling and follow-ups, regular vaccinations in addition to home visits for newborns, and at 8 months of age. They also participate in teamwork with physicians and collaborate with different professionals when necessary. All nurses had a set time for regular phone calls to answer the parents' questions.

Data collection and sample

This study was conducted from October 2022 to February 2023 at five different CHC centres in western Sweden. Eight CHC centres were invited to participate in the study, but three could not be reached or did not respond. Five CHC centres managers agreed to participate in the study and gave the researchers permission to invite nurses to participate. The chosen CHC centres are within primary care; all of them are publicly financed and are either publicly or privately managed.

Fourteen nurses were invited by the first author via phone or email, and twelve of them agreed to participate in the observational study.

All of the nurses signed informed consent form before participating (see Table I). They all worked as CHC nurses, four specialized in paediatric nursing, and eight in public health nursing. Their mean experience of work in CHC was 8.17 years and their ages ranged from 36 to 60 years (mean, 49 years). Table I includes the participants. To maintain anonymity, all were de-identified with fictitious names.

All families gave their consent to have an observer present during their health care visit and each observation involved new children and families.

They all received oral information from both the nurse and the observer (the first author) and were also offered written information about the study stating that they could withdraw at any time that the result will be reported for academic purposes and be published in a scientific journal. They were also informed that no single individual could be identified.

The observations took place in the nurse's natural setting, a room for health visits, team visits and phone calls. The phone calls were at a set time and on speaker. During the phone calls, only the nurse's reactions were observed, as it was not possible to observe any interactions.

During the participant observations, the first author (VB) as the observer, sat on a chair behind the visitors, often in a corner, so that the visitors would not be confused and would be as natural as possible. During the phone calls, the first author (VB) sat next to the nurse. The observations started with the first author (VB) or the participating nurse asking

Table I. Description of the participants.

Participant	Specialisation	Years of experience
Alice	Public health	11
Brita	Public health	12
Cornelia	Public health	6 months
Dagny	Public health	20
Ebba	Public health	13
Fredrika	Public health	18
Gudrun	Paediatric Nurse	5 months
Hildur	Paediatric Nurse	2
Ida	Public health	3½
Jessica	Paediatric Nurse	4
Kajsa	Public health	4½
Lovis	Paediatric Nurse	10

Table II. Type of observation.

Type of observation	Number of observations	Hours of observation (h)
Health visit Nurse	23	20
Phone calls Nurse	17	4.5
Team visits of nurse with physician	9	7

the families for permission to observe the encounters. The observations consisted of 23 health visits, 17 phone calls, and nine team visits by a nurse with a physician (see Table II). A total of 49 observations were conducted, lasting 31.5 hours. Health visits at the CHC centre involved observations with nurses and visiting families with children. Nurses and children and families were present during the observations. Informal conversations after each observation were used when the observer needed answers from the participating nurse about an observed situation.

It could clarify a situation that was not obvious from the field notes on each observation (Polit & Beck, 2021). According to Foster et al. (2021), handwritten field notes can be of assistance and during the observations such notes were made at quite a high speed, while attempting to keep them clear and detailed. The field notes included descriptions of the interactions between the nurse, child and parent. The handwritten notes were reviewed for clarity shortly after each observation. The observation lasted for the entire health visit, team visit, or phone call period.

Data analysis

To identify how nurses use knowledge to promote health, an inductive qualitative content analysis was conducted (Graneheim & Lundman, 2004; U. Graneheim et al., 2017). The analysis aimed to identify patterns, differences, and similarities, and was performed in several steps. In the first step the first author (VB) read the text to become familiar with it and to gain an initial understanding. The second step involved dividing the text into meaning units related to the aim and context. In the third step codes were created from the meaning units that retained the manifest content. The codes were then discussed with the other authors and sorted into subcategories and categories (see Table III). The work of abstracting codes and subcategories by describing similarities and differences led to categories corresponding to the aim. Categories were abstracted and interpreted based on their latent content (Graneheim & Lundman, 2004). Thereafter, a theme emerged.

Ethical considerations

Ethical approval was obtained from the Swedish Ethical Review Authority, registration number 2022–03858–01. The study was conducted in accordance with the ethical research guidelines outlined in the Declaration of Helsinki (WMA, 2024). Participants received written and verbal information about the purpose of the study and gave written consent. All data were handled confidentially and transcribed audio-recorded materials were coded and pseudonymized. Collected data will be saved and stored in a fire-proof cabinet for 10 years, as well as on a safe server in accordance with University West data storage guidelines.

Results

Description of the environment/study setting

The waiting room was the first impression of the family. Some children's furniture was found in all the CHC centres and nurses´ rooms, for the children to use. Immediately after entering the room, almost all the children who could walk went directly to the miniature furniture. There are different ways to decorate the family waiting room. Pictures of children playing were common, as well as information about various meetings, training courses on infant massage, child cardiopulmonary resuscitation (CPR), and parenting groups. There was often a nursing chair and toys for children of different ages, big toys such as tents, and small ones such as rattles.

At the CHC centre, all nurses' workplaces were equipped with a desk, a computer, an office chair for the nurse, and one or two chairs for visitors. There was also equipment for the nurses' work, such as a changing table with measuring equipment for small children and a baby scale, and measuring equipment for older children, including a scale to stand on. Every nurse's visiting room contained children´s

Table III. Example of coding process.

Meaning units	Condensed meaning units	Code	Subcategory	Category
"The child should receive treatment with laxative for as long as she needs it" (Alice)	The child should receive treatment for as long as she needs it	Information about treatment	Sharing to learn	Decision-making
"When you come straight from preschool, you should be dirty up to your ears, that´s how it should be" (Cornelia)	Coming straight from preschool, the child should be dirty up to the ears	Pointing out and normalizing	Normalizing concerns	Guiding parents

furniture, a table for drawing, and various toys for children of different ages. The equipment for the assessment of the children, such as the bags for the visits of the 2½ years old, was always out of the children´s sight, locked away, or on a high shelf.

How nurses promoted health in families with children resulted in one overarching theme: health promotion as a professional competence is a craft of interaction for caring and mutual learning.

The health promotion approach in nurses' encounters with families appears in the interactions between the nurse and the parent and child. It comprises nurses' way of caring for parents and children, speaking to them and actively listening to their concerns. Furthermore, it comprises the nurses' way of acting on the parents' concerns and their way of using the parents' unique knowledge about their child to guide parents in their parenthood. Thus, the professional competence of the health promotion approach can be seen as a skill involving interaction and mutual learning. This skill can be summarized in three categories where nurses used their competence to create trust and support, make decisions and guide parents.

The themes and the three subcategories are presented in Table IV.

Creating trust and support

Creating trust and a supportive relationship in the encounter involved confirming parents and building trust as well as dealing with barriers.

Confirming parents

The nurses confirmed parents by genuinely paying attention to them in the encounter and treating them with respect. How the nurses paid attention to the parents to reach the family was already observed in the welcome in the waiting room. In this way, the nurse obtained information from them before the examination. What seemed particularly important for the nurses was to start the welcome by looking at the parents during the greeting as a way of confirming and her attention was focused on the well-being of the family.

A family that had recently moved to the area came for a regular visited the CHC centre and nurse Dagny, with their firstborn, 6-week-old child. The observations showed how Dagny created trust by getting to know them, exhibiting interest, mutual understanding, and knowledge. The parents sat on two chairs opposite Dagny and talked about various things such as the move and what the family network was like.

The parents had questions about parenting groups and activities for babies, to which Dagny responded by telling them what age the child should be before starting an activity and suggested a parent group as they showed interest in joining one, which was confirmed by the parents asking Dagny to sign them up. After the visit they followed the advice and signed up for a parent group.

An already established trust could be demonstrated through the parent beginning to tell the nurse about the family´s well-being immediately after the welcoming phase without waiting for the nurse´s questions.

One noticeable outcome of confirming the parents was observed when the nurse engaged in praising the young child during conversations. These interactions often occurred at the changing table, either before or after the child's assessment. As a result, communication with both the parents and the young child became more seamless and efficient.

Nurses used their practical knowledge to build trust during encounters with families. For example, sitting on the floor during the examination was at the same level as the child. In this way, they invited the child to an interaction at the child's level and made the unique encounter relaxed and trustful.

Dealing with barriers

Sometimes, the nurses had difficulties building a trusting relationship due to various barriers that hampered the encounters. A barrier could be a lack of mutual listening, in which the nurse and parent failed to listen to each other. It could be about a mother not feeling well after giving birth resulting in her not being receptive to the nurse or the nurses felt stressed about being late because of their tight schedule.

Such barriers could lead to poor conditions for interaction and thus difficulties in building a trusting relationship. Because of the tight visiting schedule, lack of time risked becoming a barrier to optimal interaction.

For example, during one visit, nurse Alice missed a child´s signals due to lack of time.

> A 3-year-old child came with a parent for a team visit to undergo a speech check. The child did not speak one understandable sentence during the visit. The parent spoke the entire time, and the child was very

Table IV. Overview of categories and subcategories.

Overarching theme	Health promotion as a professional competence is a craft of interaction for caring and mutual learning		
Category	Creating trust and support	Decision-making	Guiding parents
Subcategory	Confirming parents	Reaching the child for interaction and cooperation	Normalizing concerns
	Dealing with barriers	Sharing in order to learn	Setting boundaries
		Not having all the answers	Follow- up

> active. Alice did not pick this up further because of the tight schedule and ended the meeting quickly, instead of acting on the child´s signals about having speech problems.

In this case, the lack of time became a barrier to mutual listening, and the nurse was unable to combine her theoretical and practical knowledge to meet the needs of the child. In an informal talk with Alice after the visit, the nurse explained that a new appointment was planned for the child and family. The nurse also confirmed that stress hampered the encounter due to lack of time and struggled to keep to the schedule.

Another health visit included a mother with an 8-week-old baby, where the mother underwent routine screening for postpartum depression.

> During the visit, the nurse Alice spoke to the baby, recognized a responsive smile, and confirmed it by smiling even more and giving praise. However, the mother did not listen to the nurse and stated that the baby was later smiling than the sibling, despite the fact that the child was not late smiling at all. Alice tried to explain to the mother that the attachment process might take time. The screening showed no depression, but the mother was not able to listen to Alice, and it was difficult to know if anything Alice told her was received. In an attempt to explain to the mother, Alice highlighted the importance of the attachment to the child and its development, using evidence-based knowledge while feeling unsure about whether the mother would receive and understand the information. There was no response from the mother at this point, but Alice points out that it is important for both mother and family to continue to come to the CHC centre regularly. Help was available, if needed. The visit ended with a new appointment for a return visit.

Decision-making

Decision-making involves the nurses basing their decisions on the insights and information gathered during their interaction with the family. This included reaching the child for interaction and collaboration, mutual sharing to learn with the parents, and being aware that sometimes the nurses did not have all the answers.

Reaching the child for interaction and cooperation

Getting the child's attention for an interaction began when the nurse invited the child to communicate to achieve cooperation. As the child's participation is required during examinations to obtain reliable results, the nurse´s ability to engage with and support the child is important. It was often necessary to involve the parents to help the child participate. During the visit, the welcoming phase was often followed by asking if the child knew about the examination and had been prepared in any way. The answers from both the child and the parent guided the nurse in how to plan and proceed with the examination. When the nurse reached the child through verbal or nonverbal communication, cooperation was enabled. Due to the need to maintain the child´s full attention, the pace of assessment was fast.

The observation of a 4-year-old child showed that the child had not been prepared before the examination. Even so, the child was able to cooperate and interact with nurse Brita while sitting safely on the parent´s lap.

Another regular health visit showed a 2½ year old child cooperating nonverbally with support from the nurse through role-play. Using toys such as animals and dolls seemed important for reaching child in the interaction. When the nurses came to welcome families, they often started to role-play with the children using the toys in the waiting room. Many nurses working clinically during and after Covid have noticed that a lack of toys and child friendly equipment due to infection control hamper relationship building. In addition to supporting relationship building, CHC nurses also observe child´s behaviour and see developmental flags with toys as tools.

> Nurse Cornelia asked the child about their teeth and whether they could roar like a tiger. The child opened her mouth and roared. Cornelia praised the child and continued the assessment by asking if the teeth were brushed and in response the child nodded. The child was also fully attentive when asked about the doll and if it was time to weigh it? The child nodded again and Cornelia placed the doll on the scales. They looked at the weight together, and then Cornelia asked if it was time to weigh the child and the child moved closer.

This example shows how Cornelia reached the child by communicating through play at a fast pace to maintain attention and achieve a result. The child´s cooperation was demonstrated through a playful response, even though the communication was nonverbal. Cornelia's ability to be flexible in reaching the child is important for achieving the goals of the assessment. The nurses' self-awareness of their competence was used to find the required tools and knowledge about how to deal with the child full of emotions through imagination and play. The observations demonstrated that other nurses achieved the result in a similar manner in different situations, showing presence while listening to the child´s needs. Another way of showing openness and awareness when a child visited the nurse at a regular 2½ year old health visit was to use a bag with various toys for developmental assessment.

> Nurse Ida sat on the floor and tapped it to reach the child. Skills and imagination enabled Ida to use experience to obtain a result from the assessment by receiving attention and interaction from the child.

To understand the well-being of the babies, the nurses needed to reach and interact with them in a different way than with older children.

> Nurse Gudrun spoke to a baby and received a response in the form of a smile and baby talk, and the mood rubbed off on the parents hence they also began to speak to the baby using their voice in the same positive way, praising the child with words similar to Gudrun´s.

This was a positive side effect that stimulated empowered parenting. It is important for nurses to use their individual skills to interact with and make professional assessments of the resources needed. Using the voice in a positive, encouraging way, and praising the child through eye contact was one way to reach them.

Sharing in order to learn

Nurses and parents share to learn about the importance of knowledge exchange. Nurses possess professional knowledge of children's health and development, while parents have knowledge of the unique child and family situation.

The observations showed that a prerequisite of sharing was to treat the parent as a valuable person to be listened to for mutual understanding. Listening to each other, and the sharing of knowledge enables learning.

The following example shows sharing to learn in a collaborative relationship between nurse Lovis and a parent during a health visit to the CHC centre, where the 12-month-old child needed an extra weight check. The family had several children and there was an established relationship.

> The child was sitting on Lovis' lap on the bench in the nurse´s reception room, and Lovis gave the child an easy puzzle representing fruits and had a conversation with the mother at the same time. They discussed words for different fruits in the native language. The parent appeared relaxed, which confirmed the nurse's interest in and respect for the parent's valuable knowledge. When the nurse asked the mother what the word for pear was in the native language, the parent responded with a laugh saying the word, which the nurse repeated. Still talking to each other, the nurse placed the child on the scales and recorded their weight.

In this way, the nurse demonstrated that, when using one´s competence to make an assessment, expert knowledge also consists of managing and changing roles. The parent was an expert in their native language and the nurse learned from this expertise in a collaborative relationship, in addition to words in the native language. Another example of sharing mutual understanding was when the nurse asked the parent to answer questions about the child´s development when the child refused to participate. The following example shows how nurse Alice relied on the parents´ parenting abilities and shared mutual understanding.

During a team visit, nurse Alice seemed satisfied with only the parents' responses to follow-up on the child's speech development. The child refused to cooperate, but the nurse demonstrated that the parents were valuable in a trusting, collaborative relationship when they shared a mutual understanding that the child would not interact during the visit.

> During a team visit nurse Alice seemed satisfied with only the parents´ responses to follow-up the child´s speech development. The child refused to cooperate but the nurse demonstrated that the parents were valuable in a trusting, collaborative relationship since they shared a mutual understanding that the child would not interact during the visit.

The exchange of knowledge at the CHC centre started in a similar way at all visits and also with phone calls, in that the nurse asked questions after the greeting. If the nurse already had an established relationship with the parent, getting to the core of the matter seemed quicker, and depending on the responses, decisions were made and different actions taken. Knowledge exchange was needed to obtain valuable information about the child in order to make a professional judgement of the assessment.

An observation from a health visit where a 10-month-old child had symptoms of dry skin provides an example of how knowledge is shared as the nurse (Ida) first listens to the parent and then makes her own assessment.

> The parent stood at the changing table, putting a nappy on the child after it had been weighed and said that the skin on the child's legs felt dry. Ida touched the skin of the child´s legs and confirmed that it felt that there were dry patches. The nurse gave advice to the parents as direct information containing factual knowledge about not bathing too often because the skin was sensitive and also the importance of using a special cream for dry skin to protect it.

During the encounter, Ida listened to the parent´s concern, confirmed it, and showed respect for the parent´s knowledge by making a professional judgement. Sharing to learn equally requires a reciprocal relationship in which both parties listen to each other. Collaboration is a prerequisite for using practical and theoretical knowledge to make a professional assessment of a child´s needs.

Not having all the answers

The CHC nurse needed to be aware of situations where knowledge was lacking and did not always know the answer to every question. To maintain control over the situation, it is important to accept not always knowing.

Most health visits to the CHC centre were customary and routine, and parents had questions about certain symptoms or behaviour. If the nurse could not respond to the question, the parent was immediately informed. The dialogue with the parents was then usually self-explanatory, and more of a statement from the nurse that she lacked knowledge.

If the nurses realized that the necessary knowledge was lacking, they always seemed to have a plan for how to obtain it. This could include consulting a colleague at the CHC centre, psychologist or physician when required. The following example is about a 4-year-old at a regular health visit.

> The parents were concerned about the child´s symptoms in different areas of tongue redness. They asked the nurse Cornelia if it was a dangerous condition. Cornelia then replied that the condition was not familiar and therefore she needed to plan further by consulting a physician to help the family.

A plan was made for further action, and the child received the support needed, as the nurse knew the importance of remaining competent, admitting her lack of knowledge, and planning further to meet the child's needs.

Guiding parents

Guiding parents was about creating a trusting relationship and empowering them in parenting practices. This included normalizing concerns, setting boundaries when needed, and guiding parents to care for the child´s best interests. Follow-up is required to maintain a trusting relationship. To remain competent, it was important that the nurse had a further plan for the family.

Normalizing concerns

Normalizing parents' concerns was needed to prevent unnecessary anxiety over a matter that did not threaten children's well-being. The nurse was able to convince the parents that the matter was completely normal and nothing to worry about. If the parent insisted that something was wrong, it indicated that the parent did not perceive the child´s real need. On these occasions, nurses used experience to guide parents. The following example is of a 4-year-old child, where the parent was concerned about dirt on the child´s body.

> Nurse Cornelia responded that children should be dirty when coming straight from preschool, pointing out that it was normal. When telling the parent about this, the nurse used trust in the relationship as a resource, normalizing the parent´s concern. The parent seemed to listen, and there was no further mention of concern.

Normalizing a parent´s concerns in this way is an example of how nurses supported and guided parenthood based on the child´s needs. In another observation of a 10-month-old child at a health visit, the parent was concerned that no teeth would be visible in the child's mouth.

> The nurse Ebba responded that the teeth would come when they did. The parent needed further confirmation that the situation was normal, and Ebba confirmed once more that it was a completely normal situation.

The situation was similar to other concerns that needed to be normalized, thus avoiding unnecessary anxiety and supporting parents in maintaining control of the child´s real needs.

Setting boundaries

Parents needed help from nurse to set boundaries in certain situations in the child´s best interests. The nurse guided the conversation by focusing on the child´s needs and what was good for the child. A parent phoned nurse Fredrika to get medicine and help stop the child coughing.

> Fredrika tried to explain that it appeared to be a virus, and that no medicine could help. The parents seemed to push and did not listen much to what the nurse tried to explain. Fredrika had to point out in a clear voice rather abruptly that, based on evidence, there was no cure.

Occasionally during health visits, siblings joined in and sometimes took the focus away from the child to be examined. The nurse needed to devote full attention to the child and therefore had to immediately set boundaries for the sibling. Other situations were more obvious when it came to the needs of the examined children. The nurse assessed the child in silence and then clarified the outcome for parents.

> This situation involved a 9- month-old child, where one of the visiting parents did not speak Swedish, and an interpreter was used. The child wore thin summer clothes, had no hats or jackets, and socks instead of shoes. Nurse Dagny first assessed the child in silence when the mother undressed the child and then checked the child´s wellbeing by talking to it, waiting for a response, and a smile. After obtaining the weight and measurements, the parents dressed the child at the changing table. Dagny explained to parents the importance of buying warm clothes for their children. The cold and rainy weather on this autumn day did not need to be used as an

explanation. Nonverbal factual knowledge was evident and appeared to be the cause of the following reaction on the part of parents. The Swedish speaking parent explained the situation to the other parent in their native language. The fact that this parent also chose to say "yes" to Dagny in Swedish seemed to indicate that they both understood the seriousness of what the nurse said.

The nurse summarized the health visit, and the family was booked for a new appointment in approximately a month.

Follow-up

The follow-up was about maintaining the relationship with the families by summarizing and planning how to move forward, thereby maintaining and continuing the existing relationship between the nurse and the parent. Parents participated in the follow-up plan, usually through the confirmation of the next appointment. The option to decide for themselves if and when a new contact was needed showed that nurses had trust in their parenting, thus empowering them. In assessing the mother's well-being after birth, the nurses demonstrated their professional competence and responsibility through a follow-up plan in accordance with the guidelines and the mother's unique needs. More frequent visits for follow-up conversations with the nurse were regulated by the guidelines, which provided support to the mother. One way of measuring maternal well-being after childbirth is screening for depression and domestic violence (DVS), which is performed when the child is 6–8 weeks old.

A mother came for a health visit with 8-week-old baby. The mother filled out the questionnaires. Nurse Dagny checked the answers and explained the notice that the DVS screening showed exposure to violence "outside the family". The mother's response was that this is probably not unusual and that she also received help from work. Dagny pointed out that the mother has four points for well-being and then declared that the mother must be feeling well, which the mother confirmed. The nurse booked a new appointment in a month after confirmation from the mother. Dagny searched for a date that suited the unique needs of the mother for a follow-up talk within a time interval that was strategic and followed local and national guidelines.

Mothers' confirmation of the new appointment was an important part of the follow-up, as it could make them feel that they were acknowledged and empowered by participation.

The phone calls observed also highlighted the importance of parents' participation. They often ended with a summary of the conversation by the nurse and confirmation that a new phone call should be taken into consideration if needed, either by the nurse or the parent. By giving the parents the choice to call again if needed, trust in parenting was shown. Another way of encouraging parent participation was to ask the parents directly when they wanted to return for follow-up. Having these questions posed respectfully by the nurses conveyed a sense of participation. Nurses created opportunities for parents to build their knowledge and skills through the learning processes CHC nurses create within the nurse and parent interactions.

Discussion

This study aimed to explore how CHC nurses use their professional competence to promote health for children and their families and our research has provided important evidence of CHC nurse practice which is lacking to date. The overarching theme: health promotion as a professional competence is a craft of interaction for caring and mutual learning, reflects CHC nurses' work in doing health promotion. The categories encompass subcategories that illustrate the work as a craft, with interaction as a fundamental process integrated into each aspect. A recent study by Bohlin et al. (2022) highlighted that CHC nurses are bridge-builders due to their relationship with the child and family. Our results show that learning that develops from interaction is dependent on encounters between the nurse, child, and family.

As the shared learning outcome of the encounter was dependent on the interaction process, which in itself can be considered health promotion in line with the Ottawa Charter (WHO, 1986), and states that health promotion is a resource and a process to improve health. As the work of promoting health starts at the beginning of life (WHO, 2008) the CHC nurses' work can make a difference for the children.

As a prerequisite for the ongoing process between nurses, children and families, the encounter can be considered as a movement towards health through knowledge. Furthermore, the result shows that the encounter consists of a social practice in which mutual learning occurs. Thus, the CHC centre is considered a community of practice in our study and described by Lave and Wenger (1991) as a practice of a working community since families are in specific social circumstances, the CHC centre, and are involved in a situated activity where mutual learning takes place.

The nurses' clinical practice was to identify the child´s unique needs, as well as resources within and around the child and family. To succeed, nurses cared for the families as a unit with a child-centred focus and showed the importance of inviting them as valuable partners in the encounter, which is also the foundation of family centred care (Benzein et al., 2008). The nurses in the study invited families as valuable partners when they shared their knowledge

of the child's needs and situations. Promoting health, identifying and strengthening available resources around the child and family aligns with the salutogenic perspective of focusing on available resources around the individual (Antonovsky, 1979).

The results encompass health promotion care, showing that learning is situated in the ongoing process of relating to others, which corresponds with Pennbrant and Svensson (2018), who argue that learning gained from practice expands the scope of knowledge. Acquiring knowledge in the practice context, as in the present study, affects the learning process, which aligns with Nilsson and Lindström (1998), who described that a good learning process could enhance both the learning and development of a sense of coherence as a healthy outcome.

Nursing requires a wide range of competencies and in their clinical work, the CHC nurses needed to use both theoretical and practical knowledge, as well as time for reflection. When the nurse was unable to use her competence because of obstacles that hampered the encounter, there was a risk of ethical stress caused by missing the child´s needs and rights. Nurses could have difficulties with interactions because of barriers, such as a lack of time. This emerged when, for example, a 3-year-old child came for a speech check. Although the nurse identified shortcomings regarding language, the visit ended quickly, and the nurse confirmed that stress and striving to keep on schedule hampered the encounter, which aligns with Ersson et al. (2021), who reported that lack of time was a barrier in daily work for CHC nurses. This also hampers nurses' opportunities to reflect both on-encounter and also after-encounter since the chance of health promotion care and a healthy outcome for the child and family is reduced because the parent is not able to participate in decisions. The risk of feelings of disempowerment increases then and also the chance of a sense of coherence will decrease due to lack of time.

Recent research by Kwame and Petrucka (2021) describes effective communication in nurse-patient interactions as a core component of nursing care and that tight time schedules and work overload are global barriers for nurses (Kwame & Petrucka, 2021). The importance of finding risk factors and identifying the child´s and family's unique need for resources such as determinants highlights the nurses' work in CHC as a part of health promotion that might lead to an increase in healthy outcomes and reduced risk of physical ill health.

Therefore, it seems necessary that nurses' in CHC as safeguards of the children´s needs and rights and their development of competence based on their knowledge of their clinical practice in CHC requires time for reflection. Reflection both on-encounter and after-encounter which also aligns with Schön (1992) and Pröckl (2023) that the time for reflection on practice increases the prerequisites for developing professional judgement and as our result points out, a more healthy outcome.

Reflections on shared learning in encounters were important for nurses to respond to the unique needs of each family, and reflection-in-time was used on most occasions.

In our study, parents played a crucial role as collaborative partners, as nurses relied on them due to the young age of the children. Often, parents acted as listening partners during information-sharing and decision-making processes with the nurses. Their relatively quiet presence may be influenced by the nurses' tight schedules observed in our study. However, a significant aspect of health promotion work involves empowering parents to utilize their resources, enabling better support for their children and families, as highlighted by the WHO (2008).

Reeder and Morris (2021) stress the importance of health professionals being proactive in fostering parental confidence, empowering them to play an active role in shared decision-making as collaborative partners. It is widely recognized that a hierarchy of power exists in healthcare, where patients depend on the nurse's expertise, increasing the risk of disempowerment rather than empowerment (Coyne et al., 2016; Delmar, 2012; Reeder & Morris, 2021). Coyne et al. (2016) further suggest that a child-centred approach should prioritize the child's rights, ensuring their active participation in all aspects of healthcare delivery.

Considering CHC, the observations showed that nurses are dependent on the parents during the encounter, i.e., to encourage the children to cooperate during assessments. In this way parents became collaborative partners in CHC which aligns with recent research and study of action research design that shows the importance of collaborative relationships for the nurses´ use of learning principles. A deepening learning insight for the nurses of the study as well as the learning environment for how the nurses use learning principles within parent education was also of importance (Thompson et al., 2023).

Focusing on the child while maintaining partnership with the family reflects Coyne et al. (2018) child-centred approach, which emphasizes addressing the needs of both the child and family. Health promotion for children's rights and well-being (Swedish National Board of Health and Welfare, 2014) becomes clearer when applying the framework by Coyne et al. (2016, 2018). Their approach underscores the importance of commitment, active listening and fostering trust between nurses, children and families to provide tailored care and support.

Nurses' diverse knowledge serves as a key resource in health promotion. Competence, as revealed in our study, involves utilizing skills in interactions to foster mutual learning and effective communication. This aligns with Fenwick's (2006) view of competence as "performing knowledge."

To strengthen health promotion in CHC, terms such as health-promoting care or promotion through caring might be appropriate. Ultimately, nurses' skilled application of knowledge and interaction is vital for enhancing the process of tailored care since shared learning outcome was dependent on the healthy learning process from the interaction which is supported by research of Lindström and Eriksson (2011).

WIL could be seen as a pedagogical model to understand health promotion work and the knowledge of learning in health care (Pennbrant & Svensson, 2018). As WIL bridges both theory and practice (Sunnemark et al., 2023), it integrates and includes work-based learning experiences that can lead to the development of different types of knowledge and enable learning (Björck & Willermark, 2024).

Strengths and limitations

A strength of this study was the use of participant observations as the methodology, which made it possible to explore how CHC nurses promote health in families with children.

The chosen method enabled a description of the nurses' everyday work/day-to-day work in the CHC and strengthened the validity, which aligns with Larsson (2009) that participant observations form the basis for a claim of validity, as described above (Larsson, 2009).

Purposeful sampling for data collection was chosen to enable a representative selection of participants and areas, which is a strength. The high and low socio-economic, as well as urban and suburban areas in the western part of Sweden, increased the possibility of transferability to CHC and ensured credibility. The relatively small number of observation hours (31.5 h) could be considered a limitation; however, as the observations were rich in data, we do not believe that the number of hours weakens the analysis. Another possible limitation could be that not all authors took part in the data collection; however, as first author shared information about it, all authors were involved from the beginning. All authors had a preunderstanding of being nurses. To minimize the risk of bias and ensure credibility, all authors were involved in the analysis process and discussed and agreed on the results (Elo et al., 2014). To achieve dependability, all authors worked together to ensure the validity of the results and the associated categories on which they reached a consensus (Graneheim & Lundman, 2004; Lindgren et al., 2020).

Conclusion

The results of the present study highlight the fact that the ongoing process of interaction between nurse, child and family can be considered health promotion care of a healthy outcome. A collaborative partnership with parents increases the chance of sharing decisions-making. This creates possibilities for parents to have feelings of sense of coherence, knowledge building and a strengthened empowerment in parenthood and when practical knowledge is combined with theoretical knowledge, nurses' expertise is reflected.

For nurses' continuous learning there is a need for a pedagogic tool to ensure experience-based knowledge in practice and to understand the important process of the health promotion care of interaction. As the ongoing process of healthy learning occurs between nurses and families, the interaction can be considered a pedagogical tool of WIL, the necessary integration of both theory and practice to understand and achieving a healthier outcome of experience-based knowledge in mutual sharing and learning.

It is important that CHC nurses value the family as a collaborative partner and, likewise, theoretically and practically, as equally valid components. When theory is not used during encounter because of a barrier, the child has increased risk of not having a healthy outcome. Drawing upon their competence in practice, there is a need for routines with set times to reflect on current situations, based on both previous experiences and theoretical knowledge.

To increase the chance of a healthy outcome and learning for the child and family it is of importance to safeguard their needs and rights. Nurses in CHC should have an awareness of being proactive in supporting parents so that they can feel empowered and participating in decision-making. Having an awareness of being proactive in supporting parents means a maintaining of the competence for the nurses and an increasing chance of a more healthy and collaborative relationship between the nurse and parent.

Future research is needed to study nurses' perspectives on how they manage health promotion and interactions during CHC encounters.

Acknowledgments

We wish to thank all the participating CHC nurses for making this study possible and generously sharing their valuable knowledge.

Author contributions

CRediT: **Veronica Bohlin:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Validation, Visualization, Writing – original draft, Writing – review & editing; **Hrafnhildur Gunnarsdottir:** Conceptualization, Formal analysis, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing – original draft; **Katarina Patriksson:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing; **Elisabeth Dahlborg:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing.

Author´s contributions statement

All authors: VB, HG, KP and ED have made substantial contributions to conceptualization and design of methodology. Acquisition and read-through of data, first author: VB. Data curation, all authors: VB, HG, KP and ED. Formal analysis and interpretation of data, application ethical permission, all authors: VB, HG, KP and ED. Project administration was conducted by first author: VB. All authors: VB, HG, KP and ED have been involved in the investigation, drafting the manuscript or revising it critically, the validation of the results and gave the final approval to be published and agreed to be accountable for all aspects of this work, ensuring that questions related to the accuracy of any part of the work are appropriately investigated and resolved.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The author(s) reported there is no funding associated with the work featured in this article.

Data availability statement

The participants of this observational study did not consent to have their documents publicly available, as they contained personal information that could be used to identify the participants.

Ethics

Study approved by Research Ethics Committee in Sweden.

Notes on contributors

Veronica Bohlin is a registered nurse and PhD student in work-integrated learning at the University West. She collaborated with child healthcare.

Hrafnhildur Gunnarsdottir is a registered nurse with a PhD in Public health. She holds a position as a senior lecturer at University West. She is an experienced researcher in qualitative methods and has conducted research in different contexts. Expert areas include qualitative content analysis and thematic analysis, health promotion, and the mental health of children and adolescents.

Katarina Patriksson is a registered nurse and has a PhD in healthcare sciences. She holds a position as an associate professor at the University West. She is an experienced researcher in qualitative methods and has conducted research in different contexts. The expert areas are observation studies, thematic analysis, child-and family centred care in the neonatal context, research in public health, and language barriers.

Elisabeth Dahlborg is a registered nurse and PhD in nursing pedagogics. She holds the position of professor at University West. She is an experienced researcher in qualitative methods and has conducted research in different contexts. The expert areas include discourse analysis, thematic analysis, norm criticism, and work-integrated learning.

ORCID

Veronica Bohlin http://orcid.org/0000-0002-0045-3427
Hrafnhildur Gunnarsdottir http://orcid.org/0000-0002-7915-8972
Katarina Patriksson http://orcid.org/0000-0001-9687-6143
Elisabeth Dahlborg http://orcid.org/0000-0003-3702-8202

References

Antonovsky, A. (1979). *Health, stress, and coping* (1st ed.). Jossey-Bass.

Antonovsky, A. (2005). *Hälsans mysterium* (2nd ed.). Natur och kultur.

Benner, P. (1984). *From novice to expert: excellence and power in clinical nursing practice*. Addison-Wesley.

Benzein, E., Hagberg, M., Persson, C., Saveman, B.-I., & Syrén, S. (2023). *Att möta familjer inom vård och omsorg*. Studentlitteratur.

Benzein, E., Johansson, P., Arestedt, K. F., & Saveman, B. I. (2008). Nurses' attitudes about the importance of families in nursing care: A survey of Swedish nurses. *Journal of Family Nursing*, *14*(2), 162–180. https://doi.org/10.1177/1074840708317058

Billett, S., & Choy, S. (2011). Cooperative and work-integrated education as a pedagogy for lifelong learning. *International handbook for cooperative and work-integrated education*, *2*, 25–30. 10.1007/978-90-481-3939-2

Billett, S., & Choy, S. (2011). Cooperative and work-integrated education as a pedagogy for lifelong learning. *International Handbook for Cooperative and Work-Integrated Education: International Perspectives of Theory, Research and Practice*, *2*, 25–30. https://doi.org/10.1007/978-90-481-3939-2.

Björck, V., & Willermark, S. (2024). Where is the 'WIL' in work-integrated learning research? *Studies in Continuing Education*, 1–15. https://doi.org/10.1080/0158037X.2024.2378718

Bohlin, V., Nolbris, M. J., & Wigert, H. (2022). Child health care nurses' experiences of language barriers during home visits. *Public Health Nursing*, *39*(1), 146–152.

Bowlby, J. (1956). Mother-child separation. In K. Soddy (Ed.), *Mental health and infant development. Vol. 1. Papers and discussions* (pp. 117–112). Basic Books, Inc.

Coyne, I., Hallström, I., & Söderbäck, M. (2016). Reframing the approach from a family-centered to a child-centered care approach for children´s healthcare. *Journal of Child Health Care*, *20*(4), 494–502. https://doi.org/10.1177/1367493516642744

Coyne, I., Holmström, I., & Söderbäck, M. (2018). Centeredness in healthcare: A concept synthesis of family-centered care, person-centered care and child-centered care. *Journal of Pediatric Nursing*, *42*, 45–56. https://doi.org/10.1016/j.pedn.2018.07.001

Delmar, C. (2012). The excesses of care: A matter of understanding the asymmetry of power. *Nursing Philosophy*, *13*(4), 236–243. https://doi.org/10.1111/j.1466-769X.2012.00537.x

Eklund, A.-L., Jangsten, E., & Gunnarsdottir, H. (2022). Assessing and promoting responsive interaction between parents and children- a qualitative study of the experiences of child health care nurses in Sweden. *Journal of Pediatric Nursing*, *63*, e95–e101. https://doi.org/10.1016/j.pedn.2021.10.006

Ekström-Bergström, A., Thorstensson, S., & Bäckström, C. (2022). The concept, importance and values of support during childbearing and breastfeeding- a discourse paper. *Nursing Open*, *9*(1), 156–167. https://doi.org/10.1002/nop2.1108

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open*, *4*(1). https://doi.org/10.1177/2158244014522633

Ersson, M., Henström, M., Almquist-Tangen, G., Hesketh, K. D., & Delisle Nyström, C. (2021). How to support child healthcare nurses in Sweden to promote healthy lifestyle behaviours from the start of life. *Children*, *8*(8), 696. https://doi.org/10.3390/children8080696

Fenwick, T. (2006). Learning as grounding and flying: Knowledge, skill and transformation in changing work contexts. *Journal of Industrial Relations*, *48*(6), 691–706. https://doi.org/10.1177/0022185606070112

Foster, L., Sloan, L., Clark, T., & Bryman, A. (2021). *Bryman´s social research methods* (Sixth ed.). Oxford University Press.

Gilmer, C., Buchan, J. L., Letourneau, N., Bennett, C. T., Shanker, S. G., Fenwick, A., & Smith-Chant, B. (2016). Parent education interventions designed to support the transition to parenthood: A realist review. *International Journal of Nursing Student*, *59*, 118–133. https://doi.org/10.1016/j.ijnurstu.2016.03.015

Graneheim, U. H., & Lundman, B. (2004). Qualitative research analysis in nursing research: Concepts, procedures, and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Graneheim, U., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today*, *56*, 29–34. https://doi.org/10.1016/j.nedt.2017.06.002

Hrybanova, Y., Ekström, A., & Thorstensson, S. (2019). First-time fathers experiences of professional support from child health nurses. *Scandinavian Journal of Caring Sciences*, *33*(4), 921–930. https://doi.org/10.1111/scs.12690

Kolb, A. Y., & Kolb, D. A. (2017). *The experiential educator: Principles and practices of experiential learning*. ISBN: 9780998599908.

Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: Barriers, facilitators and the way forward. *BMC Nursing*, *20*(1), 158. https://doi.org/10.1186/s12912-021-00684-2

Langeland, E., Ausland, L. H., Gunnarsdottir, H., Arveklev, S. H., & Vinje, H. F. (2022). Promoting salutogenic capacity in health professionals. In M. B. Mittelmark (Ed.) et al. The handbook of salutogenesis (2nd ed. pp. 611–624). Springer.

Larsson, S. (2009). A pluralist view of generalization in qualitative research. *International Journal of Research and Method in Education*, *32*(1), 25–38. https://doi.org/10.1080/17437270902759931

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge University Press. https://doi.org/10.1017/CBO9780511815355

Lindgren, B.-M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *International Journal of Nursing Studies*, *108*, 108. https://doi.org/10.1016/j.ijnurstu.2020.103632

Lindström, B., & Eriksson, M. (2005). Salutogenesis. *Journal of Epidemiology and Community Health*, *59*(6), 440–442. https://doi.org/10.1136/jech.2005.034777

Lindström, B., & Eriksson, M. (2011). From health education to healthy learning: Implementing salutogenesis in educational science. *Scandinavian Journal of Public Health*, *39*(6_suppl), 85–92. https://doi.org/10.1177/1403494810393560

Lundström, S., Jormfeldt, H., Hedman Ahlström, B., & Skärsäter, I. (2020). Mental health nurses´experience of physical health care and health promotion initiatives for people with severe mental illness. *International journal of mental health nursing*, *29*(2), 244–253. https://doi.org/10.1111/inm.12669

Marttila, A., Lindberg, L., Burström, K., Kulane, A., & Burström, B. (2017). *Utökat hembesöksprogram för förstagångsföräldrar- samverkan mellan Rinkeby BVC och föräldrarådgivare inom Rinkeby-Kista socialtjänst. Slutrapport utvärdering 2017*. [Translation in English by author; Expanded home visiting programme, the Report 2017]. Karolinska institutet.

Nilsson, L., & Lindström, B. (1998). Learning as a health promotion process: The salutogenic interpretation of the Swedish curricula in state education. *Internet Journal of Health Promotion*. http://rhpeo.net/ijhp-articles/1998/14/index.htm

Oberle, K., & Allen, M. (2001). The nature of advanced practice nursing. *Nursing Outlook*, *49*(3), 148–153. https://doi.org/10.1067/mno.2001.112959

Pennbrant, S., & Svensson, L. (2018). Nursing and learning-healthcare pedagogics and work-integrated learning. *Higher education, Skills & work-Based Learning*, *8*(2), 179–194. https://doi.org/10.1108/HESWBL-08-2017-0048

Polit, D. F., & Beck, C. T. (2021). *Nursing research: Generating and assessing evidence for nursing practice* (11th ed.). Wolters Kluwer.

Pröckl, M. (2023). Bildandet av professionellt omdöme: Om den levda kroppen som utgångspunkt och resurs. *Högre Utbildning*, *13*(2), 103–106. https://doi.org/10.23865/hu.v13.5304

Reeder, J., & Morris, J. (2021). Becoming an empowered parent. How do parents successfully take up their role as a collaborative partner in their child´s specialist care? *Journal of Child Health Care: For Professionals Working with Children in the Hospital and Community*, *25*(1), 110–125. https://doi.org/10.1177/1367493520910832

Rikshandboken i Barnhälsovård. (2023). *Barnhälsovårdens nationella program*. [English translation by author, the national child health care programme].

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Sage.

Sandberg, H. (red.). (2022). *Pedagogik för sjuksköterskor: Pedagogiska perspektiv och handledning i VFU*. (Andra upplagan). Studentlitteratur.

Schön, D. A. (1992). *The reflective practitioner: How professionals think in action* (1st ed.). Routledge. https://doi.org/10.4324/9781315237473

SFS. (2018): 1197. *The Swedish codes of statutes (SFS), act (2018: 1197) on the United Nations convention on the rights of the child*.

Shorey, S. (2021). Health promotion among families having a newborn baby. In G. Haugan & M. Eriksson (Eds.), *Health promotion in health care- vital theories and research* (pp. 173–184). Springer. https://link.springer.com/content/pdf/10.1007%2F978-3-030-63135-2.pdf.

Sunnemark, L., Sunnemark, F., Dahlqvist, K., Gahnström, E., Assmo, P., & Piper, L. (2023). Bridging theory and practice through work-integrated learning (WIL): Critical perspectives on the conceptualisations of WIL at a university in Sweden. *Critical Studies in Education*, *65*(4), 403–420. https://doi.org/10.1080/17508487.2023.2294462

Swedish National Board of Health and Welfare. (2014). *Socialstyrelsen. Vägledning för barnhälsovården*. [English translation by author, Guideline for child health care] Socialstyrelsen, 2014-2014-5.

Thompson, D. L., May, E. J., Leach, M. J., Smith, C. P., & Fereday, J. A. (2023). Applying learning principles within parent education: Exploring nurses´ practice and parents´ experiences. *Patient Preference and Adherence*, *17*, 2949–2970. https://doi.org/10.2147/ppa.S426043

Tynjälä, P. (2008). Perspectives into learning at the workplace. *Educational Research Review*, *3*(2), 130–154. https://doi.org/10.1016/j.edurev.2007.12.001

Vygotskij, L. S. (1978). *Mind in society: The development of higher psychological processes*. Harvard University Press.

Wallby, T., & Hjern, A. (2011). Child health care uptake among low-income and immigrant families in a Swedish county. *Acta Paediatrica*, *100*(11), 1495–1503. https://doi.org/10.1111/j.1651-2227.2011.02344.x

Wettergren, B., Blennow, M., Hjern, A., Söder, O., & Ludvigsson, J. F. (2016). Child health systems in Sweden. *Journal of Pediatrics*, *177*, S187–S202. https://doi.org/10.1016/j.jpeds.2016.04.055

WHO. (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa. 21 November. https://www.who.int/teams/healthpromotion/enhanced-wellbeing/first-global-conference

WHO. (2008). *World Health Organization. Commission on social determinants of Health. Closing the gap in a generation: Health equity through action on the social determinant of health. Final report of the commission on social determinants of health*. World Health Organisation. http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.p

World Medical Association. (2024). *Declaration of Helsinki: Ethical principles for medical research involving human subjects*. https://www.wma.net

Paper B

Tuning in to provide tailored and adjustable health promotion support in children's best interest – an interview study with child healthcare nurses

Veronica Bohlin, Elisabeth Dahlborg, & Katarina Patriksson

B

Published: ***Journal of Child Health Care*****, March 19, 2026**

CC-BY 4.0

Check for updates

Original article

JCHC

Journal of Child Health Care
2026, Vol. 0(0) 1–15
© The Author(s) 2026

Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/13674935261436453
journals.sagepub.com/home/chc
Sage

Tuning in to provide tailored and adjustable health promotion support in children's best interest – An interview study with child healthcare nurses

Veronica Bohlin[1], Elisabeth Dahlborg[1] and Katarina Patriksson[1]

Abstract

Child healthcare (CHC) nurses play a crucial role in supporting children and families from early life. This study describes CHC nurses' experiences of health promotion in Child health service (CHS), focussing on how they develop and apply their competence. Fourteen nurses from five CHC centres were interviewed, and the data were analysed using qualitative content analysis. One overarching theme emerged: *tuning in and adapting support for the family in the child's best interests* – supported by three categories: finding opportunities to promote health, growing in one's work, and organisational support. The findings emphasise CHC nurses recognising their own competence and using learning processes, such as work-integrated learning, to achieve healthier outcomes for children. Continuous professional learning also enables nurses to cope with the challenges of an evolving healthcare environment.

Keywords

child health services, health promotion, nurse specialists, professional competence, qualitative research

Introduction

Understanding health promotion in Swedish Child Health Services (CHSs) requires insight into Child healthcare (CHC) nurses' clinical experiences (Swedish National Board of Health and Welfare, 2014). Recognition of health promotion as a process and resource enables individuals to increase control over and improve their own health as outlined in the Ottawa Charter (World Health Organization, 1986). Occupational stress among healthcare professionals is a well-known

[1]Department of Health Sciences, University West, Trollhättan, Sweden

Corresponding author:
Veronica Bohlin, Department of Health Sciences, University West, Gustava Melins gata 2, Trollhättan SE-46186, Sweden.
Email: veronica.bohlin@hv.se

global issue, which affects wellbeing (Brand et al., 2017). Nevertheless, Swedish CHSs form a key health promotion arena reaching nearly all young children, from birth to 6 years of age (Wettergren et al., 2016). The need to promote equal and optimal health and development for children, in accordance with Swedish legislation and guidelines (SFS 2017:30; SFS 2018:1197; Swedish National Board of Health and Welfare, 2014), underscores the importance of CHS work delivered through a child- and family-centred perspective.

The Swedish national CHS programme is structured across three levels: universal interventions for all children, which include standard health visits and assessments; selective interventions for children with specific needs, such as additional visits or consultations with other professionals; and targeted interventions for vulnerable children requiring extra support, including assistance from social services (Reuter, 2018). A prerequisite for meeting children's unique needs is to identify them by adhering to the national programme through standard visits and providing additional support when needed (Reuter, 2018; Swedish National Board of Health and Welfare, 2014).

Background

Child healthcare nurses' health promotion competence

Multiple factors can influence CHC nurses' work in CHSs. According to Ekström-Bergström et al. (2022) and Langeland et al. (2022), CHC nurses need to have specific competence to identify both risk factors and health-promoting factors, encompassing all aspects of child and family health as well as the practice of health promotion itself. A qualitative study from India found that healthcare professionals' performance in maternal and child health services depends on contextual and health system-related factors, such as supportive colleagues and personal job satisfaction (Gouroumourty, 2025).

Antonovsky (1979, 1987) describes generalised resistance resources (GRRs) – such as resilience and supportive relationships-as determinants of health that help individuals develop a sense of coherence (SOC). SOC enables people to perceive the world as understandable, manageable, and meaningful, thereby enhancing health and decision-making (Lindström and Eriksson, 2011).

Healthcare is in a constant state of transformation, presenting complex challenges that require ongoing adaptation. A key to addressing these changes, as emphasised by Tynjälä (2008), is that workplace learning is essential for fostering lifelong learning. Today, the need for continuous professional development is more pressing than ever, as it facilitates work-integrated learning (WIL), which bridges practical experience with theoretical understanding (Billett and Choy, 2011).

CHC settings function as 'communities of practice', where shared participation and interaction foster professional identity and health promotion competence. It works especially when supported by organisational learning (Säljö, 2014; Wenger, 1998). Learning in situated activities occurs through interaction with others (Wenger, 1998; Wenger-Trayner, 2006) and facilitates the development of health promotion competence, particularly when the organisation supports knowledge sharing, skill development, and adaptation to new challenges (Säljö, 2005, 2014). Workplace learning in CHS can, therefore, be understood as WIL, integrating theoretical knowledge with practical experience (Sunnemark et al., 2023). To strengthen individual learning and professional competence, workplaces should provide effective and sustainable WIL opportunities that support continuous learning and the development of expertise in nursing (Andersson et al., 2022). Moreover, reflective practice is essential to enable deeper understanding and professional growth (Schön, 1983).

Previous research

CHC nurses are the first point of contact for families with young children, and a trusting nurse–parent relationship is essential for a healthy outcome (Bohlin et al., 2022). However, nurses sometimes feel that their knowledge of promoting responsive parent–child interactions is inadequate (Eklund et al., 2022). CHC nurses' experiences of health promotion are shaped by various challenges, including barriers and the need for tailored strategies to enhance understanding and maintain a child-centred perspective (Hallgren et al., 2022; Lind et al., 2024). Bohlin et al. (2025) highlighted health promotion in CHSs as a process of interaction for; sharing, caring and mutual learning, where WIL supports understanding of the dynamic integration of theory and practice, as described by Pennbrant and Svensson (2018). Previous research highlights gaps in CHC nurses 'supportive abilities and the need to enhance their capacity for accessibility and inclusiveness (Engström et al., 2021).

To explore how CHC nurses apply their experience, skills, and competence in health promotion, it is necessary to examine their work practices (Harder et al., 2017).

Considering previous research and the role of reflection on experience in developing competence (Schön, 1991), there remains a gap in knowledge regarding how CHC nurses develop and apply their competence in health promotion.

Aim

To describe nurses' experiences of health promotion in child healthcare.

Methods

Design

This study employed a qualitative method with an inductive approach, aiming to identify patterns from individual interviews (Polit and Beck, 2021). The interviews with CHC nurses were conducted in their workplace.

Ethical considerations

Ethical approval was obtained from The Swedish Ethical Review Authority, registration number 2022-03858-01. The study was conducted in accordance with the Declaration of Helsinki (WMA, 2024). Participants received both written and verbal information about the study's aims and provided their written informed consent. Participation was voluntary, and participants were informed that they could withdraw from the study at any time.

Data collection and participants

Data were collected at five CHC centres with CHC nurses working with families from diverse backgrounds. Purposive sampling ensured participation. All CHC nurses were specialised in working within the national CHS programme, including growth monitoring, health counselling, vaccinations, and home visits for infants.

The study was conducted from 5th October 2022 to 9th February 2023 at five CHCs in western Sweden. Eight CHCs were invited to participate; three managers could not be reached, while five

agreed to take part and granted the researchers permission to invite CHC nurses. All participating centres are part of the Swedish primary healthcare system, either publicly or privately managed, and publicly funded.

The interviews were conducted in the nurses' consulting rooms or in other rooms where privacy could be ensured. The first author (VB) approached the study with preunderstanding based on experience as a former CHC nurse. The initial questions were 'What does health mean to you?' and 'What does it mean to you as a CHC nurse to work with children and families to promote health?'

Data analysis

To explore CHC nurses' experiences of health promotion, a qualitative content analysis with an inductive approach was used. This method emphasises identifying variations in communication to reveal patterns (Graneheim et al., 2017; Graneheim and Lundman, 2004). The first author read the audio-recorded and transcribed interviews to become familiar with the material and then divided the text into meaning units and coded to reflect the manifest content (Table 1).

Table 1. Examples of the coding process.

Meaning units	Condensed meaning units	Code	Subcategory	Category
"To make visible if the parents are annoyed with each other, what is behind it which you take and describe what you see and hear". (Amanda)	Making visible what you see and hear if the parents are annoyed with each other	Making visible what you see and hear	Identifying the needs of the family	Finding opportunities to influence and promote health
"To reflect on one's own treatment and what went well, what went less well…to think about it and not be afraid to develop". (Betty)	Reflecting on one's own treatment and not being afraid to develop	Reflecting and developing	Reflection as a tool for learning	Growing in your work

The authors discussed the codes collaboratively to minimise subjective interpretation, drawing on their nursing experience. The codes were organised into subcategories and overarching categories, leading to an overarching theme. The analysis involved an iterative review to identify a common thread and relate the content to the study's aim to increase trustworthiness (Graneheim et al., 2017; Guba and Lincoln, 1994).

Findings

Fourteen CHC nurses were invited via phone or email and all consented verbally and in writing. Fictious names were used to ensure anonymity. Five participants specialised in paediatric nursing, while nine specialised in public health. All of them were de-identified using fictious names to ensure anonymity (Table 2).

Table 2. Description of the participants.

Participant	Specialisation	Years of experience
Amanda	Public health	11
Betty	Public health	12
Clary	Public health	6 months
Dorothy	Public health	20
Ellen	Public health	13
Felicia	Public health	18
Ruth	Paediatric nurse	5 months
Helena	Paediatric nurse	2
Ingela	Public health	3½
Jennifer	Paediatric nurse	4
Kristina	Public health	4½
Lilly	Paediatric nurse	10
Madeleine	Public health	7
Vera	Paediatric nurse	4

Participants had 5 months to 20 years (mean 7 years 10 months) of CHC experience and were aged 36–60 years (mean 49 years 10 months). Interviews lasted between 24 min and 1 h 8 min, totalling 8 h and 47 min (mean 37 min).

Analysis of health promotion work revealed one overarching theme: *tuning in and adapting support for the family in the best interests of the child* (Table 3).

Finding opportunities to influence and promote health

Opportunities to influence and promote health allowed the nurses to make a meaningful difference for the children. Health promotion was central to their work, reflecting their impact on children's development. Inclusivity and trustworthiness were prerequisites for identifying families' needs, supporting parenthood, and addressing challenges.

Table 3. Overview of the overarching theme, categories, and subcategories.

Overarching theme	Tuning in and adapting support for the family in the best interests of the child		
Category	Finding opportunities to influence and promote health	Growing in your work	The need for organisational support
Subcategory	Identifying the needs of the family	Own experience as a base	Engagement of the manager
	Dealing with obstacles	A mutual sharing of knowledge	Need for external assistance
	Encouraging parenthood	Reflection as a tool for learning	

Identifying the needs of the family. The CHC nurses described encounters as opportunities for active listening and patience, aiming to convey a sense of security and build trust. Gaining the trust of both children and families was essential for identifying their unique needs and establishing positive relationships. Consequently, it was important to include all family members and recognise each of them as individuals.

Once trust was established, parents opened up, allowing the nurses to address each family's concerns effectively. Open communication was crucial, even on challenging topics, helping both nurses and parents feel comfortable asking questions. A CHC nurse illustrated how to achieve a successful encounter in the following quotation.

> I think the most important thing in the encounter itself is that we work from a health perspective, to succeed in making the parent feel safe about being able to ask and be unsure and dare to mention things that they feel in their parenting (Lilly).

The CHC nurses described various family situations, such as when a single mother required special attention, highlighting the importance of identifying the child's and mother's social network and support system. By observing parents' cues, nurses recognised family resources, understood unique needs, and provided support through universal or additional CHS interventions.

To understand families' needs during encounters, CHC nurses adapted their approach to each family unit, making the family's perspective central to promoting the children's best interests.

Family participation and needs could vary between visits. This meant that adjusting support was an ongoing process that sometimes required multiple encounters. CHC nurse Ruth emphasised mutual understanding as a key step in gaining a comprehensive view of the family.

> and because we meet so often, you usually get small things each time that you can try to put together to form a picture (Ruth).

The CHC nurses emphasised that actively listening and empathy provided valuable insights into the families' situations hence accurately identifying families' needs also required parents to be receptive and engaged. Some participants noted that responsive parents often asked questions and showed interest in learning more.

The CHC nurses shared examples of openly framed questions that allowed families to express their needs. By listening to parents' responses, nurses identified potential risk factors. Occasionally, when parents did not respond, the nurses adapted by asking more focused questions. One participant noted her principle of treating others as she would like to be treated.

Dealing with obstacles. All CHC nurses reported obstacles during parent interactions. Some parents resisted advice, interpreted by the nurses as signs of insecurity in their parenting. This resistance made it difficult to identify certain risk factors, as parents often refrained from answering questions. To address this, CHC nurses employed various strategies to understand parents' needs and encourage them to engage. This approach was vital in sensitive situations, such as childhood obesity or parental vaccine hesitancy, with the nurses' focussing on the child's best interests. When parents remained unreceptive – for example, refusing vaccination – nurses provided information on its importance.

> At a vaccination age I will ask parents again, so they don't have to come every time and feel that we are going to argue again (Amanda).

CHC nurses sometimes worked with parents' receptivity over an extended period. With time, initially non-receptive parents became more responsive. Some nurses emphasised skills such as patience and sensitivity in tuning their support to meet parents' needs, helping them become more attentive to their child's wellbeing.

Time pressure was another obstacle. Tight schedules required prioritising visits for younger children, delaying older children and regular home visits for eight-months-old infants. CHC nurses sometimes had to forgo breaks to manage their workload.

Encouraging parenthood. All CHC nurses appeared confident in their role of supporting and encouraging parenthood. Their aim was to help parents feel secure by providing tailored health promotion advice. Some described how they encouraged parents to find solutions using their own resources. Supporting parents in building trust in their parenting involved fostering self-esteem through affirmation and encouragement, enabling them to feel confident in asking questions. Several nurses noted that parents developed and gained confidence when they could formulate their own questions.

> Strengthen their confidence in their own ability (parents) to do the right thing for their children and to think correctly themselves about the decisions they make (Betty).

Parent groups served as a forum for meeting other parents and creating support networks. These networks provided opportunities to discuss everyday challenges related to their children and to offer mutual support.

Growing in your work

CHC nurses emphasised that their professional experience was essential for their growth in practice. The mutual sharing of knowledge between nurses and parents depended on their previous professional experiences, which they drew upon during encounters with families. The nurses also recognised the value of reflecting both during and after interactions to learn from their experiences with children and parents.

Own experience as a base. The nurses adapted their knowledge based on experience and the needs of each child and family. They also described their professional experience as a source of strength and security, providing confidence even when specific knowledge was lacking. The CHC nurses were self-assured in their role, recognised gaps in their knowledge, and actively sought to acquire the necessary skills and information.

The nurses were also aware that their experiential knowledge expanded as they encountered different family constellations. They described their growing experience as 'baggage' – a valuable knowledge base.

Despite their experience, maintaining professionalism could be challenging, as encounters with complex family issues sometimes triggered lingering emotions.

While maintaining a professional stance during these interactions, the emotional impact of challenging encounters could persist afterwards. The nurses described relying on their intuition and tacit knowledge, often sensing that something might be wrong based on a 'gut feeling'.

They also emphasised using their accumulated experience appropriately to meet the needs of each child and family.

> We all have our baggage with all our different points of view, so that as a CHC nurse you always get to see what kind of person you have in front of you in every encounter (Ingela).

A mutual sharing of knowledge. The CHC nurses described knowledge sharing as a natural and valuable process. They highlighted mutual exchange and the importance of active listening. Parents were regarded as active participants in this exchange.

The nurses consistently adapted the information they provided based on what they learnt during the encounters. Sometimes, they recognised that the parents could not absorb all the information at once, so they shared it in smaller portions over multiple interactions. One CHC nurse referred to this approach as 'knowledge injections'.

Knowledge sharing between CHC nurses and parents extended beyond spoken words to include body language. Some CHC nurses sensed emotional cues, remaining receptive to parents' words and body language.

> It feels as if you relieve someone sometimes by taking it (emotions) (Kristina).

Through active listening during mutual knowledge sharing, CHC nurses could acknowledge and ease parents' emotions, recognising that parents possessed valuable insights about their children that the nurses needed to understand.

Reflection as a tool for learning. CHC nurses' need for reflection arose in different situations but carried a consistent purpose: to understand why they reacted as they did in interactions with children and parents. One reason reflection was necessary was that nurses often absorbed and processed parents' emotions during active listening. As time for formal reflection was limited, they frequently had to carry these emotions and experiences with them throughout the day, which could resurface after work, such as in the car or at home, highlighting the importance of organised reflection time. Another key reason for reflection was to facilitate knowledge sharing and mutual learning. When nurses had the opportunity to reflect on a family prior to an encounter, it allowed them to retain insights and enhance their understanding for future interactions.

Letting go of certain emotions and situations could be difficult, prompting CHC nurses to seek opportunities to debrief and reflect with colleagues. This highlighted the importance of collective reflection for learning and professional growth. Some nurses described reflection as valuable and developmental for the nursing profession. Although there was no designated time for reflection, it was common practice to seek out a colleague when needed.

Additionally, the nurses maintained ongoing contact with the child psychologist regarding challenges with children and families, providing further opportunities to reflect with others and to understand their own reactions in various situations.

> Then sometimes there can be things that you find out that might be good for your colleagues to know too, some cultural difference or something (Madeleine).

They also believed that reflecting and learning collaboratively with colleagues could lead to meaningful and necessary changes in the workplace.

The need for organisational support

CHC nurses highlighted the need for organisational support in their health promotion work with families, emphasising both managerial engagement and access to external assistance.

Engagement of the manager. The CHC nurses described the manager's commitment as an important source of professional support. Having a manager who advocated for them and spoke on their behalf in various situations was particularly meaningful. Another way a committed manager could provide support was by allocating regular, structured reflection time. Although nurses reflected individually, having designated reflection sessions was valuable, as it ensured that all CHC nurses had the opportunity to engage in the process. Organised reflection time became easier to implement when it was established as a routine known to everyone.

> …we brought up a case and reflected so it was very good (Felicia).

A set time for reflection was considered support from a committed manager.

Need for external assistance. Social Services was an important source of external support when a child required additional assistance. Occasionally, CHC nurses needed to alert Social Service about a child of concern; however, they did not always receive the expected support, which could be frustrating. Lack of assistance sometimes arose unexpectedly in situations where help was needed for a child.

Another source of external support was the Central Child Health Service Unit, which provided training and regular meetings for all CHC nurses in western Sweden. Nurses valued this support, as it allowed them to feel acknowledged and to receive training on various topics, such as postpartum depression screening and breastfeeding.

Collaborative networking involved working with others to focus on the child and strengthen support for children and families. This included partnering with libraries to organise visits for parent groups, teaching the importance of language and introducing books. Networking could also mean involved coordinating with midwives to hold joint parent group sessions arranging schedules in collaboration with yoga studios sometimes, which many mothers attended for exercise. In addition, collaboration with preschools was important when multiple perspectives were needed to assess a child's situation. Through such partnerships, organisations such as CHC centres and preschools could advocate more effectively for the best interests of the child, as they could consider the child's needs from different angles.

Discussion

The findings highlight CHC nurses' professional experiences in health promotion work and the continuous process of applying both theoretical knowledge and practical experience to provide tailored support. Awareness of the interaction process when encountering children and families, combined with WIL, integrating theoretical knowledge with practical experience (Sunnemark et al., 2023), and the process of sharing and mutual learning as a form of healthy learning (Bohlin et al., 2025; Lindström and Eriksson, 2011), can serve as a foundation for preparing and guiding health promotion in clinical practice.

By actively listening and adapting their work to meet each child's and family's individual needs, CHC nurses strive to create a safe and trusting relationship where the child's health and wellbeing are

the focus. Their flexible interactions contribute to ongoing professional learning and the development of health promotion competence. However, the findings highlight several obstacles to fully utilising professional competence and reflection time, particularly due to tight schedules, which can increase the risk of suboptimal outcomes for children. The subcategory *Dealing with Obstacles* illustrates how limited time can make it difficult to prioritise breaks or follow-ups, leading to potential ethical stress when nurses cannot provide tailored support. Tight schedules are particularly critical because neglecting or delaying health visits under the universal measures of the national CHS programme prevents nurses from assessing children's needs and supporting optimal health and development, as outlined in Swedish legislation and guidelines (SFS 2017:30; SFS 2018:1197; Swedish National Board of Health and Welfare, 2014).

The category of *Growing in your work* addresses the requirement for CHC nurses to grow in their profession and professional role in order to promote health in the child́s best interest. The subcategories *Own experience as a base* is about being able to handle health promotion from onés own experience. The mutual sharing of knowledge depended on previous experiences and is needed in the encounter between a nurse and families, as well as acting as a tool for a healthy outcome. According to CHC nurses, *The need for organisational support* is crucial both internally and externally. The manageŕs engagement was obvious when there were opportunities for a specific reflection time in the workplace. These reflection sessions ensured that the CHC nurses remained engaged with the ongoing processes.

The need for external assistance was important so that health promotion work could continue uninterrupted when the child required such assistance. When Social Services failed to respond adequately, the CHC nurses felt neglected and there was a risk of ethical stress, which could be detrimental to childreńs health outcomes. According to Article 3 of the United Nations Convention on the Rights of the Child (SFS 2018:1197), all children have the right to have their best interests treated as the primary concern.

When nurses cannot tune in to children's unique needs, their professional competence is underutilised, health promotion work is compromised, and children's chances of achieving a healthy outcome are reduced. If parents feel disempowered, collaboration with a CHC nurse may become more hierarchical and less partnership-oriented (Reeder and Morris, 2021), limiting SOC development for both nurse, child and family, potentially affecting children's future experiences with healthcare (Sahlberg et al., 2020). Therefore, the wellbeing of CHC nurses is crucial for effective health promotion (Brand et al., 2017).

Despite the challenges, CHC nurses' descriptions of opportunities to influence health promotion demonstrate that they experienced SOC, as their work was meaningful. This aligns with research showing that SOC provides health benefits and supports professional engagement in health promotion (Antonovsky, 1987; Lindström and Eriksson, 2006; Vinje and Mittelmark, 2006). This may help explain why CHC nurses choose to remain in CHS despite the risks of ethical stress, highlighting the importance for healthcare organisations globally to prioritise nurses' wellbeing (Brand et al., 2017). Antonovsky (1979, 1987) emphasised that GRRs are important for managing stress and promoting health. CHC nurses apply their skills – such as patience, tact, and professional knowledge – as GRRs to strengthen children's and families' own resources, thereby enhancing the potential for positive development and healthy outcomes.

Sometimes, good intentions did not lead to the desired outcomes. For example, within the category *Identifying the Needs of the Family*, one CHC nurse explained that her intention was to treat parents as she herself would like to be treated. This reflects a normative approach to encounters. Instead of tuning in to the unique needs of the family, the nurse relied on her own norms, which meant that the family's specific needs could be overlooked. This finding highlights the importance of

nurses being aware of their own values and assumptions, as prescribed norms may inadvertently exclude rather than include families, consistent with findings from a study on CHC parenting groups and reasons for non-attendance (Forslund Frykedal et al., 2019).

The participating CHC nurses appeared aware of the importance of reflection for their professional growth. During the encounters, theoretical knowledge was integrated into practice through a dynamic process of WIL, with nurses reflecting on their actions to plan future support for families. They also navigated the lack of dedicated reflection time by spontaneously seeking out colleagues when needed. The crucial skill of tuning in and recovering from emotional strain may be difficult without opportunities to process emotions. Reflection is essential for professional development, both *in* and *on* action (Schön, 1983). Rather than relying solely on structured reflection sessions, nurses initiated discussions with colleagues using shared dialogue to process experiences and insights in real time. This demonstrates their flexibility and awareness within the constraints of demanding schedules, while also highlighting the need for allocated time in CHC nurses' schedules to safeguard children's rights as active participants in encounters (Sahlberg et al., 2020).

Research emphasises that learning occurs through experiences in interactions, which is a fundamental process for developing expert competence (Hutchings and Jarvis, 2012; Tynjälää, 2008). CHC nurses rely on collaboration with other professionals to complement and strengthen their own competence. By working together and sharing experiences, they create a community of practice where knowledge can be deepened and professional practice further developed (Lave and Wenger, 1991).

Limitation

One limitation of the study is that another data collection had been conducted prior to the interviews with twelve of the participants, which may have influenced their responses. Another limitation could be the amount of participating CHC nurses, though a strength of the study is the broad sample of them, drawn from five centres located in both well-functioning urban areas and rural areas with fewer amenities. Another strength is that all authors are nurses with specialisations within healthcare, neonatal intensive care and pedagogy, each bringing diverse experiences, providing valuable preunderstanding of nursing competence. To strengthen credibility and facilitate transferability, the analysis process was presented in tabular form. The findings were also discussed by all authors to ensure trustworthiness and reflecting against the literature (Graneheim et al., 2017; Guba and Lincoln, 1994).

Implications for practice

CHC nurses awareness of their professional skills and competence is crucial for promoting the best interests of the child, thereby increasing the likelihood of positive health outcomes. It is important to have a pedagogical theme as a basis for discussion so that the CHC nurses can have conversations in workplace, about how to handle practical experiences with theoretical knowledge. In this way, opportunity to enhance lifelong learning is created. WIL can serve as a pedagogical approach to prepare nurses for effective health promotion in CHS's.

Further research is needed to explore how healthcare settings can best provide wellbeing and support for CHC nurses, enabling them to deliver high-quality health promotion.

Conclusion

The findings highlight the importance of CHC nurses becoming aware of their own competence and using learning process, such as WIL, to promote the best possible health outcomes for children. Findings also highlight the fact that workplace conditions can strengthen or weaken an individual's SOC. The CHC nurses needs to have the ability to tune in to the unique needs of the child and family. Therefore, managers need to give them opportunities to reflect with each other for developing SOC and a lifelong learning in the child́s best interests. Continuous professional learning also supports nurses in coping with challenging healthcare changes.

Acknowledgements

We wish to thank all participating CHC nurses for valuable knowledge sharing in taking time to share your experiences.

ORCID iDs

Veronica Bohlin https://orcid.org/0000-0002-0045-3427
Elisabeth Dahlborg https://orcid.org/0009-0001-5728-9242
Katarina Patriksson https://orcid.org/0000-0001-9687-6143

Ethical considerations

Ethical approval was obtained from the The Swedish Ethical Review Authority, registration number 2022-03858-01.

Consent to participate

Informed consent to participate in written and verbally.

Consent for publication

Informed consent in written and verbally.

Author contributions

All authors contributed to the conception and design of the study and methodology. Acquisition and compilation of data; first author. Data curation, all authors. Analysis and interpretation of data, ethical permission application, all authors. Project administration, first author. All authors have been involved in drafting and critically revising the manuscript, validation of the results, and approval of the final version for publication. The authors are responsible for all aspects of the work and have ensured that questions related to the accuracy of any part of the work were appropriately investigated and resolved.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was supported by the Department of Health Sciences, University West, Trollhättan, Sweden and The Red Cross Home Foundation.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Data Availability Statement

Data are kept in a locked, safe server for research use at University West. The participants in this interview study did not consent to having their data publicly available as they contained personal information that could be used to identify them.

References

Andersson A, Graneheim UH and Nilsson MS (2022) Newly-graduated nurses'work-integrated learning: a qualitative study from an educational and occupational perspective. *Nurse Education in Practice* 59: 103290. https://doi.org/10.1016/j.nepr.2022.103290

Antonovsky A (1979) *Health, Stress, and Coping*. San Francisco: Jossey-Bass.

Antonovsky A (1987) *Unraveling the Mystery of Health: How People Manage Stress and Stay Well*. San Francisco, CA: Jossey-Bass.

Billett S and Choy S (2011) Cooperative and work-integrated education as a pedagogy for lifelong learning. In: *International Handbook for Cooperative and Work-Integrated Education: International Perspectives of Theory, Research and Practice*, pp. 25–30.

Bohlin V, Nolbris MJ and Wigert H (2022) Child health care nurses' experiences of language barriers during home visits. *Public Health Nursing* 39(1): 146–152. https://doi.org/10.1111/phn.12977

Bohlin V, Gunnarsdottir H, Patriksson K, et al. (2025) The nurse in child healthcare as a craftsman to use professional competence and build a health promotive relationship-an observation study. *International Journal of Qualitative Studies on Health and Well-Being* 20(1): 2527146. https://doi.org/10.1080/17482631.2025.2527146

Brand SL, Thompson Coon J, Fleming LE, et al. (2017) Whole-system approaches to improving the health and wellbeing of healthcare workers: a systematic review. *PLoS One* 12(12): e0188418. https://doi.org/10.1371/journal.pone.018

Eklund AL, Jangsten E and Gunnarsdóttir H (2022) Assessing and promoting responsive interaction between parents and children: a qualitative study of the experiences of child health care nurses in Sweden. *Journal of Pediatric Nursing* 63: e95–e101. https://doi.org/10.1016/j.pedn.2021.10.006

Ekström-Bergström A, Thorstensson S and Bäckström C (2022) The concept, importance and values of support during childbearing and breastfeeding: a discourse paper. *Nursing Open* 9(1): 156–167. https://doi.org/10.1002/nop2.1108

Engström M, Hiltunen J, Wallby T, et al. (2021) Child health nurses'experiences of addressing psychosocial risk factors with the families they meet. *Acta Paediatrica* 110(2): 574–583. https://doi.org/10.1111/apa.15492

Forslund Frykedal K, Marimani M, Rosander M, et al. (2019) Parents'reasons for not attending parental education groups in antenatal and child health care: a qualitative study. *Journal of Clinical Nursing* 28(17–18): 3330–3338. https://doi.org/10.1111/jocn.14912

Gouroumourty R, Maheshwari M, Prasad A, et al. (2025) In depth exploration of drivers of community health workers' performance in maternal and child health services: a multistakeholder perspective from rural Indian setting. *BMC Primary Care* 26(1): 179. https://doi.org/10.1186/s12875-025-02851-9

Graneheim UH and Lundman B (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today* 24(2): 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Graneheim UH, Lindgren B-M and Lundman B (2017) Methodological challenges in qualitative content analysis: a discussion paper. *Nurse Education Today* 56: 29–34. https://doi.org/10.1016/j.nedt.2017.06.002

Guba EG and Lincoln YS (1994) Competing paradigms in qualitative research. In: Denzin NK and Lincoln YS (eds) *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications, pp. 105–117.

Hallgren J, Bäckström C, Pettersson M, et al. (2022) A prospective cross-sectional study of child healthcare competence among nurses within primary healthcare in Sweden. *Nordic Journal of Nursing Research* 43(1): 20571585221096548. https://doi.org/10.1177/20571585221096548

Harder M, Enskär K and Golsäter M (2017) Nursesúse of pliable and directed strategies when encountering children in child and school healthcare. *Journal of Child Health Care* 21: 55–64. https://doi.org/10.1177/1367493516679014

Hutchings M and Jarvis P (2012) The relationship between practice, theory and research. In: Higgs J, Barnett R, Billett S, et al. (eds) *Practice-Based Education: Perspectives and Strategies*, Sense Publishers, pp. 175–186. https://doi.org/10.1007/978-94-6209-128-3_13

Langeland E, Ausland LH, Gunnarsdottir H, Arveklev S and Vinje H (2022) Promoting salutogenic capacity in health professionals. In: Mittelmark MB, Bauer GF, Vaandrager L, et al. (eds) *The Handbook of Salutogenesis*. Cham: Springer, pp. 611–624.

Lave J and Wenger E (1991) *Situated learning : legitimate peripheral participation.* Cambridge: University Press.

Lind BM, Wigert H, Jenholt Nolbris M, et al. (2024) Child healthcare nurses' experience of communication with 4-year-old children during their visit to the child health care center. *Public Health Nursing* 41(5): 1098–1105. https://doi.org/10.1111/phn.13351

Lindström B and Eriksson M (2011) From health education to healthy learning: implementing salutogenesis in educational science. *Scandinavian Journal of Public Health* 39(6_suppl): 85–92. https://doi.org/10.1177/1403494810393560

Pennbrant S and Svensson L (2018) Nursing and learning-healthcare pedagogics and work-integrated learning. *Higher Education, Skills and Work-based Learning* 8(2): 179–194. https://doi.org/10.1108/HESWBL-08-2017-0048

Polit DF and Beck CT (2021) *Nursing Research:Generating and Assessing Evidence for Nursing Practice*. 11th edition. Philadelphia: Wolters Kluwer.

Reeder J and Morris J (2021) Becoming an empowered parent. How do parents successfully take up their role as a collaborative partner in their child's specialistcare? *Journal of Child Health Care* 25(1): 110–125. https://doi.org/10.1177/1367493520910832

Reuter A (2018). *Barnhälsovårdens nationella program. [National Child Health Care Program]*, Available at. https://www.rikshandboken-bhv.se/verksamhetsriktlinjer/barnhalsovardens-nationella-program/ (acessed 30 October 2025).

Sahlberg S, Karlsson K and Darcy L (2020) Children's rights as law in Sweden–every health-care encounter needs to meet the child's needs. *Health Expectations* 23(4): 860–869. https://doi.org/10.1111/hex.13060

Säljö R (2005) *Lärande Och Kulturella Redskap: Om Lärprocesser Och Det Kollektiva Minnet [Learning and Cultural Tools: On Learning Processes and the Collective Memory]*. Stockholm: Norstedts akademiska förlag.

Säljö R (2014) *Lärande i Praktiken: Ett Sociokulturellt Perspektiv [Learning in Practice: A Sociocultural Perspective]*. Lund: Studentlitteratur.

Schön DA (1991) *The Reflective Practitioner. [Elektronisk resurs]: How Professionals Think in Action*. London: Routledge.

SFS (2017) *Swedish Health care act* [Hälso-och sjukvårdslag]. (accessed 30 October 2025).https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/halso-ochsjukvardslag-201730_sfs-2017-30/

SFS (2018 1197) *Swedish law on United Nations conventions on the rights of the child* [Förenta nationernas konvention om barnets rättigheter]. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-20181197-om-forenta-nationernas-konvention_sfs-2018-1197/ (accessed 30 October 2025).

Sunnemark L, Sunnemark F, Dahlqvist K, et al. (2023) Bridging theory and practice through work-integrated learning (WIL): critical perspectives on the conceptualisations of WIL at a university in Sweden. *Critical Studies in Education* 65: 403–420. https://doi.org/10.1080/17508487.2023.2294462

Swedish National Board of Health and Welfare (2014) *Vägledning För Barnhälsovården*. Stockholm: Socialstyrelsen. Available at. https://www.socialstyrelsen.se/publikationer/vagledning-for-barnhalsovarden-2014-4-5/ (accessed 30 October 2025).

Tynjälä P (2008) Perspectives into learning at the workplace. *Educational Research Review* 3(2): 130–154. https://doi.org/10.1016/j.edurev.2007.12.001

Vinje H and Mittelmark MB (2006) Deflecting the Path to Burn-out among Community Health Nurses: How the Effective Practice of Self-Tuning Renews Job Engagement. *The International Journal of Mental Health Promotion* 8: 36–47. doi: 10.1080/14623730.2006.9721750.

Wenger E (1998) *Communities of Practice: Learning, Meaning, and Identity*. Cambridge: Cambridge University Press.

Wenger-Treyner E (2006) Communities of practice: a brief introduction. Available at. https://www.wenger-trayner.com/introduction-to-communities-of-practice/ (accessed 25 March 2025).

Wettergren B, Blennow M, Hjern A, et al. (2016) Child health systems in Sweden. *The Journal of Pediatrics* 177: S187–S202. https://doi.org/10.1016/j.jpeds.2016.04.055

WMA (2024) *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*. World Medical Association.

World Health Organization (1986) *Ottawa Charter for Health Promotion*. Geneva: WHO.

Strengthening Parenthood through Specialised Nursing and self-awareness

A Work-Integrated Learning Approach within Child Health Services

This licentiate thesis explores how child healthcare (CHC) nurses use their professional competence to promote health. Findings highlight *Health promotion as professional competence is a craft of interaction for caring and mutual learning* and positions work-integrated learning (WIL) as a pedagogical model to understand health promotion in the context of CHC practice. The interaction between the nurse, the child and the family is seen as a dynamic process of caring, knowledge-sharing and learning. *Interactioning* is used as a neologism for the three-ing concepts that are dependent on each other. *Tuning in and adapting support for the family in the best interests of the child* describes reflections and the need for self-awareness as a resource for decision-making as well as using themselves as a tool of their own competencies. CHC nurses need time for reflection to maintain self-awareness that enables professional growth and development for continuous learning.

ISBN: 978-91-89969-46-9 (printed)
ISBN: 978-91-89969-45-2 (electronic)