The school health service (SHS) is part of the children’s public health programme in Sweden and serves every individual aged 6–19 years (Socialstyrelsen, 2004). According to the Swedish school law (Svensk Författnings samling, 1985), the main objective of the SHS is to follow pupils’ development, maintaining and improving their mental and bodily health as well as promoting a healthy lifestyle. In Sweden, children and young people are generally healthy, but psychosomatic symptoms and poor mental health among both schoolchildren and adolescents are areas that need attention (Socialstyrelsen, 2009). Excess weight and obesity also present a major health issue in Sweden (Socialstyrelsen, 2009), as in the rest of Europe and the US (Ebbeling et al, 2002; Wang et al, 2002; Lobstein and Frelut, 2003).

A fundamental objective of the SHS’s health promotion work is to strengthen the individual’s control over his or her own health. To enable individuals to take control of their own health, it is important to create a trusting and open atmosphere where they feel involved and respected (Eweles and Simnett, 2005). Consequently, the face-to-face encounter with pupils is regarded by school nurses as one of the most important parts of the SHS. Conversations with pupils, both spontaneous and planned, were described by school nurses as important tools for health promotion in the SHS (Morberg et al, 2006).

In Sweden, opportunities to have a personal health dialogue with the school nurse are offered to children in grades 4 and 7 in compulsory comprehensive school, and during their first year of upper secondary school. The aim of these dialogues is to evoke an interest that will lead to a healthy lifestyle. These dialogues focus on school situation, relationships, leisure activities, physical activities, eating habits, tobacco use, alcohol and drug use, sexuality and perceived health (Socialstyrelsen, 2004).

In a questionnaire, Danish pupils aged 11–15 years reported that it was important that the school nurse listen, ask questions about their health and give good advice, supporting the pupils’ own ideas. Health dialogues worked well when pupils had an influence over what was discussed, and when enough time was allocated (Borup, 2000). Pupils aged 15 years found it important to be treated with respect and to be heard during mental health-promoting dialogues (Johansson and Ehnfors, 2006). Twelve-year-old Finnish pupils wanted more individual counselling in the SHS based on their individual health status (Mäenpää et al, 2007).

According to the National Board of Health and Welfare (Socialstyrelsen, 2004), health dialogues have been developed by school nurses as a tool for the SHS’s preventive work, but research on how they are experienced by the pupils is scant. The pupils’ opinions about the
health dialogues and how they are carried out require more research. Article 12 of the Convention on the Rights of the Child (UNICEF, 1989), describing children’s rights to be heard and to be taken into account in matters concerning them shows the necessity of asking children for their opinion on the SHS’s health dialogues.

Qualitative interviews are useful for gaining a more in-depth understanding of how pupils of different ages experience preventive health dialogues and conversations concerning their own health.

**Aim**
The aim of the study was to elucidate pupils' perspectives on health dialogues with school nurses.

**Method**
A qualitative descriptive design was chosen with the intention of obtaining a detailed understanding of pupils’ own perspectives on health dialogues (Creswell, 2007).

This study used focus group interviews on the basis that the interaction between group members may create new dimensions of the substance that might remain undetected in one-on-one interviews (Holloway and Wheeler, 2002). Focus group interviews are also considered a useful method for exploring children and young people's own experiences and knowledge. Group interviews can also increase the likelihood that they will voice their own opinions (Heary and Hennessy, 2002).

**Participants**
Pupils in grades 4 and 7 in compulsory school and in their first year of upper secondary school who had recently visited their school nurse for a health dialogue were asked to take part in the study. They were invited to do so by their teachers, based on information from the researcher. Pupils who expressed an interest in taking part in the study were invited to the interviews. The participating pupils were from various schools located in different socioeconomic areas in a county in southern Sweden. In the interview groups, pupils from 11 schools served by 12 school nurses participated. A total of 15 groups: 37 boys and 37 girls, from different ethnic groups were interviewed. Interviews were planned with four to six participants in each group matched in terms of age, sex and school year, according to Heary and Hennessy’s (2002) recommendations. Kreuger and Casey (2000) also recommend that unisex groups are best when children and young people are interviewed in groups. Three of the groups consisted of just three participants, as a number of children who should have participated were sick the day of the interview. Two groups came to be mixed because both boys and girls had been invited by the teacher to participate in the same group, the others were unisex. For ethical reasons, the researchers decided to conduct the interview with all the children who had prepared themselves for the interview even if the groups came mixed. The composition of the focus groups is shown in Table 1.

**Data collection**
The focus group interviews were conducted without distraction in rooms at the pupils’ schools during school days. Two researchers without professional connection to the pupils performed the interviews. During the interview, one of the researchers (KE) made field notes and took care of practical things. The other researcher (MG) acted as a moderator, supporting the discussion to allow the pupils to freely discuss their opinions about the health dialogues with each other.

To facilitate the communication about the health dialogue experiences and to obtain rich information, the children were asked to describe a health dialogue. Their description was followed up with delving questions about their experiences of the health dialogue, their participation and possibilities to influence the content, and how these were carried out. Questions about what factors they considered important for a successful conversation were also included. If the discussion began to stray, the moderator concluded the topic to steer the discussion back to the aim of the study. When the pupils answered with many brief contributions, the moderator made a summary of the discussion which the pupils then responded to in order to validate the moderator’s interpretation (Kvale, 1997). At the end of the interview, the researcher (KE) presented a brief summary of the discussion and gave the participants the opportunity to confirm or clarify it, according to Krueger and Casey (2000). After the interview, the participants received a movie ticket for their time. The interviews, which lasted about 1 hour each, were recorded and transcribed verbatim.

**Data analysis**
Qualitative content analysis according to Krippendorff (2004) was performed and, further, the inductive

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**Table 1. Composition of the focus groups**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Gender</th>
<th>Total groups</th>
<th>Participants per group</th>
<th>Total of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Boys</td>
<td>2</td>
<td>5;3</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>Girls</td>
<td>2</td>
<td>5;5</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>Both</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Boys</td>
<td>3</td>
<td>6;5;3</td>
<td>14</td>
</tr>
<tr>
<td>7</td>
<td>Girls</td>
<td>2</td>
<td>6;5</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>Both</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>First year upper secondary school*</td>
<td>Boys</td>
<td>2</td>
<td>6;6</td>
<td>12</td>
</tr>
<tr>
<td>First year upper secondary school</td>
<td>Girls</td>
<td>2</td>
<td>6;6</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>37 Boys /37 Girls</strong></td>
<td><strong>3–6</strong></td>
<td><strong>74</strong></td>
</tr>
</tbody>
</table>

*Grade 4=10–11 years old, Grade 7=13–14 years old, 1st year upper secondary school=16–17 years old
Research approach as described by Elo and Kyngas (2008) was used based on the fact that previous knowledge of the pupils’ perspective on the health dialogues was scant. When using content analysis, the text is analysed through various steps:

- Each interview was read through several times to obtain a sense of its content and to apprehend essential features of the interviews
- Notes and headings describing the content related to the aim of the study were marked in the text as codes
- The codes and the related text were placed together in coding sheets, and grouped into preliminary categories based on similarities and differences of the content
- By going back and forth among the preliminary categories, the codes and the text, the subcategories were identified. During this process the researchers strove to be close to the text
- The subcategories were abstracted and sorted into four categories based on their underlying meanings.

To increase the credibility in the data analysis, the two researchers who conducted the interviews performed the analysis first independently and then in an open dialogue until consensus was reached (Lincoln and Guba, 1985).

Ethical considerations
Written information was sent to children who were interested, as well as to the parents of the pupils in grades 4 and 7, according to the guidelines for human and social research in Sweden (Vetenskapsrådet, 2007). The written information described the aim of the study and the interview procedure, and provided information about the child’s right to withdraw at any time and about confidentiality when the study’s outcome was presented. This information was also reiterated vocally at the beginning of each interview. Consent was received from the pupils (and the parents, when applicable) before the interviews. The appropriate research ethics committee in Linköping, Sweden approved the study (application registration number: dnr 36-08).

Results
The results are classified into four categories, with three subcategories each. An overview of the results can be found in Table 2.

### Table 2. Overview of the results

<table>
<thead>
<tr>
<th>Category</th>
<th>Preparation creates preparedness</th>
<th>Adaptability creates dialogues based on wishes and needs</th>
<th>Providing opportunity for knowledge and insight about health and lifestyle</th>
<th>Providing opportunity to develop a trustful relationship with the school nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcategory</td>
<td>Voluntariness, Information about topics for discussion, Focus on my health situation</td>
<td>Participation, Respect, The school nurse’s quality and sensitivity</td>
<td>A picture of my own health, Want to be healthy, Highlighting health risks and providing inspiration for change</td>
<td>Establishing contact with the nurse, Insecurity about the secrecy, Seeking confidence</td>
</tr>
</tbody>
</table>

Preparation creates preparedness
The pupils expressed a wish to be prepared in order to make the best use of the health dialogue. They wanted information about the ‘voluntarism’ concerning whether or not to attend. The pupils were not fully informed about the extent to which they had the right to refrain from participating in the health dialogue or about whether it was compulsory to attend. They wanted to be well and truly informed about the aim of the health dialogue in order to decide whether they wanted to participate. Being invited to talk with the nurse was also discussed as a possibility to get support from her, something the pupil may not have considered earlier and thus not sought. Consequently, according to the pupils’ own discussion, it could be an advantage not to know that it is voluntary to attend the health dialogue.

‘Yeah, but ... if you feel bad and have to go there, then you talk about it. If you feel bad and don’t want to go, you don’t go. Then you don’t have anybody to talk about it with.’ (grade 7, 13–14 years old)

Being prepared in advance with ‘information about the topics’ the nurse would bring up was desired.

‘Otherwise maybe you just sit there like a question mark.’

‘Like, what’s she talking about?’ (grade 4, 10–11 years old)

This way, during the conversation the pupils could decide which of the topics that arose they wanted to discuss. If they were unprepared they could be taken by surprise and feel forced to discuss things they may regret afterwards; they might also miss the opportunity to discuss questions they may have a need to talk about but did not have time to think through beforehand.

‘Sometimes it can be that it’s a bit embarrassing to talk about something that’s happened and stuff, and then you’d like to talk to your parents first. So you don’t get home and the school nurse has said that everything’s great when it’s actually not that good. Because then your parents and the school nurse sort
of don’t know, but instead think everything’s fine even though it’s actually as bad as it can get. (grade 4, 10–11 years old)

The pupils also found it important for the nurse to have an opportunity to think about the individual pupils’ needs and how she could bring the subjects up. When pupils had answered a health questionnaire in advance and their nurse had gone through it, they experienced that the health dialogue had a clear ‘focus on their own individual health situation’.

‘It was good to fill it in beforehand, because then she knows ... she checks through it before you get there.’ (grade 7, 13–14 years old)

Adaptability creates dialogues based on wishes and needs
The nurse’s adaptability to the individual pupil’s wishes and needs was crucial to the pupils’ experience of the health dialogues.

They felt ‘participation’ when the dialogue affected areas relevant to them and their life situation, but if they found the dialogue irrelevant or uninteresting they simply wanted the nurse to finish. The most meaningful discussion arose when the nurse asked questions and they were able to answer, and when the nurse was attentive to their willingness to continue the discussion. It was an advantage if the nurse initiated the discussion and the pupil could then fill in and move the discussion forward, particularly when the discussion referred to more private and sensitive subjects (e.g. relationships with others or sexuality).

‘Hmm ... it’s pretty hard if there’s something that’s very personal and you don’t want to bring it up yourself, and she maybe starts asking questions about it. I mean ... yeah, gradually more comes out easier in some way.’

‘Yeah.’ (grade 7, 13–14 years old)

The pupils found it important to be treated with ‘respect’, as well as having the freedom to decide the length and depth of the discussion. On the contrary, a nurse who ‘nagged’ without paying attention to the pupils’ desires might have a negative effect on the discussion (e.g. pupils becoming tired or wanting her to stop).

‘If there’s something you, if you’ve been honest about something that’s not good that you’re not really proud of something. It’s not that fun if she just keeps at you—then it just feels hard.’

‘better if she’s understanding and such ...’

‘she shouldn’t stick her nose in it but she should try.’ (upper secondary school, 16–17 years old)

Providing opportunity for knowledge and insight about health and lifestyle
The pupils talked about the health dialogues as an opportunity to gain knowledge about and insight into their health and lifestyle. The pupils said they got a ‘picture of their own health situation’ related to the different areas that were brought up for discussion. They described it as not only a health check-up but also a type of examination of their health and lifestyle. Getting this picture was something the pupils appreciated.

‘Then when you’ve said it and she says this ... but you spend an hour and a half on the computer or TV on Mondays ... yeah, maybe it’s not that good that I sit for so long ... so you learn ...’
Research

If the nurse brought up the health risks from using tobacco, this could give pupils who smoke a possibility to reflect on their own tobacco use even if they had told the nurse they were non-smokers.

‘Then you have to think a bit. My God, do I sit that long at the computer?’ (grade 4, 10–11 years old)

The experiences from the health dialogues were twofold: pupils could either feel pride over the fact that they were healthy and led a healthy lifestyle, or they could experience a sense of guilt for being unhealthy, or for having unhealthy habits (e.g. eating too much candy or drinking too much alcohol). The pupils voiced wishes to ‘be healthy’ and have healthy habits, and did not want to feel accused of being unhealthy and not taking care of themselves. The wish to be seen as a healthy person could restrain them from being honest in the health dialogue, even though they understood that the conversation was meant to help them. The pupils said it was the nurse’s role to bring up health problems for discussion that she as a nurse considered to be a risk. At the same time, she was to be aware of the pupil’s own thoughts and keep the discussion at a constructive level to prevent the pupil from feeling accused and unsuccessful.

‘Beat around the bush a little—say you could eat like this instead of like this’

‘hmm …’

‘I mean don’t bring up weight right away …’

‘Don’t say right away you weigh too much …’

‘no …’

‘more that maybe you should lose a few pounds there’s a big difference because then you don’t think that you weigh too much but instead that maybe I could weigh a little less and that would be better.’

‘Yeah it would feel good if she said maybe you should skip those sandwiches and have some fruit instead. And you’d do that otherwise the words just echo in your head like that.’ (upper secondary school, 16–17 years old)

‘Highlighting possible health risks and providing inspiration for change’ was desired by the pupils. They felt that it was the nurse’s role to highlight and discuss health risks occurring in their age group. This gave them the opportunity to reflect over their lifestyle even if they had not been honest about their habits in the conversation. For example, if the nurse brought up the health risks from using tobacco, this could give pupils who smoke a possibility to reflect on their own tobacco use even if they had told the nurse they were non-smokers.

‘It helps a lot that the person understands how important it is to quit and such.’

‘If you don’t smoke she can tell about it anyway, in case you do.’

‘Then she should inform everybody.’

‘Yeah, if you smoke even though you’ve ticked “No”, she says it and then maybe you think oh no, I didn’t know that. I have to quit.’ (grade 7, 13–14 years old)

Through discussion about the pupil’s individual health situation combined with careful and gentle recommendations, the nurse could inspire the pupil to consider some lifestyle improvements to promote his or her health.

‘Then you get to know what you’re in for and such. And that’s probably pretty important. Because if there’s something you should improve and … or something you know is bad maybe you won’t do it anyway because you don’t have the energy. But if you talk to the school nurse maybe she’ll help you so you can start improving and thinking about it more.’ (grade 7, 13–14 years old)
Providing opportunity to develop a trustful relationship with the school nurse

Being invited to a health dialogue with the nurse was seen as an opportunity to 'establish contact with the nurse,' particularly for pupils who had not previously done so. This allowed them to get to know the nurse and to determine whether she was someone who could be contacted for future needs.

'You get to meet with her and see who she is and such if you have problems later you know …'

'know who she is.'

'It's easier to go talk to a person you’ve met before.' (upper secondary school, 16–17 years old)

The pupils expressed feelings of 'insecurity' at not knowing the extent to which they could rely on the nurse keeping their information confidential. They were, to some extent, aware of the nurse's obligation to contact their parents if the situation revealed a need for it and this fear was raised during the interviews. Feelings of insecurity could keep them from telling the nurse something. Even if they thought she could help, they resisted telling her because they did not want their parents or teachers to know.

'Because I think she's going to tell. But I don't know if she will but I don't dare tell her everything.' (grade 4, 10–11 years old)

'So if you were going to tell about something you felt that it was super important that the school nurse didn't tell anyone ... you wouldn't do that the first time you met with her?'' (the interviewer)

'Nah, I wouldn't have told my secret then. A really big one.' (grade 4, 10–11 years old)

Through their conversations with the nurse, the pupils were 'seeking trust' in the relationship with her. If they sensed that she was to be trusted, they felt free to share more private issues at a later stage. One way the relationship with the nurse could be strengthened was to be offered a health dialogue more frequently—at least once a year. The pupils felt that such an invitation from the nurse could allow them to get to know her better and develop a more trustful relationship with her.

Discussion

The nurse's approach was an important part of how the pupils' experienced the dialogues, and they felt that reciprocity in the encounter was a prerequisite for creating a satisfactory health dialogue. Prerequisites for a satisfactory health dialogue, as well as opportunities for a satisfactory outcome of a health dialogue, were expressed by the pupils.

Prerequisites for a satisfactory health dialogue

The importance of being adequately prepared in order to be able to actively participate in the health conversation was highlighted by the pupils. Through preparation, they had the possibility to talk about topics they considered relevant and also to avoid topics they did not want to discuss. The pupils said that if, for example, they had filled in a questionnaire in advance and the nurse had gone through it before the visit, the nurse was also prepared to focus on their specific needs. Adolescents aged 11–19 years old also described being satisfied with their visit to a physician in primary care when they had filled in a health questionnaire beforehand. The possibility to discuss their health concerns with the physician was expressed as important, and they reported fewer unanswered questions compared to a control group who did not use a questionnaire (Olson et al, 2009). Being prepared is seen as a prerequisite for being in a position to take a more active part in the encounter and to be able to make the best use of the health conversation according to individual pupils' needs.

The nurse's responsibility to clearly describe the aim of the health dialogue and the voluntary nature of participation are underlined by the pupils’ comments. The pupils learned that attending a health dialogue could be an opportunity for them to gain insight into possible health risks they had been unaware of—information they might have missed out on if they had been fully informed about the dialogue's voluntary aspect. Carefully clarifying the purpose of the health dialogue and stressing that it is based on what the individual pupil wants to discuss could be one way for the nurse to cope with this contradictory message.

The pupils in the study described the situation as being full of contradictions: they do not want the nurse to nag, yet they want her to bring up and explain health risks. A prerequisite for a trusting relationship between district nurses and patients in health counselling was described by the nurses to be their approach to promoting patient participation in the conversation and not being judgmental or critical (Eriksson and Nilsson, 2008). According to 11-, 13- and 15-year-old pupils, a satisfactory health dialogue entails being heard and then receiving suggestions and advice (Borup, 2000). Similar results were also found by Loman (2008) in describing adolescent girls’ opinions about suitable nursing strategies to promote physical activity: nurses were to individualize their approach and try to support personal thoughts about possible changes. Receiving advice and information was also seen as useful, and it was important that the nurse showed respect and not be too direct, as this could be experienced by the girls as threatening and forceful (Loman, 2008). To make it easy for pupils to openly discuss their health, school nurses described the need for an encounter in which the pupil and the nurse can talk, listen and exchange information in a supportive way (Borup, 2002). Good pedagogical
encounters between nurses and patients have also been described as ‘players in same field encounters’ (Friberg et al, 2007), whereby the patient participates and the nurse is sensitive to what the patient wants to know. The pupils’ descriptions in our study are in line with what has been expressed by nurses on the subject.

Opportunities with a satisfactory outcome from a health dialogue

A possible outcome of the health dialogues was described by the pupils as the opportunity to gain knowledge about, and insight into, one's individual health and to get individually tailored advice, just as the guidelines require (Socialstyrelsen, 2004). They wanted the nurse to make appropriate recommendations to promote their health, but not in an authoritarian way. The pupils also stated that if the nurse is insensitive to what the pupil wants and how he or she wants to continue the discussion, the pupil becomes increasingly passive. The unilateral conversation in which the nurse acts without an individual approach and the pupil lacks the possibility to affect the conversation has also been described as a negative outcome by Finnish school-children 11–12 years of age (Mäenpää et al, 2007). One possible method for improving the health dialogue is motivational interviewing (Rollnick and Miller, 2002). This method has a client-centred approach and is used in the fields of different lifestyle improvements concerning things like tobacco consumption, obesity and lack of physical activity. The counselling is based on the individual's concerns, interests and motivation for change, and the focus is on the individual's perspective and ambivalence in a collaborative discussion (Rollnik and Miller, 2002).

The results showed that the pupils felt some uncertainty over the nurse's observation of confidentiality; they voiced a need to get to know the nurse and form an idea of whether or not she was trustworthy. Especially in the first meeting with a patient, district nurses described building trust as a foundation for further relations and as an important part of health counselling (Eriksson and Nilsson, 2008). Seeking more support from the nurse after an encounter in which the pupil had established trust with him or her has also been described by Johansson and Ehnfors (2006). Lack of confidentiality has also been seen as an obstacle to seeking support in primary health care by 11–16-year-old children (Gleeson et al, 2002). Having the opportunity to meet the nurse more often was seen as a way to get to know him or her better in this study, and the pupils featured in Johansson and Ehnfors (2006) expressed the same thing. As a way to gain trust in the nurse, the pupils described a desire to meet with her regularly and suggested meeting at least once a year. The nurses in Morberg et al (2006) described the individual conversation with the pupil as one of the most important parts of their counselling work to promote the pupil's health. A health visit including a health dialogue in grades 4 and 7 and the first year of upper secondary school (Socialstyrelsen, 2004) does not seem sufficient, according to the results of both this study and others described above.

To improve health dialogues from the pupil's perspective, it is important to develop methods that enable pupils to take advantage of the health dialogues in the ways they express as desirable. From the pupil's perspective, it is of great importance that the nurse understands what effect the pupil's life situation has on improving the pupils' health. Dialogues between nurses and adolescents through an empowerment approach are described by Jolly et al (2007). In these dialogues, both the nurse and the adolescent have important thoughts to share and it is important that the nurse listens to the adolescent's thoughts and pays attention to what affects him or her. Based on what the adolescent has talked about, the nurse can then give advice based on the individual's ability to promote health. At the same time, the nurse can clearly describe health areas that need improvement without acting in an authoritarian way (Jolly et al, 2007). This empowerment approach is precisely in line with what the pupils in our study asked for. The health dialogues in the SHS, during which the nurse can clearly talk about possible health risks and at the same time provide advice without giving feelings of guilt or expressing accusation, can be seen as a 'balancing act'; there is a need for more knowledge to better understand how nurses can succeed in this delicate task. Further research including individual interviews and observation studies can be one way to improve the health dialogues in the SHS from the pupils’ perspective.

Limitations

A convenient sample was used in this study. Children and adolescents who voluntarily expressed their interested were invited to interviews, and could be atypical according to their experiences of the health dialogue. In the interviews both positive and negative descriptions of the health dialogues emerged, which can strengthen the findings. Another factor that might strengthen the findings is the fact that children from different schools representing different socioeconomic backgrounds, who had met different nurses participated and furthermore, both boys and girls participated. However, the selection of the participants has to be considered regarding transferability of the results (Lincoln and Guba, 1985).

To allow the pupils to express their perspectives, focus groups were used. A disadvantage could have been that children who are not comfortable talking in groups may not have wanted to participate in the focus groups or have not had a chance to fully express their opinions. Both taciturn and more talkative pupils participated, and according to Thomsson (2002) the moderator tried to include everyone in the discussion. It is important to have knowledge about the developmental stages of children in order to be able to perform the interview in an acceptable way (Peterson-Sweeney, 2005); in the present study, both researchers who conducted the interviews together had earlier experience as paediatric nurses, working with
children and adolescents. One of the researchers was also a senior researcher with much experience of interviewing children and adolescents. The researcher, who was the moderator, had experience working as a school nurse, which allowed her to understand the organization of the school and the SHS, which Kreuger and Casey (2000) argue to be important for receiving a correct result.

**Conclusions**

Health dialogues can be seen as a useful part of health promotion according to the pupils. They wanted the dialogue to be a conversation in which each pupil's individual needs and wishes were discussed and respected. A need to be prepared for the topics that would arise in the conversation was expressed by the pupils. The nurse was expected to initiate the health dialogue and to pay attention to the specific topics the pupil wanted to talk about, as well as the extent to which the pupil wanted to continue the dialogue and the level of detail he or she was comfortable discussing. The health dialogue could contribute to knowledge about, and insight into, their health, and inspire them to have a healthy lifestyle. If the pupil was allowed to participate and felt respected during the health dialogue, he or she developed trust in the interaction with the nurse. This could facilitate further visits for support. The results of this study can be seen as guidelines to assist in the development of the health dialogues based on pupils' own perspectives.

**Conflict of interest:** None declared

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**Contributions**

**Study design:** MG, KE, HL, BS; **data collection and analysis:** MG, KE, HL, BS; **all authors have contributed to the development and revision of the article**


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