The Public, the Mother and the Child

Public Health Initiatives Promoting the Strong and Happy Child – Focusing on Food and Mental Health

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Preface

This paper, «The Public, the Mother and the Child − Public Health initiatives promoting the strong and happy child − focusing on food and mental health», was prepared for presentation in a workshop at the University of Catania, June 2005.

The theme for the workshop was *Price of Life: Welfare Systems, Social Nets and Economic Growth*. The workshop addressed important questions related to European welfare systems and policies, both in a historical and contemporary perspective. Such questions have a new actuality within the EU, where the new members have different welfare systems with various historical traditions. The very protective ones from Western Europe have to implement restrictive reforms because of the global economic competition, as well as the internal population evolution (ageing, more poor people and families linked to unemployment, integration of immigrant population) of its internal demand (in the number of sophisticated cares) and the costs of new medical techniques. The workshop invited contributions that discussed the cultural importance related to the protection and maintenance of life for individuals and human groups and the allocation of resources that societies in different historical contexts have organized to reach this goal.

The Phoenix Network is supported by the European Commission, within the framework of the Socrates Programme (Erasmus Thematic Networks). It also receives funding from the Portuguese Government, and collaborates with other institutions as the Compostela Group of Universities. The University of Bergen has been a member of the Phoenix Network from the beginning in 2002. Researchers from The Rokkan Centre and the Department of History have participated in several of the arrangements and activities within this network. The chair of the network is Prof. Laurinda Abreu from the University of Evora, Portugal.

This paper written by Rokkan Centre researchers Kari Ludvigsen and Kari Tove Elvbakken is prepared by combining results from different projects within a broad field of historical and institutional oriented research on prevention and prevention policy. It will be published in a volume from the Compostela Group of Universities, The European Issues series – European Health and Social Welfare Policies.

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Summary

This paper addresses public health initiatives towards the youngest children and their mothers, namely The Mother and Child Health Centers (MCHC). The orientations and the content of the MCHC are discussed, focusing two fields of prevention policy: Measures to promote healthy nutrition and mental health. Our argument is that that these are central fields within the public health prevention policy and that an analysis of measures taken within these fields gives a good opportunity to discuss the general role of MCHC as part of public health. The article discusses these efforts to promote healthy nutrition and the prevention of mental health problems among children from a political science perspective, focusing historical and institutional elements. We also draw upon earlier studies of other public health institutions, of propaganda for healthy nutrition, and studies of mental hygiene and psychiatry. The analysis follow the development of the MCHC in Norway from the beginning of the 20th Century when the first centres were opened, until new guidelines were given from the health authorities in 2003. However, the weight is upon the period from 1950s until the present.

Sammendrag

Dette notatet er en analyse av de norske heslestasjonene, som er helsetiltak rettet mot de yngste barna og deres mødre. Vi drøfter orienteringen til og innholdet i helsestasjonsvirksomheten gjennom fokus på tiltak for å fremme sunn ernæring og god mental helse. Argumentet er at dette er to sentrale oppgaver for forebyggende helsearbeid, og at tiltakene på disse områdene gir mulighet til å diskutere den generelle rollen til helsestasjonenes rolle i offentlig helsearbeid. Vårt statsvitenskapelige inntak retter lys mot historiske og institusjonelle elementer ved helsestasjonenes virksomhet. Analysen bygger på tidligere studier av andre helseinstitusjoner, ernæringspropaganda og mentalhygiene og psykiatri. Vi følger utviklingen av helsestasjonsvirksomheten fra etableringen tidlig på 1900-tallet fram til 2003, da nye retningslinjer ble vedtatt. Vekten vil imidlertid være på perioden fra 1950-tallet og fram til i dag.

Introduction

This paper addresses public health initiatives towards the youngest children and their mothers, namely The Mother and Child Health Centers (MCHC). The orientations and the content of the MCHC are discussed, focusing two fields of prevention policy: Measures to promote healthy nutrition and mental health. Our argument is that that these are central fields within the public health prevention policy and that an analysis of measures taken within these fields gives a good opportunity to discuss the general role of MCHC as part of public health. The article discusses these efforts to promote healthy nutrition and the prevention of mental health problems among children from a political science perspective, focusing historical and institutional elements. We also draw upon studies of other public health institutions (Elvbakken and Riise 2003), of propaganda and campaigns against overweigh (Elvbakken 2002) and studies of mental hygiene and psychiatry (Ludvigsen 1999).

We follow the development of the MCHC in Norway from the beginning of the 20th Century when the first centres were opened, until new guidelines were given from the health authorities in 2003. Although the development is followed during almost a century, we will concentrate on the decades after 1950. Regulations, such as legislation and guidelines from the health authorities, are discussed as important framework for the centres. The changing weight placed upon education and information about nutrition and mental health, as well as the variations in the scope and focus of these activities will be examined. We will also discuss the orientation of the efforts, whether the efforts can be characterized as having a universal orientation, or as aimed towards vulnerable population groups.

During the 20th century, a number of measures were taken to protect and control children and their environment, from infancy to adolescence. The basis was both the aim to secure child welfare and to avoid future social and health problems in the population. Different countries chose different arrangements for giving such initiatives, in accordance with the main structures of the health systems and public health institutions in each country. Internationally, the first Mother and Child Health Centers can be traced back to the turn of the 19th century. Around 1900, public statistics on child births and mortality were of great importance to the increasing interest in child health. The background was a very high mortality rate, especially among infants born to unmarried mothers. Infant mortality was discussed within the medical profession and efforts to reduce the mortality were given priority. Medical journals that published articles and mortality statistics were followed closely in many countries and among public health authorities across Europe.

In Norway today, MCHC is well established as a local public health institution. The services from the MCHC are given to all free of charge and the target group includes all infants and small children and their families during the first six years of life. This makes the MCHC an institution for prevention efforts with a universalistic approach. The MCHC are located in the local environment and aim to have a good availability. The MCHC offers health controls, vaccination and health education. A program for

approximately 10–15 visits during the first six years of live is recommended. The typical program for visits is constructed around the recommended vaccination program. Health information is given, also to some degree following information programs. Several studies among the users of the services during the 1990s show that the MCHC can be characterized by a high degree of legitimacy, the families find the services useful and follow the program for visits.

The local government is responsible for the services, and the personnel consists of health visitors and medical doctors as the main groups, but also physiotherapists and psychologists might be included. Approximately 60 000 children are born each year in Norway, which makes the potential population for these services about 360 000 children. Personnel resources have increased during the last ten years, especially in order to increase the efforts to prevent mental health problems.[1]

The challenges for the health situation of infants and small children have changed a dramatically during the history of the MCHC. Today, the infant mortality rate in Norway is among the world` s lowest, at 0, 38 % (SSB 2003). Better living conditions, sanitary conditions, decline in infection diseases and better nutrition were important factors contributing to the decreasing rates in earlier periods. At present, other health concerns pose risks to children, like asthma, allergic problems, psycho-social problems and accidents (SSB 2005). However, the health situation of Norwegian children is good. At the same time, some old and somehow forgotten health problems, such as malnutrition and infectious diseases like diphtheria, re-occur now and then, challenging the priorities of the services.

Phases in the development of the MCHC

In what follows, we will focus on some milestones in the development of the MCHS. As points of departure for dividing the history of the MCHC into four phases, we use important policy changes like the implementation of formal guidelines. The following table shows some important events in the history of the Norwegian MCHC.

[1] The personnel statistics does not distinguish between resources for MCHC and school health services (including children and youth from 0 to 20 years as target groups), so the total number of approximately 1800 public health nurses and 230 medical doctors in full- time positions covers both services (SSB 2005)

Milestones	Year	Characteristics
First control station opened in Oslo	1911	Private initiative, promoting breastfeeding, especially for
First public centre in Oslo	1935	First public centre opened in Oslo – and other cities followed
College for educating health visitors founded in Oslo	1947	The education builds upon the education of nurses, focus on public health
Legislation on MCHC	1972	All municipalities have to organize and run MCHC
Legislation for municipal health services	1982	All primary health services are to be organized and run by local government
Central government guidelines for health services from 0 to 20 years	2003	Ends the division of prevention health services for small children and school children

The MCHC have gone through important changes. The institution has evolved from an institution for the poor, to one that is offered to everybody, from a selective to a universal perspective. It started as a private initiative, but has become a public responsibility. Voluntary work has been replaced by state and local government responsibility. The themes for health education have changed during history, along with changing priorities in the more general prevention and promotion policy. The MCHC has advocated an educational approach to control and regulation of the health status of children and childhood care, becoming a neighbourhood institution in the process. Our project is to study these lines through an analysis of changes within two fields of efforts; promoting better nutrition and mental health.

We will distinguish four phases in the shaping of the MCHC. The starting point of the *first phase* is marked by the opening of the first MCHC in Oslo in 1911. Its ending in the 1950s is marked by the passing of legislation regulating the health visitor services in Parliament. Voluntary organisations and city health authorities were the main actors. The service was especially designed to meet the needs of poor infants and their mothers. The target group was growing, and the services aimed at reaching larger groups of children. The *second* phase lasted until the beginning of the 1970s. Public health authorities acknowledged responsibility and built several centres, especially in towns and cities. The MCHC grew to be more universal in its approach. Vaccination became important in the 1950s, and new vaccinations were included in the programme. New legislation in 1972 made local authorities responsible for the MCHC, marking the introduction of a *third* phase. The centres now aimed to reach all children. The perspective of the work and the tasks were widened. Prevention of mental health problems became regarded as a central focus for health centre work. Several projects were implemented to develop new methodology for the services, especially with regard to the psychosocial questions. At the turn of the 21st century, the MCHC can be said to have entered into a *fourth* phase**,** marked by ambiguous ambitions**.** On the one hand, traditional orientations and efforts, such as the implementation of the vaccination program, have seen a renewed interest, following the return of some of the infectious

diseases, at least in some part of the world. On the other hand, psychosocial work has expanded, for example through specially designed programs for parent education.

The first phase: The fight to reduce infant mortality

Beginning in the 1880s, Europe and the United States saw a notable increase in public concern over children's health, *from infancy through adolescence*. A number of measures were taken to protect and control children and their environment. Sunshine, fresh air, adequate food, cleanliness, physical training, and vaccination, were recommended by the experts. *Infants and infant mortality were a primary concern almost everywhere.*

In France, doctors established centers connected to the birth clinics to give the mothers of the newborns information, especially concerning breast feeding. The professor of pediatrics Baudin in Paris established the first institution for tracking mothers after childbirth (Styr 1937). The medical profession in Norway as well as in other European countries was internationally oriented. As a young state with a new medical faculty, Norwegian authorities gave priority to supporting medical professionals traveling abroad to learn (Elvbakken and Ludvigsen 2003). This was also the case for initiatives to reduce infant mortality. Fröhlich, the first Norwegian professor of pediatrics, spent time in Paris. Frölich was engaged in the research on child nutrition, especially vitamins, and he was among the first to isolate vitamin C in 1908 (Lyngø 2003). Frölich was the one who took the initiative to establish the first center in Norway (Toverud 1945).

Maternal and child health centres for the poor were established in Norway by voluntary organizations during the early 1900s, with support from influential medical experts. The first Norwegian center dates back to 1911. Two different types of centers were opened. The first type, a centre for mothers nursing their newborns, opened in 1911 as part of local parish work.

Nutrition was the first task of these centres, providing poor mothers with the motivation to feed their infants in healthy ways. The aim was to promote and increase breastfeeding among the mothers (Styr 1937). In the second type, voluntary women's organizations opened centers for mothers with information as a tool for decreasing the infant mortality rate and promoting better infant nutrition. An important part of the latter was to teach mothers to make adequate milk formulas.

Around 1900, the Norwegian infant mortality was around 10%, reaching far higher in parts of the country (Falkum and Larsen 1981). The infant mortality rate decreased in the following years, but there were great variations between different groups of the population. During the period of 1900–1905, the infant mortality among children of single mothers reached as high as 12, 5%, while the rate for children of married mothers was 7, 5% (Toverud 1945).

Following the Norwegian Sanitary Act of 1860, sanitary commissions were established in every municipality. In the fast growing cities particularly, the sanitary commissions discussed the mortality rate among infants and young children. Infant

mortality as a societal problem became understood in relation to breastfeeding and nutrition. In the capitol, Kristiania, the sanitary commission addressed the worryingly high mortality rate among infants of unmarried women. In the 1880s, they were taking surveys of the milk supply and discussing mothers` chances to breastfeed their newborns (Elvbakken and Kjærnes 1994). The voluntary child health centres that were established in Norway from the early 1900s were mainly aimed at the control of poor infants and small children. They were located in the largest cities, and run by voluntary organisations. The intention of the first health centres was to provide poor mothers with advice on nutrition, particularly breastfeeding. Infants fed with different kinds of formula were found to be at risk, as the formulas were often diluted with unclean and dirty water, increasing the risk of gastrointestinal diseases.

Feeding and nourishment of infants and small children have been among the topics for health education within the framework of the MCHC from the very beginning. It has always been important to argue for and to promote the breastfeeding of infants. At the same time the practise concerning the breastfeeding and the feeing of small children has changed over time. But nutrition and food have always been among the topics.

Mental hygiene was a crucial concept for the understanding and handling of child mental health and for the work towards prevention of mental illness from the late 1920s. Ideas related to the mental hygiene movement also were an important foundation when initiatives gradually were taken to give the MCHC a role related to the prevention of mental illness.

From the late 19th century, the rising interest among various expert groups on childhood also came to include the mental health of the children. Norwegian psychiatrists, like their colleagues abroad, showed a rising engagement in these questions. Among the important sources of inspiration were the programme of the American Mental Hygiene Movement, aiming to prevent mental illness and social problems. The importance of childhood and the right upbringing of children were central aspects of this programme, and this movement has been seen as the single most important inter-war development in new attitudes towards children, and it has been related to a notable shift in the way in which children were perceived in the inter-war era, marked by an emphasis on the child's mind and mental health, not only its physical condition (Stewart 2001:50) Related to the mental hygienic movement, was the so-called Child Guidance ideas, that made the emphasis of the minds of children particularly manifest. Having its source in the United States, the ideas of Child Guidance were multifaceted, based on historical contingencies and various intellectual interests. Thus, the practice in different countries inspired by these ideas also varied (Ludvigsen 2004).

In Norway, psychiatrists and psychologists in the late-1920s initiated pioneer mental hygiene work, publishing scientific and popular works, and establishing associations and outpatient clinics promoting the ideas and techniques associated with mental hygiene. Norwegian mental hygienists stressed the crucial role of prophylactic work towards children. According to Dr. Rohde Moe, the mental hygiene of the child was the real mental hygienic work, in which the individual, the school, the physicians and society shared an interest (Rohde Moe 1935).

The mental hygienic advisory services were on a small scale in the 1930s, and the work was done voluntarily by a few physicians and nurses. In the late 1930s, local

authorities gave financial support to the mental hygienic work in the largest cities. The clientele of the first out-patient mental hygiene clinics was made up both by adults and children. However, children and young persons made up the majority of the Oslo – clinic's clientele in the late 1930s (Dedichen 1936). Mostly parents, but also schools and children's homes, searched for advise on the handling of troublesome children. These children were not mentally ill, but demonstrated nervous symptoms or odd behavior. Observation and testing of the child, interviews with the parents and advising were the main means of this work (Dedichen 1936).

The psychiatrists and psychologists working with mental hygiene were ambitious, and saw an increasing interest from the public for the services they offered. The MCHC was a possible arena for expanding their work. In 1939, initiatives were taken to establish a stronger cooperation with these centers (FT 1939, 19, nr.4 p 26). The promotion of this idea intensified after World War 2.

During the *first phase*, infant mortality was the main concern of the MCHC-founders. The problem of high infant mortality was understood to be related to the nutrition situation. Medical doctors argued for breastfeeding to secure adequate growth and to combat infectious diseases. The highest mortality rate was seen among children of unmarried and poor mothers. To support these mothers and to secure their nutritional status, some of the MCHC actually supplied them with milk and with cod liver oil. Breastfeeding was seen as insurance for infants in poor families. The propaganda focused the role of the mother and argued for her nutrition (as quoted from Frölich 1911):

> «The cause behind the high mortality rate is almost solely inappropriate nutrition, leading to intestinal sickness, rickets, skin diseases and cramps. Children raised with milk formulas have little resistance against children's diseases and horrifying many children dies every year – because of their mother's idleness or ignorance. The MCHC shall first and foremost give young and inexperienced mothers competent guidance and then also, through encouragement and reward give the women inspiration to breastfeed their own children.»

The activities slowly expanded, as well as the scope of the centres. In 1925, prenatal control was included. In 1930, MCHC from ages 1 to 7 were initiated (Sundal 1952:203). The first initiatives for including mental health work into the services came in the late 1930s.

There was a great expansion in the number of centres after 1935. The first public centre was opened in 1937. During the 1920s and 1930s, parishes in Oslo organized centers for mothers where their infants could be controlled. City health authorities in Oslo, Bergen and Trondheim opened similar centers during the 1920s and 1930s. These initiatives were often combined with so-called mothers' hygienic services, and also provided advisory services regarding contraceptives. In smaller municipalities, MCHC were dependent on voluntary organizations for a very long time.

The second phase: Gradual public responsibility

Maternal and child health centres expanded in the post-war period. About 400 existed by 1945. Still, most of them were run by voluntary organisations, the largest owner being the Norwegian Sanitary Organisation for Women, *Norske Kvinners Sanitetsforening* (NKS). However, local governments, counties and the state supported the centres financially. Most of the health centres were administered by a medical doctor. In the 1930s, the mother – and – child health centres were seen by medical experts as possible arenas for the strengthening of various individual preventative health work. The MCHC were particularly mentioned as possible arenas for the prevention of mental problems and mental illness.

The Norwegian mother and child health centres of the 1950s were run by voluntary organizations, and the work was based on traditional medical principles, using regular health control as it main service. The main purpose was to prevent bad health among children, along with early discovery of somatic and mental disabilities.

The health centres were organised in different ways throughout the country. Their recourses varied, as did the number of clientele served. In the largest cities, the health centres had their own localities, were open daily, and employed different specialists. In the countryside, the health centres were typically run by the local physician and nurse, and served the public a couple of days a month (Sundal 1952:203). Dr. Sundal's philosophy was that the health centre should give mothers all the answers to their questions about the infant that an engaged physician or nurse could provide, whether the questions regarded care, nutrition, playing, or child-rearing in general.

Physicians were central in the initiation of health centres, as well as the nurses who worked alongside them. In 1947, a new state college was established, with the aim of educating nurses in the prevention of health problems (Schiøtz 2003). The public health nurses were given an education of one year on top of the standard nursing education. The education was designed to prepare them for work within the boards of health, the prevention of tuberculosis and within MHCS and school health services. Information and educational work in health centres, schools and homes were central tasks. The nurses were taught hygiene, epidemic diseases, health administration, psychology, psychiatry and pedagogy. The specially educated public health nurses got the administrative responsibilities of health centres, and also within the school health services, which was regulated through legislation from 1957. The physician held the medical responsibility (Elvbakken and Kjærnes 1994:84).

The most important tasks of the health centres during this period were medical control of infants and small children, along with the advising of parents on child nutrition and care. Some of the centres also offered prenatal medical control of women (Nordby 1989:182).

The health centre offered examinations and clinical observations of the child: The weight and length of the infant was to be controlled, as well as its health situation in general. During this period, new screening methods were used, measuring the growth

and physical development of children. The health centres were not intended to perform curative services; rather, the purpose was advice and prevention, given to mothers with healthy children. Throughout the 1950s, vaccination became a central task for the health centre nurses. The largest health centres also employed dentists. Bad dental health among children was a central argument behind the establishment of the first public health centre in Oslo in 1939 (Toverud 1945).

The leading Norwegian paediatrician, Dr. Alfred Sundal, saw the health centres as an important tool securing child health. Dr. Sundal put great weight on administering the right nutritional principles, and worked for increased attention to be paid to the examination of the children's nutritional condition. Advice on general hygienic matters was also important. However, he also saw mental hygiene as an integrated part of the health centre work. Besides the examination of the bodily health, the doctor and nurse, he argued, should also make notes on the mental condition and development of the child (Sundal 1952: 206). The central idea of Dr. Sundal's work was formulated as «The scheme of the child's whole regime around the clock». The health centre should, in his vision, be a central part of this regime.

Legislation regulating the work and services of public health nurses passed Parliament in 1957, giving the county council responsibility for organizing the public health nurse services. The public health nurses were given the administrative responsibility for MCHC and the school health services, while the physician was still responsible for the medical services. From 1950 to 1970, MCHC gradually became a public responsibility with a stronger universal character, still focusing on nutrition, health control via screening of weight and height, together with vaccination.

To illustrate the role of changing views and practise of the MCHC during the second phase, breast-feeding serves as a crucial example. The view on breast-feeding taught at the health centres changed and the percentage being breastfed declined. Turning to the third decade of the 20th century, regularity became an aim – infants should be fed regularly, in clean and orderly circumstances. In the period from the 1920s to the 1960s, a new general tendency within the health education literature can be traced, focusing stricter regimes concerning the feeding of the infants. (Skard and Vesje 1971) give the following characteristics of the new feeding regime for infants during the 1960s:

> «.. (we could experience) a steadily increasing period of time before the newborn baby was allowed to be laid to the breast (increasing from 10 to 24 hours), a stricter attitude towards the meals; a fixed number of meals to declared points of time, fixed intervals, the number was reduced and the interval was increased gradually, further advices about fixed and constantly shorter time at the breast (from 30 to 8–10 minutes).»

Focusing regularity and control made it more convenient to bottle-feed the infants. The period in which the infants were breastfed steadily declined. During the last part of the 1960s the influence and the importance of breast milk substitute-industry grew. The influence was important, especially through the advertising, but the industry also managed to fit into the information programme within the MCHC, giving mothers leaflets and also samples of formula. It went so far that the Director of Health in 1968 warned against the practise of the maternity wards to distribute formula to the mothers and the newborns (Guidelines 1968).

During the 1960s some limbering-up was seen in the practise of counselling. The mothers were advised to give some attention to the rhythm of the child. We might see a turn towards a new phase, where the needs for the infant came to be more important (Vesje 1961:42):

> «One does have to try to learn to know the natural rhythm of the child. The first month is a period of learning, both for mother and child. If one allows the needs of the infant to be taken into consideration during the first time, the mother and child usually find a diurnal rhythm – just as regular as a clock, having approximately 3–4 hours intervals… When the child has come to such regularity in its needs, it will be dependant on this regularity… A regular life, with fixed sleeping – and eating hours is of great importance for a healthy life style during the whole childhood».

The 1950s saw new ambitions in a wide range of health services. The care of children defined as problematic in different ways also became reorganized, and new expert groups entered the field, bringing new knowledge. During the first decades after World War 2, the initiatives of the Norwegian central government also included modernizing mental health and child welfare legislation. The politics of child mental health protection in the 1950s put weight on prophylactic work and local treatment, and was based upon a new concept of mental dysfunction, stressing the importance of the environment (Seip 2004: 98). The first psychiatric institutions for children in Norway were established during the late 1940s: A psychiatric clinic run by the Oslo school authority, and a Mental Hygiene Advisory Clinic in Oslo. In 1953, the first private child psychiatric institute was set up by Dr. Nic Waal, who was the first Norwegian specialist in child psychiatry.

Securing better mental health was among the new priority areas for the MCHC, initiated by experts and government. The concept of mental health work was now closely related to the ideas of mental hygiene. After WW2, Norwegian psychiatrists argued for the expansion of mental hygienic efforts into arenas such as health centres and school health services (Brekke 1952: 282). Leading psychiatrists saw the health centres as an arena for promoting child mental health, through the advising of mothers by experts on psychiatry and psychology. Besides being a measure for securing harmonic and happy individuals, the mental hygienic advisory work was seen as the most important prophylactic means towards mental and nervous disease among adults. The Norwegian psychiatrists saw enormous tasks waiting after the war. By promoting mental hygienic work in different arenas, and particularly starting with children, they hoped to reduce the overwhelming need for psychiatric hospitals and care (Lohne Knudsen 1952: 279, Brekke 1952: 282).

The powerful Norwegian director of Health, Karl Evang, had strong relations with the central actors and organizations that initiated the early mental health and child guidance activities. Preventive health care was a central part of the program formed by Evang after World War 2, giving MCHC an important role, throughout the country and broaden their topics. The main purpose, in Evang` s words, was to secure advice on nutrition and family planning, tasks that he strongly promoted in the inter-war years. In addition, Evang wanted to supply the health centres with expertise on mental hygienic advising, social work and dentistry (Nordby 1989: 182–183). Despite the ambitions of the health director and other experts to broadening their scope, the health centres mainly dealt with the physical health of the child until the 1970s. The role of mental

hygienic work remained small, vaccination, nutrition and health controls were still the main fields of achievement.

Third phase: Municipalities run the institutions and new efforts

During the third phase, the health centres became fully established as a public service for all Norwegian children (Elvbakken and Kjærnes 1994, Solberg 1995). Local municipalities were given the obligation to run the services and offer all children and their parent attendance to a MCHC through legislation from 1972. There existed around 1400 health centres in Norway in 1972. Only 180 of these were public, and many of them were small (Bogen et al 1976). Gradually, the public took over the centres. The MCHC now became defined as a universal service, with the aim of reaching all infants and small children and their families. The underlying idea was to secure the weakest by reaching everyone, and to establish a unitary primary health care system for children throughout the country.

In 1972, the centres became the responsibility of the local government, but had strong state regulation. The present legal framework is the Municipality Health Service Act of 1982, which gave municipalities the responsibility for all primary health care, including MCHC and school health services. In 2003, new guidelines were established, giving local government responsibility to provide these services to all residents, from pregnancy through the end to the 20th year, covering childhood and primary and secondary school.

The practical work of the health centres became regulated by the central Health Directorate through official guidelines and handbooks. A more systematic program for somatic health control was developed (Solberg 1995). By 1975, the number of specially educated health nurses expanded. Also, other expert groups like social workers, psychologists and pedagogically educated staff became more common. A central government description defines the MCH work broadly as a cornerstone in the prevention of somatic, mental and social health injuries among children (NOU 1979:28, page 69). The 1970s saw an increasing weight placed upon new tasks for the MCHC. Particularly, work with psycho-social problems and disabled children became reinforced (Bogen et al 1982, Hauge et al 1982): Also, the increasing number of immigrant children was seen as an important challenge for the health centres.

The general focus on health promotion increased in the 1980s, both internationally and nationally (Aarø 1994). A range of public policy documents and plans were made, discussing the role of health promotion, its scope, tasks and challenges, and suggesting new initiatives to strengthen this work (NOU 1979:53, NOU 1984:28). The Norwegian 1984 Local Health Service Act made preventive health work and non-institutional health service a local government responsibility, including the MCHC. The local government became key actors in the preventive health work, including the primary preventive work towards children and youth (Elvbakken and Mæland 1997:7).

The services were still a public responsibility, with a strong weight on universality. However, the context of the work was changing. New principles for local government and new forms of regulation influenced the health centres. New legislation on local government from the early 1990s, made it possible for Norwegian municipalities to choose the organizational structure for the services given, also the institutional framework and organization of the MCHC. In the mid 1990s, however, most municipalities still ran the MCHC within the scope of public health services (Elvbakken and Mæland 1997).

In the beginning of the 1990s, the Directorate of Health replaced the old guidelines for the practical work with different types of publications to advice the personnel. One may say that the regulation of the health centre work became less detailed. Textbooks were produced, such as the so called *Helsestasjonsboka* by Heian and Misvær (1989). Whereas the old guidelines had been very detailed, describing the screening to be performed and which topics to address for each and every planned visit at the MCHC, the new textbooks may be characterized different. The textbooks also offered advice to the personnel, but in a more guiding and open way.

It seems to be reasonable to expect that the priorities and orientations within the MCHC – have seen local variations, due to variations in the local government organization and the competence available. However, after the 1980s, the geographical variations regarding financial resources and priorities seem to have grown larger (Elvbakken and Mæland 1997, Solberg 1995: 36). After the World War 2, the expanding health centres were seen as possible arenas for mental hygienic work with children. Mental health has gradually become a more important topic within the services, particularly since the 1980s.

During the third phase, the perspectives on infant feeding changed markedly. The rate of the infants being breastfed markedly increased. An important paperback book, with the title «The breastfeeding book», published by the nutritionist Elisabeth Helsing Almaas (1970), can be said to represent a new tendency in infant feeding counselling. Most of the former advises were replaced by recommending individual adjustment to the needs of the child, (and the mother), supplied by practical advices tackling problems of different kinds. During the 1970s advises about breastfeeding were dramatically changed. New advisers also occurred, and a very active self-help group, *Ammehjelpen*, was established. Whereas the number of meals had been a topic for regulation earlier, was the message from 1979 changed to this: «Frequent meals will be the best stimulus for milk production». The demand for regularity and the fear for over-stimulating were replaced by the underlining of the importance of the mother's love:

> «The child needs safety and love. Especially during the first weeks of life, the infant is in need of spending much of the time in your arms – the baby needs the warmth of your body and your nearness, like it has been used to for months before the birth. But, – do not forget that the child also has a great requirement for rest»

From the late 1960s psychosocial problems were put into focus for the ambitions for the MCHC. Centres were to take a central role in work aimed at preventing physical, mental and social problems among children. The 1970s saw a range of experiments related to the prevention of mental problems. Voluntary organizations and experts

expressed ambitions and made projects to give the MCHC a new orientation (Solberg 1995:31). Experts on psychology and psychiatry saw new challenges for prevention, since some of the «old» tasks were seen as superfluous because of the better health situation.

The child psychiatrist Hilchen Sommerschildt played an important role, together with psychologist Birgit Bogen (Bogen et al 1972, Hauge et al 1982). In 1969, a committee was set up by the Directorate of Health, initiated by the child psychiatrist Hilchen Sommerschildt. The committee proposed a strengthening of the mental hygienic work within the MCHC (Bogen et al 1969). The aims were to give a better knowledge of child development, to secure immediate support and help for families with beginning problems, and to give long-lasting support to families with children having mental problems. A wide range of actions was suggested: The organizing of parent groups, advising of parents and controlling of the mental state of the children. At-risk families were to be reached through cooperation with social workers and other local services, with the MCHC coordinating the services for children with mental problems and cooperating with the child psychiatric institutions. Sommerschildt and psychologist Birgit Bogen played an important role in the transforming of the MCHC. Together with a public health nurse and a physician they made up a team that conducted research projects and experiments in local settings, a work that served as an important foundation for the formulation of the 1972 Act (Bogen et al 1969, 1972, Solberg 1995: 32). The Act stated that the health centres were supposed to prevent illness and injuries, and to promote the physical and mental health of children.

These ideas for MCHC were gradually put into practise (Bogen et al 1972, 1976, 1982, Hauge et al 1982). New professionals entered the centres. Psychologists gave the public health nurses advice on the mental health of the children. Physiotherapists were also engaged in the work. The 1980s saw an increased weight given to the prevention of mental health problems in Norway. Work emphasising the MCHC as an arena for promoting mental health among children and families continued (Hauge et al 1982). However, it is unclear if these new ambitions were put in practise in a way that changed the character of the health centres completely (Elvbakken and Kjærnes 1994).

Fourth phase: New orientations in prevention policy and practise?

What can be seen as a fourth phase in the history of the MCHC started in the 1990s. Changes in policy, population and new work methods seem to challenge the health centre work, making ambiguous ambitions a central feature of the MCHC. At the same time, population changes have placed a new pressure on the services. After several years with decreasing birth rates, Norwegian birth rates expanded in the 1990s, when the number of newborns reached around 60 000 yearly (SSB 2003). New themes, like sexual assaults, have further increased the emphasis on psycho-social work. The work methods of the MCHC have changed. Particularly, the organizing of parent education groups around different themes has become a common method (Mæland and Bonstra 1993).

Data from a survey among all Norwegian municipalities (430) in Norway in 1996 shows that the traditional tasks for the MCHC dominate the focus of the services, such as vaccination, breast feeding and the screening of growth (Elvbakken and Mæland 1997). On the other hand topics as preventing accidents and mental health problems are also given priority.

Studies from the 1980s show that almost 100% of newborns visit the MCHC (Solberg 1987). Thus, as a universal service it must be viewed as a success. However, studies also demonstrate alarming variations in the use of its services. In 1982, a registration of all visits to the MCHC in some counties showed variations in vaccination rates, as well as in the general use of the services. In Oslo, the use of the MCHC-services are less frequent among disabled children, children of single parents and children in contact with the child welfare authorities. Another challenge of the 1990s was that of «old» health problems showing up again. The vaccination programme has been put on the agenda again. In 1993, diphtheria was discovered in Norway. There are reports from cities experiencing trouble, fulfilling the vaccination programme. Nutritional problems have also resurfaced. A study among immigrant children in Oslo demonstrated a high rate of children with anaemia. Health personnel seem uncertain when it comes to information about infant nutrition. There are still differing opinions regarding the proper food for the smallest children.

Today, the Norwegian infant feeding situation is characterized by an exceptional high breastfeeding rate. More than 90% of the newborn babies are being exclusively breastfed at the age of 1 month, whereas 96% are exclusively breastfed during the first week of life. At the age of 6 months, nearly 80% are exclusively breastfed (SSB 2005). The situation can further be said to be characterized by a relatively liberal regime concerning the practise of introducing solid food.

The idea of the crucial role of environmental factors in producing and preventing mental problems has been strong since the 1950s. However, the concepts were changing, and in the last decades the concept of psycho-social problems has formed the basis for mental health prevention work. In the 1990s, policy documents saw the MCHC as an important factor in the maintenance of local networks, and suggested a stronger advisory role for the centres (Elvbakken and Mæland 1997). In 1992, the health problems related to psycho-social conditions were listed as among the most important challenges for the MCHC (Larsen et al 1992: 299). According to the definition, psycho-social problems were of a wide range, embracing themes like mental illness, psychosomatic diseases, marital problems, mourning, behavioural problems, drug and alcohol abuse, bad care and violations.

The Norwegian government has put increasing weight on mental health since the mid-1990s. Health promotion and service integration were central ambitions in the plans of action for reforming the services and increasing its resources that were launched in 1997. Local health authorities, including the MCHC, have been given a central role in maintaining these ambitions. The intention was to strengthen the role of the MCHC in the psycho-social work by increasing its competence. During the plan period, the evaluation of the mental health reforms indicated severe deficiencies in the mental health services for children and youth. A strategic plan launched by 7 ministries in 2003 intended to cope with this, mainly through preventive work of different kinds,

Cooperating for mental health. This work was seen as a responsibility for everyone who conducted work related to children and youth. Again, the MCHCs were viewed as an important arena for this work, particularly because of the easy access and universality of their services (Viljugrein 2004). This was in line with the 2003-guidelines for the MCHC-work, stating that psycho-social prevention is to be an integrated part of MCHC.

Educating parents to make them perform the right conduct and upbringing of their children was a crucial part of the health centres. The efforts of the last decade to strengthen the psycho-social prevention have been partly based on new methods and perspectives. Regulation of emotions and the right balance of emotional relations and conduct were crucial to mental hygiene. In the policy of the 1990s, the so-called relations-oriented perspective formed the basis for the orientations of the MCHC, underlining the potential resources of the families and the role of parents as models for their children. To support the self and identity of the child has become a crucial role for parents. The symptoms that the child shows are interpreted in a system of family relations. However, problematic emotional reactions and conduct of parents is still seen as an important background for the mental problems of children (Stangenes 2004): To teach parents to use their resources in the right way is thus an important task for the MCHC. This new perspective is present in the central government policies for the prevention of mental problems. To maintain these tasks, new services supplementing the MCHC have been suggested. Such new models for the mental health preventive work with families have been tried out through local initiatives from the 1990s. A programme for the financing of local initiatives to strengthen family work was launched by the government in 1995. The ambition of this «Parent education programme» was to strengthen local mental health promotion through a model based on early interventions and the establishment of so-called family centres. Some of these new initiatives are aimed at families already facing psycho-social problems, but with the intention to offer the same easy access and low-stigma profile as the MCHC. Thus, MCHC is meant to have a wider scope of services than these new initiatives (Stangenes 2004).

Old ambiguities and new challenges to the health centres

In a very interesting study into the history of child upbringing, the Norwegian professor of pedagogy Monica Rudberg (1986) underlines that the understanding of children and their upbringing has been changing. Changing views are, according to her analysis, connected to the fact that different professions have been the leading experts within this field. Medical doctors took over for clergymen as experts in child-caring and upbringing. After the World War II medical doctors to some extend were replaced by psychologists. For infant nutrition, it seems more likely to argue that medicine has been the leading discipline. Infant nutrition, focusing what and when children ought to eat, has been a scientific field for medicine. On the other hand, the relation between mother and newborn, focusing breastfeeding, is important within child psychology. In such a

perspective infant nutrition might be seen as a field of interest for many disciplines, food and meals has been a topic of continuity within the scope of the MCHC.

Control and education have been central aspects of MCHC during the different periods described in this paper. For the last decades, controlling aspects have become less clear. The name of the services has changed, the out-patient clinics used to be named «Control centres», but this is not the case any longer. The services are not conceptualized as control-institutions, but as centres to visit. MCHC is an important resource for local communities. The access is easy, and the use of the services carries little stigma. The services offered by the MCHC have great legitimacy among the public, and great authority towards the parents.

However, the controlling aspects are still present and necessary in its practical work. This may lead to dilemmas between different ambitions and tasks for the services. A thorough screening activity has many positive aspects. It can ensure that almost every child receives a certain amount of health control, and almost every parent is given some information on matters of childhood and health. The central idea of the universalistic approach of the Norwegian MCHC has been to reach the families with potential troubles through the screening of everyone. Also, to secure a universal health service for everyone, a good health control and information programme for everyone should be offered. However, the psycho-social approach and the ambition to strengthen the local community and local networks through MCHC may conflict with the traditional universalistic health control approach. The controlling aspects also have to be balanced against the legitimacy of the services.

Both the traditional tasks and the psycho-social tasks involve parent education and information programs. The more offensive information strategies of the earlier periods, for example on breast-feeding, have been changed. New educational methods are being used. The idea is that the knowledge and experience of the parents are resources that are as important as formal expert knowledge. Today, the securing of child mental health and the prevention of mental problems are seen as a central part of MCHC-work in Norway. The 2003 regulation of MCHC-work formally places the psycho-social aspects of preventative health care as a responsibility for the health centres. However, the motivation and ability to share experiences, and to participate actively in group meetings are demanded from these new methods. Also, blaming parents – still imbedded in the central perspectives on the psycho-social work – may well be an obstacle to reaching families who already experience trouble of some kind. And if these parents do not show up with their children for the vaccination and health control, the universalistic approach of the services is in trouble, too.

An analysis of two white papers on prevention policy argues that Norwegian public health policy has undergone changes the last decades (Stenvoll, Elvbakken and Malterud 2005). The last white paper, presented in 2003, is putting greater emphasis on preventive work outside the established institutions, and particularly the aim of strengthening good local communities is focused. This policy may give new challenges to the old preventive institutions like the MCHC and this institution may face a risk of becoming a lower priority.

Litterature

Bogen, B., R. Karlsen og H. Sommerschildt Sundby (1969): «Notat om mentalhygienisk arbeid ved helsestasjonen».

Bogen, B., L. Solum, O. Storvik og H. Sommerschildt Sundby (1972): *Helsestasjonen i støpeskjeen,* Oslo: Universitetsforlaget.

Bogen, B., H. Sommerschildt Sundby (1976): *Helsestasjonen alltid i støpeskjeen*, Oslo: Universitetsforlaget.

Bogen, B., P.O. Næss, H.S. Sundby og P. Sundby (1982): *Helsestasjonene – en forpost for det gode liv,* Oslo: Universitetsforlaget.

Brekke, B. (1952): «Mentalhygiene». I Storsteen, E. (red.): *Sosial håndbok for Norge,* Bind I, annen sterkt forøkede utgave: 279–283. Oslo: Norsk forening for sosialt arbeide/Nicolai Olsens Boktrykkeri.

Dedichen, H.H. (1936): «Fra den Mentalhygieniske arbeidsmark», foredrag, Mentalhygienisk Forening 3.12.1936, *Folkehelseforeningens Tidsskrift,* 16 (8): 3–13.

Elvbakken, K.T. (2002): «Kampanjer i kampen mot overvekt», i Elvbakken, K.T. og P. Solvang (red.): *Helsebilder. Sunnhet og sykdom i kulturelt perspektiv*, Bergen: Fagbokforlaget.

Elvbakken, K.T. og U. Kjærnes (1994): «Helsestasjonene – tiltak for vanskeligstilte eller universell forebygging», i Elvbakken, K.T. m.fl. (red.): *Mellom påbud og påvirkning. Tradisjoner, institusjoner og politikk i forebyggende helsearbeid*, Oslo: ad Notam.

Elvbakken, K.T. og K. Ludvigsen (2003): «Hygiene og psykiatri – medisinske disipliner i statens tjeneste», *Norsk Statsvitenskapelig Tidsskrift,* 19 (1): 19: 3–27.

Elvbakken, K.T. og J.G. Mæland (1997): *Forebyggende arbeid overfor barn og unge*, rapport nr. 1–1997. Bergen: Hemil-senteret, Universitetet i Bergen.

Elvbakken, K.T. og G. Riise (red.) (2003): *Byen og helsearbeidet*. Bergen: Fagbokforlaget.

Falkum, E. og Ø. Larsen (1981): *Helseomsorgens vilkår. Linjer i medisinsk sosialhistorie.* Oslo: Universitetsforlaget.

Hauge, I.M., P.O. Næss, Å. Rytter Evensen og H. Sommerschild Sundby (1982): *Helsestasjonen og familien med det nyfødte barn*, Oslo: Universitetsforlaget.

Heian, F. og N. Misvær (1989): *Helsestasjonshåndboka,* Oslo: Kommuneforlaget.

Helsing Almaas, E. (1970): *Boken om amming*, Oslo: Gyldendal.

Larsen, Ø., D. Brekke, K. Hagestad, A. Høstmark og O.D. Vellar (red.) (1992): *Samfunnsmedisin i Norge – teori og anvendelse*, Oslo: Universitetsforlaget.

Lohne Knudsen (1952): «Omsorgen for de sinnslidende og nervøse». I E. Storsteen (red.): *Sosial håndbok for Norge,* Bind I, annen utgave: 271–279. Oslo: Norsk forening for sosialt arbeide.

Ludvigsen, K. (1999): *Kunnskap og politikk i norsk sinnssykevesen 1820–1920.* Rapport nr. 63, Bergen: Institutt for administrasjon og organisasjonsvitenskap, Universitetet i Bergen

Ludvigsen, K. (2004): «Child Guidance and Mental Hygiene in Inter-War Norway». I Andresen, Elvbakken and Hubbard (eds.): *Public Health and Preventive Medicine 1800–2000, Knowledge, Co-operation and Conflict,* Report 1-2004: 67– 84. Bergen: Stein Rokkan Centre for Social Studies.

Lyngø, I.J. (2003): *Vitaminer! Kultur og vitenskap I mellomkrigstidens kostholdspropaganda,* avhandling for dr. art graden, Universitetet i Oslo.

Mæland, J.G. og E. Bonstra (1993): «Miljørettet helsevern i kommunene – ressurser, organisering, samarbeid og aktiviteteter», *Tidsskrift for den norske lægeforening,* 112: 3331–3335.

Nordby, T. (1989): *Karl Evang. En biografi.* Oslo: Aschehoug.

NOU 1979: 28: *Helse- og sosialtjenesten i lokalsamfunnet* (Green paper).

NOU 1979:53: *Skolehelsetjenesten* (Green paper).

NOU 1984: 28: *Helserådstjenesten* (Green paper).

Rohde Moe (1935): «Et kort foredrag om Lierasylets polikliniske virksomhet», *Folkehelseforeningens tidsskrift,* 15 (4): 3–6.

Rudberg, M. (1986): *Dydige, sterke og lykkelige barn.* Oslo: Universitetsforlaget.

Regjeringens strategiplan for barn og unges psykiske helse (2003) *Sammen om psykisk helse,* Oslo.

Schiøtz, A. (2003): *Det offentlige helsevesenets historie – Folkets helse, landets styrke*, Oslo: Universitetsforlaget.

Seip, Å. Arup (2004): «Private Initiative for Public Health: the Emergence of Child Psychiatry in Post-War Norway». I Andresen et al (eds.): *Public Health and Preventive Medicine 1800–2000, Knowledge, Co-operation, and Conflict.* Bergen: Rokkansenteret, Report 1-2004.

Skard, Å. Gruda og R. Vesje (1971): *Barn og mat*, Norsk samband for småbarnsoppfostring, Sosialdepartementets småskriftserier, nr. 12, Oslo.

Solberg, L.K. (1987): *Evalueringsrapport, SYSBARN,* Oslo: Statens institutt for folkehelse.

Solberg, K. Næsselqvist (1995): *Helsestasjonen i et sosialpolitisk perspektiv.* Avhandlingsarbete i Folkhælsovetenskap (Master of Public Health): 7, Nordiska Hælsovårdshøgskolan, Gøteborg MPH.

SSB (2003) *Statistics.* Oslo: Statistisk sentralbyrå.

SSB (2005) *Statistics.* Oslo: Statistisk sentralbyrå.

Stangenes, M. (2004): «Familiesenter – fokus på familiens ressurspotensiale», *Tidsskrift for psykisk helsearbeid,* 3: 12–23.

Stenvoll, D., K.T. Elvbakken og K. Malterud (2005): «Blir norsk forebyggingspolitikk mer individorientert?», *Tidsskrift for den norske lægeforening,* 125 (5): 603–5.

Stewart, J. (2001): «The most precious possession of a nation is its children: The Clyde Committee on Homeless Children in Scotland», *Scottish Economic and Social History*, 21 (1).

Styr, F. (1937): «Barnepleiestasjoner i Norge». I Storsteen, E. (red): *Social Haandbok for Norge*, Oslo: Norsk forening for Socialt Arbeide.

Sundal, A. (1952): «Kontrollstasjoner for svangre, spebarn og småbarn i Norge». I Storsteen, E. (red): *Sosial håndbok for Norge*, Oslo: Norsk forening for sosialt arbeid.

Toverud, K. Utheim (1945): *Beretning om de første 6 års arbeid ved Oslo kommunes helsestasjon for mor og barn på Sagene (1939–1944)*, Oslo: Fabritius.

Vesje, R. (1961): *Spedbarnsstell.* Oslo.

Viljugrein, T. (2004): «Sammen om barn og unges psykiske helse», *Tidsskrift for psykisk helsearbeid,* 1 (3): 4–11.

Aarø, L.E. (1994) «Health promotion: moderne forebygging med radikal profil?». I Elvbakken, K.T. m.fl. (red.): *Mellom påbud og påvirkning. Tradisjoner, institusjoner og politikk i forebyggende helsearbeid*, Oslo: ad Notam.

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