Is Social Media Believed to Influence Adolescent Health?

Identifying Perceived Barriers and Facilitators to Public Adolescent Health Care Services:

A Qualitative Case Study of Oslo, Norway

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Abstract

Background

Existing research suggests that social media (SOME) influences body image perceptions, diet; and exercise behaviours of young adults. As such influence can be health-harming, it is important that local health care services are easily accessed, and adequately provided. Though a municipal report of 2015 revealed mental health challenges, weight and diet to be the most critical challenges among youth aged 0-20 (Municipality of Oslo, 2015), no research has been conducted on the matter, in the context of Norwegian public adolescent health care services. Municipality of Oslo offers public adolescent health care services through School-Based Healthcare Services (SBHS); and in Adolescent Health Clinics (AHCs). However, it is not known if these two arenas are providing adequate health care services, with regards to the potential problems of SOME influence; or whether or not there are any potential barriers or facilitators to access to these services.

Objective

The aim of this study, is to investigate whether or not social media is believed to influence body image perceptions, diet; and exercise behaviours of adolescents, and explore factors that are perceived as potential barriers and facilitators for access to relevant public adolescent health care services.

Method

A scoping review laid the foundation for this study. *Four databases* were searched for literature on the *topic of social media influence* (PubMed; Web of Science; PsycINFO; Scopus). Findings were summarized according to three identified key issues. 14 public health care workers in Oslo were also asked for their opinions on the same topic, using semi-structured qualitative interviews. The interview participants were also asked about what they perceived as barriers and facilitators to access. A deductive thematic analysis of interview data was carried out, according to a pre-existing conceptual framework (Khan & Bhardwaj, 1994). Factors perceived as barriers and facilitators were identified based on the subjective opinions of interview participants. The adequacy of access was qualitatively evaluated, based on the overall findings.

Results

The study confirms social media´s influences on adolescent health, and has identified both barriers and facilitators to access to relevant public adolescent health care services; existing both in the system, and among its users. Study suggests that the overall influence is mediated by the influence on body image perceptions of adolescents. Results show that adolescents are internalizing unrealistic body ideals, and also experience a social pressure to correspond to such ideals. At the same time, a general lack of resources; existing in system, contributes to the inadequacy of access to the relevant healthcare services.

Conclusion

This study strongly suggests targeting the health care system; the School-Based Health Care Services in particular, and recommends a proper implementation of Project *Low Threshold.* Study moreover suggests public health care providers to use online platforms for communication with users, as such communication is believed to facilitate access.

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I would also like to thank my mother; the mentally strongest person I know, for care and support. Not only during this study, but during my own early years as an adolescent.

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Abbreviations and Acronyms

A

AHC	Adolescent Health Clinic *(Nor. Helsestasjon for Ungdom)*
ANAD	National Association of Anorexia Nervosa and Associated Disorders

B

BUPP	Barne- og Ungdomspsykiatrisk Poliklinikk

C

CAPP	Child- and Adolescent Psychiatric Polyclinic. Specialist care unit. *(Nor. BUPP; Barne- og ungdomspsykiatrisk poliklinikk)*

G

GP	General Practitioner

L

LTPA	Leisure Time Physical Activity

P

PHN	Public Health Nurse *(Nor. Helsesykepleier)*
PLIS	*(Nor.)* Psykisk helse, Lavterskel, I Skolehelsetjenesten

S

SBHS	School-Based Healthcare Services *(Nor. Skolehelsetjenesten)*
SNS	Social Networking Site
SOME	Social Media
STD	Sexually Transmitted Diseases

1 Introduction

Ever-present access to information was gained with the introduction of smartphone technology, in the early 2000s. This technology "was adopted faster than nearly any other technological innovation" (DeGusta, 2012). It also opened doors to always-accessible social media. Although relevant statistics of Norwegian adolescents[1] only go back to 2015 (SSB, 2019, a), there has been a substantial increase in their daily/almost daily use of SOME; from 79% in 2015 to 90% in 2019 (ibid). Likewise, online searching for health-related information has increased: from 45% (prior to 2011) to 73% in 2019 (SSB, 2019, b). The contemporary technology thus appears extremely practical; as it facilitates easy access to information, and also allows for sharing of this information. However, being exposed to; navigating; and internalizing, the abundance of online information, comes with potential health risk.

A municipal report of 2015 revealed mental health challenges, weight and diet to be the most critical challenges among youth aged 0-20 (Municipality of Oslo, 2015). Mental health has also been a widely discussed topic; in the municipal context. It was the reason for why the Agency of Health *(Nor. Helseetaten)* felt it necessary to extend and develop the School-Based Healthcare Services; in order to better prevent mental illnesses in youth (Olaisen, 2007). Extending the services implied improving cooperation, and *coordination;* between public/primary and specialist/secondary care providers. It also led to the creation of *"Low Threshold" (Nor. Lavterskel);* a project with a purpose to provide "good, flexible and easily available mental health services" in high schools (Municipality of Oslo, 2019, c).

Going through adolescence is not easy. It is a time filled with changes; internal and external. Going from junior high to high school *(Nor. Videregående)* can be a remarkable transition for many. Trying to adapt and fit into new social circles, one is simultaneously expected to perform well academically. The body is also changing. While males tend to broaden out in shoulders and gain muscle; females can experience some natural fat gain. Perhaps one starts going to the gym. Leisure time physical activity (LTPA) is in fact, quite popular among adolescents in Oslo, and some gyms offer memberships from filled 11 years (SATS, 2019). Due to a variety of affecting factors, adolescents can experience a constant stress in many

[1] Aged 16 – 24. This was the lowest age category that was possible to set by default.

aspects of their lives. They can have many questions, and be ambivalent about where to look for answers. And this is where social media comes in.

I chose to write about social media and adolescent health due to personal experiences. I come from an educated and overall healthy family. My close relatives have always cared for me, fostering a personal wish to care for my own health. Being born in 1994, I joined the wave of the technological revolution; getting my first smartphone as a teenager. Being a relatively recent former teenager, I am well aware of the social, but also personal expectations, which one can experience. I also know that listening to adults can be hard; while going online to look for answers – easy. Having spent a lot of time online; I am finally pleased to see that my guesses about social media influence were correct, based on the finding of this study. I would like this study to be read by both health care professionals, parents, and children (if not too complicated for the latter. Though I know that Norwegian teenagers are excellent English speakers). Social media is an exciting modern tool. And I am convinced that it can, and should, be used; without risking one´s health.

1.1 Background and research question

The aim of this study, is to investigate whether or not social media is believed to influence body image perceptions, diet; and exercise behaviours of adolescents, and explore factors that are perceived as potential barriers and facilitators for access to relevant public adolescent health care services. There are therefore two research questions for this study; one that targets the influence, and one that targets the adequacy of access; (1) *According to public health care workers; is social media believed to influence body image perceptions, diet; and exercise behaviors of adolescents?* (2): *What are the perceived barriers and facilitators for access to relevant health care services?*

1.2 Chapter overview

Chapter 1 introduces the reader to the paper, presents the two research questions; and author´s personal motivation to write this paper. Chapter 2 presents the main health challenges reported in adolescents of Oslo, in detail; relevant public municipal adolescent health care, and Project *"Low Threshold"*. Chapter 3, the theoretical chapter, describes the concept of *access*, and the theoretical framework used for this paper. Description of methodology is found in Chapter 4, which is separated into two part-chapters; one for the scoping review (4.1), and one for the interview study (4.2). Results (Chapter 5) are also presented it two separate chapters. Chapter 5.1 presents results from the scoping review. This chapter refers to Appendix VII for illustrative extracts from articles. Chapter 5.2 presents results from the interview study, outlining identified barriers and facilitators. In this chapter, all quotes are found directly in the text. Characteristics of the system are presented in Chapter 5.2.1, and characteristics of the users follow in 5.2.2. Original interview quotes, translated for this chapter, can be found in Appendix IX. Chapter 6; *Discussion*; is split in two parts, discussing research question one (6.1) and two (6.2). This chapter also provides suggestions for further research and discussing possible limitations of the current study. Conclusion is presented in Chapter 7, after which comes a general literature list, and finally a range of Appendixes.

2 Background

Public adolescent primary care is offered to all youth in Oslo through the Municipality of Oslo. This can be done in several arenas, but the most prominent ones are schools and AHCs. Starting first grade and throughout high school, students receive continuous care through the SBHS. Apart from schools, all youth aged 12 – 24 can pay free visits to any AHC of their choice, during AHCs´ opening hours. The main primary care providers in both arenas, are the PHNs. Their education consists of a three-year basic nurse education (bachelor), plus one additional year specializing in primary care. All PHNs must follow a strict duty of confidentiality. Schools and AHCs are often located in the same district, and schools often refer their students to the corresponding AHC, and vice versa. Oslo is a fairly small capital. Many of its central places are within walking distance, and the city is also well connected by public transport.

2.1 School-Based Services

At least one PHN is always employed in each school. Sometimes, the school also employs doctors, psychologists and physiotherapists. All students are evaluated by a PHN and a doctor in first grade of primary school. In third grade; weight and height are measured, and relevant recommendations provided to students. This is again repeated in eighth grade. Sex-education is mandatory to provide, and oftentimes, schools invite someone from the AHCs, or from "Sex og Samfunn", to lecture. The latter is Norway´s "biggest centre for sexual and reproductive health and rights" (sexogsamfunn.no, 2019). SBHS moreover have a task to preserve youth´s mental health and overall wellbeing. As it has been said about SBHS; "you can consult with us about birth control, personal problems, and other everyday-challenges" (Municipality of Oslo, 2019, a).

2.2 Adolescent Health Clinics

There are currently 17 AHCs in Oslo. A list of all 17, with phone numbers, addresses and opening hours, can be found on Oslo´s municipal webpage (Municipality of Oslo, 2019, b). Both PHNs and doctors work in all AHCs; psychologists work in some. All AHCs provide basic services, and guidance, in questions of contraception; pregnancy, and abortion; gynecological examinations, and testing for STDs. Though these clinics are also said to

counsel with regards to "e.g. eating disorders, problems at home or problems with drugs" (ibid). Males have their own AHC, and are otherwise free to utilize the other 16 as well.

2.3 Project "Low Threshold"

Because of increasing mental health challenges in youth, a need for strengthened adolescent mental support was recognized. The need gave rise to the cooperative project between municipality, Agency of Health and specialist care, known as *"Low Threshold"*; which will at times be refed to as simply "The Project" in this paper. In practice, the Project encompasses the work of PHNs, psychiatric nurses, and specialists from CAPP, the Child- and Adolescent Psychiatric Polyclinic *(Nor. BUPP)*. The project started as a pilot carried out in two of Oslo´s high schools during 2004 – 2007 (Olaisen, 2007), and its reports were extraordinary. Adolescents could now receive similar care in schools, as they would have gotten consulting with specialists. This was found useful for those that were experiencing difficulties reaching out to specialist care. This included many young males; the project-initiators had noticed that these do visit SBSs, but experience a threshold to specialist care (ibid). Also approved of, was the bettered coordination between primary and secondary care sectors. It had contributed to quality of care, by giving greater knowledge to all involved actors.

The project builds on a model called the PLIS-model (see Abbreviations and Acronyms, and Appendix I for explanation*)*. PLIS is a Norwegian acronym for "mental health, low threshold, in schools-based health services". The project´s financial, administrative and academic activities and responsibilities, are regulated by "a formal, executive cooperation-agreement" (Municipality of Oslo, 2009, d). The goal of the project is to offer extended and strengthened SBSs to all youth aged 15 – 22. During the testing period (2004 – 2007), project pioneers had noticed that youth often consulted in schools about their psychosocial difficulties. An actual case has been described (Olaisen, 2007), showing a female student who was "downplayed, dissatisfied with herself and had low confidence levels" (ibid). This student distanced herself from friends and family, and told later that she had experienced "periods of depression, where she felt that she was not good enough" (ibid). The girl had also lost weight, was tormented with suicidal thoughts and had tried to kill herself. Given this, schools´ staff had experienced that the current care was inadequate, and that heavy cases left them with too much work. It was meant that current care was inadequate due to complicated referral

procedures and waiting lists (ibid). It was decided that primary and secondary care should properly unite in schools; so that the "knowledge and experience from both disciplines" could set the foundation for correct preventive care (ibid).

Currently, project is supposed to be in place in twelve municipal high schools in Oslo, a list of which can be found on Oslo´s municipal web page (Municipality of Oslo, 2019, c). Measures of the project include for instance: easily accessible services; being available (as a health provider), and having time for the visiting adolescents. Initiatives also include making SBSs in all districts equally strong; extend opening hours and supply the services properly with PHNs and CAPP-employees (Municipality of Oslo, 2009, d). In addition, school-based staff is expected to act more competent in questions of referrals to specialist care. If all these measures are met, the project is said to work optimally (ibid). In the interview study soon to be outlined, one participant had defined the Project as «short path to help" (Participant 3). The paper will have a look if this really is the case.

2.4 Main health challenges among adolescents (2015)

In 2015, Agency of Health presented a report of the main health challenges among adolescents in Oslo aged 0 – 20 (Municipality of Oslo, 2015). The report was based on interviews with municipal PHNs who worked in a total of 15 districts of Oslo. Almost all districts reported mental health challenges to be, by far; the biggest challenges in the user groups 6 – 15, and 16 – 20. Weight and diet concerns were also reported in the younger group, while an increasing drug use was had been noticed in the 16 – 20-year-olds. *Family*, a key actor; was related to most challenges. *"Many adolescents struggle at home. Many parents have difficulties understanding the severity when their child is down and experiencing problems."* (ibid). The younger group was nevertheless experiencing cohabitational problems; many coped with parental divorces and felt they were not being heard by their families. In districts with high proportions of youth with foreign cultural backgrounds, mental challenges were explained by the struggle of belonging to two cultures: *"Many of districts´ adolescents are bicultural, and many experience problems trying to find balance between their two cultures (…) The problems are often complex, and often both school- and family related"* (ibid).

Both groups also felt like they were expected to perform well; academically and in sports. This made many feel "inadequate" (ibid), adding to their mental struggles. The 16 – 20-year-

olds were said to “struggle to fit in, and be seen by busy parents” (ibid). It was mentioned that transition from junior high to high school is a “vulnerable” time period for this group. In fact, four of the districts reported high drop-out rates in high schools, and one reported “school refusal” among teenagers of all ages (ibid).

When it comes to weight and diet, these varied across the districts, but generally overweight was reported more frequently than underweight. Some places, being overweight and having a bad diet was connected to poor family economy; which by the way, many of the younger teenagers worried about. Other times, overweight was associated with poor dietary limitations, inadequate physical activity and mental health issues. Interestingly; there existed also a problem with rather underweight adolescents. These kids “focused strongly on being healthy” (ibid), and the 6 – 15-year-olds could be “too active” (ibid): “Many of the kids participate in quite many leisure-time-physical-activities. It is experienced as more challenging to make these kids take it easy, than to increase their activity levels” (ibid).

Drugs were mostly reported for the 16 – 20 age group; cannabis being the most popular drug. However; there was one case of 6 – 15-year-olds, whic connected drug abuse to loneliness; “It is problematic that many children are left alone on their own. Many have easy access to alcohol, and cannabis is widely used in some schools” (ibid).

The districts worried that insufficient resources affected necessary care provision; for instance; the presence and availability of local PHNs: «there is insufficient number of school-based health staff, which is due to district´s bad economy” (ibid). Challenges in referring teenagers to specialist care, were reported too. Such were partly attributed to parental refusal: “does not want help: parents of financially strong families can be reluctant and refuse their children to be referred to specialist care for further evaluation and treatment” (ibid).

3 Theory and framework

The aim of this study, is partly to explore factors that are perceived as potential barriers and facilitators for access to relevant public adolescent health care services.
Adequacy of access is quite vital for a user group as adolescents, as these are still developing a sense of what *health care* would mean for future life. It is therefore extremely important that they get a good impression of it. As this chapter will show; adequate access depends on the *system* (of services), its users, and the various dimensions of interaction between them.

3.1 Definitions of access

Access has different dimensions, and cannot be seen as a concept belonging to one specific domain (Khan and Bhardwaj, 1994). An early study from 1972, describing models for organizing the delivery of personal health, recognized that there are numerous indicators for access. Even though the study focused on organizational aspects, it connected organization flaws with user dissatisfaction:

«An important feature of organization is the way in which the hours of work of providers fit in with the rhythms of work and play of the consumers and of the providers of care. Needless to say the correspondence or lack of it can facilitate or hinder the seeking of care and involve satisfaction or dissatisfaction of clients and of professional personnel» (Donabedian, 1972)

This was of importance for future work in the field of healthcare, and already in 1974 A. W. Parker followed up with his definition of access (or accessibility): "the ability to reach, obtain, or afford entrance to services". Parker´s definition put emphasis on the users of health care services, and soon access was regarded in terms of barriers on both the production and the consumption sides (Lewis, 1977). On the consumption side, the economic or financial barrier was seen as perhaps the most challenging. However, this barrier is nearly irrelevant for the current study, as health services in question are mostly free of charge. On the production side, barriers can be found in the lack of necessary providers; their location (geographic distribution); how they are organized, and the scope of services they provide (Lewis, 1977). It was Lewis´ work that eventually led to the dichotomy of spatial and aspatial access to healthcare, the former being dependent on geographical factors and the latter on non-geographical factors.

Returning back to ability; much like Lewis emphasized users´ ability, Khan and Bhardwaj (1994) describe ability as something that is "modulated by the various barriers that a person must overcome before obtaining services or gaining access" (Khan and Bhardwaj, 1994). A DHEW publication of 1979 finally put together a solid definition of accessibility, that includes users and their abilities; providers; and spatial and aspatial factors:

"The ability of a population or a segment of a population to obtain available health services. This ability is determined by economic, temporal, locational, architectural, cultural, organizational, and informational factors which may be barriers or facilitators to obtaining services." (Bureau of Health Planning, 1979).

Aday, Andersen and Fleming (1980) introduced a new approach, distinguishing between potential and actual entry. Potential (or probable) entry is dependent on two things: the characteristics of the service system, and its users. The service system can be characterized by the availability and distribution of health care resources; number of employees; temporal factors, geographical location, and so on. The users can be characterized by factors such as age, income level, and health status. In practice, potential access can be investigated by looking at how the system and its users interact in a given geographical area.

3.2 Conceptual framework

In 1994 A. A. Khan and S. M. Bhardwaj released a study of access that provides, according to the authors themselves, "perhaps the most detailed clarification of the access concept" (Khan and Bhardwaj, 1994). Access is finally defined as: "the outcome of a process involving the interplay between characteristics of the health care service system and of potential users in a specified area, and moderated by health care related public policy and planning efforts." (ibid). The definition touches upon concept´s multiple dimensions and synthesizes characteristics of the two involved parts (which will hereafter be referred to as the two *domains*): users and providers. Two main categories of social indicators eventually form the framework: process and outcome indicators. Process indicators, or *inputs*, are comprised of system and population descriptors (hereafter also referred to as *constructs*). System descriptors (constructs) are: number, volume/size, distribution/location, organization, preferences/prejudices, price and quality, and say something about the facilities and the personnel. Population descriptors (constructs) are: number, distribution/location, need for service, ability to avail service, effective demand, preferences/prejudices, attitudes/values,

and tell about the potential users. It is the combination of process indicators that generates the probable or potential access to services. Different types of barriers and facilitators affect the actual utilization and satisfaction from services. Economic barriers are expected to be absent, as the consumer price for public adolescent care is zero.

Access to health care, conceptual framework (Khan & Bhardwaj, 1994)

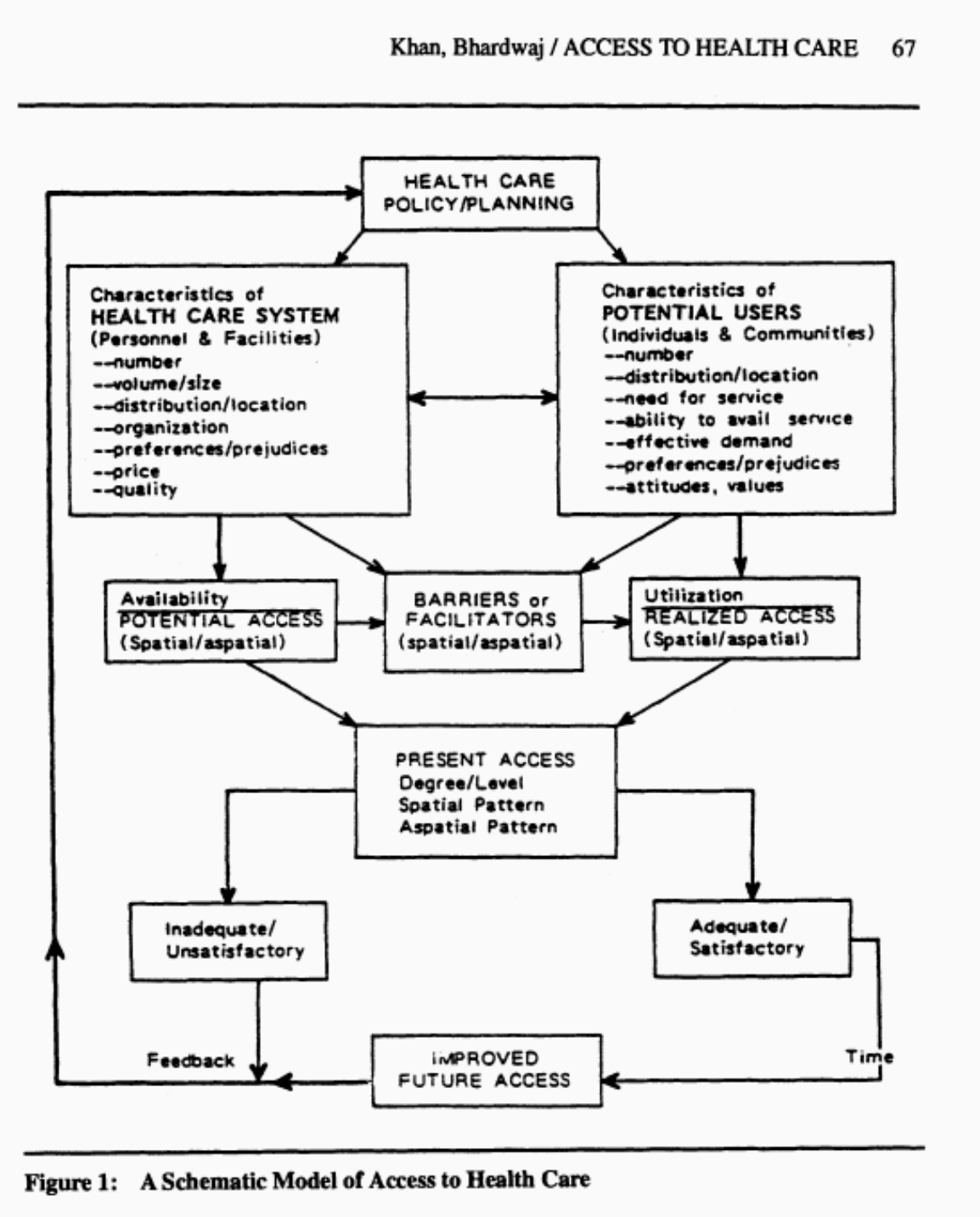

Figure 1: A Schematic Model of Access to Health Care

It should be mentioned that the framework was not used in its entirety in the interview study. Characteristics of health care system and its users (the two upper boxes) were seen as domains, and used to form the interview questions. Descriptions of barriers and facilitators (middle box) were then searched for in the interview transcriptions.

4 Methodology

4.1 Scoping review

Considering the overall aims of the study, a review of previous literature was seen as useful to map out some key points about the influence. A review is also generally recommended for updating "current personal knowledge and practice on a topic." (Cronin et. al., 2008).
As this is a qualitative case study; where the wish was to prioritize the interview study, doing a scoping review was found to be the most fitting approach for the initial literature search.

A scoping review is similar to a full systematic review. It strives for the same goals as the latter; to collect, evaluate and present the available research evidence (Arksey & O`Malley, 2005). A scoping review, however, is not required to have the same high standards for quality assessment as a traditional systematic review (ibid). In sum, "a key strength of the scoping study is that it can provide a rigorous and transparent method for mapping areas of research. In a relatively short space of time (compared with full systematic review), reviewers are in a position to illustrate the field of interest in terms of the volume, nature and characteristics of the primary research." (ibid). The aim of this particular review, was to summarize characteristics of possible mechanisms that can be driving the influence. Unlike a systematic review; which usually required studies to be somewhat uniform in their design, the scoping review method allows accessing broader topics, with different study designs (ibid). This is of particular importance for the current study since the included articles vary in their designs and methods.

The scoping review for this study was a five-step-process, guided by the methodological framework suggested by Arksey & O´Malley (2005). The five steps are: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarizing and reporting the results (ibid). In order to get a better understanding of the process, additional literature (Booth et. al., 2016) was used for support. The five steps will now be outlined.

Stage 1: Identifying the research question

The initial aim, prior to investigating the beliefs of public health care workers in Oslo; about the social media influence, was to summarize characteristics of possible mechanisms that can be driving the influence. Still; as interview participants later on would be asked about their opinions, it was felt wise to precise this detail in the first research question. Research question (1) is therefore: *"According to public health care workers; is social media believed to influence body image perceptions, diet; and exercise behaviors of adolescents?"*

Stage 2: Identifying relevant studies

Online search strategy was developed from research question one *only*; as this question laid the foundation for the study. Defining key search terms, it was assumed that influence on body image would also be evident in those articles that dealt with influence on diet and exercise. And with regards to "adolescents"; it was felt that they are one of the biggest user groups of SOME, and would therefore naturally be discussed in the identified articles. Search terms "*body image*" and "*adolescents*" were therefore excluded. The three final search terms, used to search the online databases, were therefore limited to: *social media, diet, exercise.* Depending on the database, these were combined using the Boolean terms "AND" and "OR" (for example: *social media* AND *exercise* OR *social media* AND *diet*) and truncated where possible to expand the search result. Four electronic databases were searched: PubMed; Web of Science; PsycINFO, and Scopus. PubMed and Web of Science were recommended by my faculty; *Health Economics, Policy and Management.* Web of Science had also been specifically mentioned by one of the faculty teachers[2]. PsycINFO is a database that contains literature about psychology, medicine and psychiatry. This was therefore purposively chosen, in hopes that it would provide literature on SOME influence and mental health. Scopus was added as a random database. Search strategy for each database differed somewhat, depending on for instance the ability to truncate search terms (PubMed, PsycINFO) and filter options (Web of Science, Scopus). Where the hits were too many, filters were applied to exclude articles from completely different scientific disciplines (e.g. *"zoology"* and *"veterinary sciences"* in Web of Science*)*. Another deviation from a uniform search method was setting the "best match" option as default in PubMed. Regardless of database; only articles published in English were eligible for further evaluation. Time span was limited to include only articles

[2] (And later my thesis advisor), Frode Veggeland.

published from 2010 and up. However, this was most likely unnecessary, as SOME is a fairly modern phenomenon; the oldest included study was published in 2012.

Stage 3: Study selection

A total of 1.646 online articles, divided by the four databases, were identified as eligible for further scrutiny. Screening titles and abstracts first, better familiarized the researcher with the existing literature. Studies that were obviously wrong for the current research were instantly rejected. For example: experimental studies that tested SOME-based health interventions to improve health conditions; and studies about the influence of *traditional* media. Inclusion and exclusion criteria were devised *post hoc* (Arksey & O´Malley, 2005). The final criteria were first applied to the remaining titles and abstracts; copies removed, starting with PsycINFO; as the second database after PubMed (and so on), and finally to the entire text of each article. Full-text evaluation was given to a total of 37 studies; of which two had been identified through other sources. Excel was used to keep record of the articles. A schematic presentation of the study selection process; and the inclusion criteria, are respectively found in Appendix II and III.

Stage 4: Charting the data

The final 37 texts were given a partly-systematic evaluation; where general information of each article was charted first, using tables in Word for overview. This information included: year of publication; name of author(s) and title; type of study (content analysis, interview study etc.) and its aim(a); methodology; characteristics of population or content under study, and their number; location; type of SOME investigated; main findings, and limitations of the study. Mean BMI of was also recorded where possible because it was interesting to know about participants´ thoughts and perceptions of body weight and ideals, given their own body compositions. An example of an empty Word table for charting can be found in Appendix III.

The next stage of data evaluation involved writing summaries of each included study; to get a better understanding; and a sense, of the entire data set. Writing the summaries, I first read each article taking hand notes; and later transferred them to a Word document. Data that was felt to be of particular importance; but also, similarities between studies, were written down. This meant that each article was subjectively evaluated. “The scoping study seeks to present an overview of all material reviewed and consequently issues of how best to present this

potentially large body of material are critical" (Arksey & O´Malley, 2005). It was hoped that subjective evaluation would result in richer and more various thematic map/maps later made.

Stage 5: Collating, Summarizing and Reporting the Results
In this study, attention was given to both the basic numerical analysis, "of the extent, nature and distribution of the studies" (ibid); and to the actual textual content of each article. A narrative account of findings is presented mainly just according to the textual content; synthesized and interpreted "by sifting, charting and sorting material according to key issues and themes." (ibid). Several thematic maps and sun diagrams were made; with many of the identified themes overlapping, and not mutually exclusive. In order to provide a logical description that would also fit the aim of this study, the two research questions of the study were; again, addressed. (1) *According to public health care workers; is social media believed to influence body image perceptions, diet; and exercise behaviors of adolescents?* (2): *What are the perceived barriers and facilitators for access to relevant health care services?*
The influence of SOME surfaced, after a while, as a combination of three distinct mechanisms. Namely: the technology itself (inherent nature and functions); its users (their online activities and reasons for using SOME); and trends of body ideals, that had been generally promoted in mass media. The three mechanisms are presented in their three corresponding chapters (see: Results, Chapter 5.1).

4.2 Interview study

4.2.1 Design

A qualitative interview design was used to further investigate research question 1, as well as to explore opinions about the adequacy of access to relevant health care services (research question 2). Semi-structured interviews were undertaken summer 2019, in which health professionals, who work with adolescents in municipality of Oslo, participated. A deductive thematic analysis was used next, to organize data into pre-existing domains and constructs of a conceptual framework (Khan & Bhardwaj, 1994).

4.2.2 Setting

The study explores access to free health care services targeted at adolescents. As such are available to adolescents is Oslo through primary care, it felt natural to carry out the research

in a municipal setting. Which is why high schools and Adolescent Health Clinics were targeted for the interviews to were carried out.

4.2.3 Theory

Departing from the two principal domains of the conceptual framework (Khan & Bhardwaj, 1994), *system* and *users*, the interview guide was developed. Questions were made based on constructs of each domain; originally seven for each (questions about price were dropped, as youth is not expected to pay for the discussed municipal health care services). This way, questions touched upon *system descriptors* (Number; Volume/size; Distribution/location; Organization; Preferences/prejudices, and Quality); and *population descriptors* (Number; Distribution/location; Need for service; Ability to avail service; Effective demand; Preferences/prejudices, and Attitudes/values). As such; data was collected about the *inputs* of the framework; also called *process indicators*. This data would then be used to identify possible barriers and facilitators to access.

4.2.4 Participants

The original plan was to recruit between 8 to 12 participants, as this is usually a sufficient sample, for qualitative individual interviews (Feiring, E., 2017). Representatives from AHCs and high schools were purposive sampled; as these two arenas are frequently used by youth. Letters of invitation were sent to 17 high schools and 15 AHCs, which were later contacted by phone; as no reply came. 11 individuals accepted the invitation, and three of these brought a plus one on the interview day; which resulted in a total number of 14 participants. 8 of these worked in both high school and AHCs. The remaining six worked solely in high schools. Most participants were PHNs, but several had additional other titles. Two of the participants had completely other titles. Extensive description of the participants can be found in Appendix V. Informed consent to participate in this study was obtained from all participants.

4.2.5 Data collection

Interviews were conducted in the office locations of the participants; this way creating a safe and relaxed interview setting. Each interview lasted between 30 to 45 minutes. With the exception of three interviews, where participants each had brought a plus one; all interviews were individual. Interviewing two at a time did not really harm the original design, but, quite contrary; resulted in enhanced discussion and more in-depth answers. Participants were asked

to elaborate on each of the constructs of the conceptual framework (Khan & Bhardwaj, 1994). For example: for *Location* (a construct of the System-domain), participants were asked whether or not they thought adolescents saw AHCs as remotely located; or difficult to travel to. Questions were also asked with regards to SOME influence on body image perceptions, diet; and exercise behaviours of adolescents. There was also one question about how participants would define "adequate access". The interview guide is found in Appendix VI.

4.2.6 Analysis

All interviews were audio recorded; using cell phone, transcribed verbatim, and analysed using a deductive thematic analysis method. The first step was to get familiarized with the entire data set. Therefore, hand notes were taken during the first interview reading session. Re-emerging topics were highlighted. In the next sessions, factors that were regarded as barriers and facilitators were highlighted. Data extracts were coded as barriers or facilitators, using Excel sheet. Codes were not mutually exclusive and could appear as both barriers and facilitators; and in several constructs simultaneously. Mind maps were used as an extra tool to help organizing the content. In the last stage of analysis, codes were collated and organized into the pre-existing constructs of the framework. Interview quotes were translated in one of the last drafts of the paper; to make sure context remained throughout the entire writing process. Some of the translations were done by a friend of mine, whose mother tongue is English. Original transcriptions were kept. Quotes are found in two different appendixes. Appendix IX contains a table with illustrative quotes for chapter 5.2 (Results). Appendix X contains quotes for chapter 6 (Discussion).

5 Results

5.1 Scoping review

Illustrative scoping review quotes for this chapter can be found in Appendix VII, and are marked with letters (a – t) in the text.

Two nationally representative studies; one British and one American, had investigated the relationships between decline in psychological well-being of adolescents, and the use of social media (Kelly et. al., 2018; Twenge et. al., 2018. See also: a). The U.S. study had surveyed 1.1 million US adolescents annually (12th graders since 1976 and 8th and 10th graders since 1991), noticing a sudden decline in psychological well-being during 2012 – 2016 (Twenge et. al., 2018). This was later explained by the rise of smartphone technology and increased screen-time activity, and the study concluded that social media could negatively affect psychological and overall wellbeing of adolescents (ibid. See also: *b)*. The British study; which studies 14-year-olds, found positive correlations between online activities and reports of: depressive symptoms; fewer sleep hours; more disturbed sleep; and dissatisfaction with appearance and body weight, especially in young girls (Kelly et. al., 2018). Both studies also connected increased social media usage to disturbed sleep patterns; with Twenge et. al. (2018) pointing to youth´s addiction to SOME and their fear of missing out on things.

The way social media influences health understanding and behavior today, seems to be a combination of the technology itself; its users; previous trends from traditional media, which have gradually been replaced and slightly altered; and the growing value of appearance over health. This combination is leading to a general "fitness hype" among adolescents. The hype is really just "an increased interest in health, diet, and physical activity" (Wiklund et. al., 2017), but there are several identified variables that make it rather health-harming. These variables are: adolescents´ inability to safely navigate online information; purposeful or random exposure to irrelevant or edited content; disturbed sleep, diet and exercise patterns; peer pressure; frequent upward social comparison; shaming and judging based on appearance and/or health-related behavior; and obsession with appearance over health. Peers have been attributed a particularly decisive role, as these are trusted sources of information, and can inspire and motivate to a healthier lifestyle, and provide social support. There is a general

consensus that increased education in relevant health topics and improved media literacy among young users of social media can change the negative current of influence.

5.1.1 Social media: the technology

Social media (SOME) has some unique technological characteristics that allow for instant information sharing and shaping. Users exchange both visual and textual information, contributing to the enormous pool of it. Lambert et. al. (2018) framed SOME as "an increasingly popular way for users to be both creators and consumers of health information by providing a platform to share, discuss, create, modify and exchange information with the "on-line" networks". Though the open access has its flaws, as it makes navigating and selecting proper content a challenge for many adolescents (ibid; Raggatt et. al., 2018; Ramachandran et. al., 2018. *See also: c*). Moreover; youth´s online actions can have "unforeseen and long-term consequences" (Holmberg et. al., 2016. *See also: d),* since youth can be highly opinionated in questions of health, fitness and diets. They make frequent posts about these topics; share, like and comment (Zhang et. al., 2017; Vaterlaus et. al., 2105; Villiard & Moreno, 2012; Harris et. al., 2018). This is concerning; because perhaps teenagers should not be in a position to lecture others, as they are still in the process of both physical and mental development. Of course, not all users are equally contributive, or pay equal attention to content; some just swipe past material; often disregarding a lot of it (Goodyear & Armour, 2018, a). But findings suggest that these are still affected, even by random exposure *(e)*. Users can also engage in the information and actively follow content that is recommended, or content that has been automatically sourced *(for definition; see: f)*. Active users are allegedly more exposed to influence, since their activity generates also more activity in the technology *itself.* SNSs use information about users´ profiles to preselect content, after which logarithmic patterns may lead the content in potentially any direction. This means that departing from *one* initial search, one can end up viewing unintended or irrelevant content *(g).* Several sites, Facebook among them, use "targeted social media advertisements" (Crossman, 2017) to show ''relevant and interesting advertisements to profile owners based on their likes, interests, and comments" (Villiard & Moreno, 2012). This function is supposed to provide more relevant content. However; one study tested this, with regards to fitness statuses and fitness adds; and found that not even half of the generated adds were fitness related (ibid). On the contrary; about 30 percent of the generated adds were still fitness related; even though the statuses were not, and some promoted weight loss; which

was found concerning; since one can be already underweight and still post about weight loss (ibid). Online adds were also believed to be distracting from health itself, but empowered the value of appearance. This illustrates how social media can replace relevant information with undesired, or potentially health-harming content, and is of concern as people do change "their health-related behaviours because of something seen on social media" (Goodyear & Armour, 2018, a). A study found social media to be "the most common source of nutrition knowledge" (Lambert et. al., 2018), with a majority of its participants "indicating that they do not search for nutrition information but they are exposed to it constantly" (ibid). In terms of food adds, Holmberg et. al. (2016) discovered similarities between these and how adolescents present their foods online, and concluded that food brands must influence the culture and food habits of adolescents.

In terms of presentation; the technology allows for digital alterations before posting online. Photo-editing on social media is like Photoshop, but the functions are much more straight-forward and often integrated into the SNS. A standard example is Instagram; providing options to apply digital filters before posting photos or videos. Editing prior to posting is commonplace among adolescents (Mabe et. al., 2014; Brown & Tiggemann, 2016), and is explained with the desire to present the best version of oneself *(h)*. Moreover; users often first pick the most attractive photos, which is again a strategy to enhance appearance. This creates a health problem for many, as online pictures are far from reality, and can contribute to internalization of "fake" body ideals. More about what is being posted, and why it is being posted, will be discussed further in chapter 5.1.2 and 5.1.3. For now, it is vital to understand the severity of constant exposure to content that has most likely been digitally altered, and interpretation and internalization of this content.

It can be said that social media has become an integral and habitual part of adolescent life. It is used on a daily basis, both for health-related information seeking *(For examples of information, see: i)* and communication with peers. SOME has been credited for both "expanding food choices through creating access to a variety of recipes" (Vaterlaus et. al., 2015), and for providing highly accessible varied exercise material, "with short duration and simple solutions to becoming 'healthier' (Goodyear & Armour (2018, a). Despite a great deal of misinformation online, the bottom line seems to be that youth values easily accessible information, and the fact that it is always, literally; in one´s pocket.

5.1.2 Social media: the users

In total, 24 studies (64,8%) in the current review included participants. Participants´ age ranged from 13 to 30, but since most were sampled from student populations, the mean age was normally between 18 and 20. Two Exceptions are Kelly et. al. (2018), and Twenge et. al. (2018); both studying younger samples. Most studies were American (12), followed by Australian (6) and British. (4). There was also one Swedish and one Dutch study. Instagram was the most researched SNS (8); followed by Facebook (7), Twitter (3), Tumblr (3), Pinterest (2), and finally one study investigating blogs and mobile aps. This matched the findings of Wiklund et. al. (2017); that Instagram is the most utilized SNS among Swedish adolescents aged 13 – 16; and Fardouly & Vartanian (2016); who found Facebook to be the most researched platform in 2016. 15 studies (62,5%) included both male and female participants. The remaining 9 articles featured females only; no studies focused on men. Whenever BMI of participants was provided, it was always within the normal range; 18,5 – 24,9 (WHO, 2019).

Users of SOME mediate the degree to which information is accepted; reinforced, engaged with and internalized**.** *Peers;* their feedback (e.g. likes and comments) and the contents these create, have particularly influencing powers. *Health-related* peer content has previously been categorized in six distinct groups that are applicable to the current study. Namely: "(1) pictures of the healthy foods they have cooked/eaten, (2) pictures of themselves working out or at the gym, (3) about how they have worked out or exercised, (4) fitness inspiration quotations or images, (5) before and after pictures of themselves, and (6) statistics after they have worked out (e.g. how far they ran, how many calories they burned)" (Arroyo & Brunner, 2016). It is believed that this type of content is posted online mainly for apprehension seeking and bragging, but it is also believed that feedback on SOME has the ability to reinforce pre-existing attitudes and behaviors (Hefner et. al., 2016. *See also: j)*. For instance; Goodyear & Armour (2018, a) found that liking a post without getting a like back would work as "a form of judgement" on behavior or body type; while participants of another study "felt like the person posting intended the viewers in their social network to feel shame about their own bodies" (Arroyo & Brunner, 2016). It was also felt that "In order to gain acceptance", one had to adhere to fitness (Wiklund et. al., 2017); "students in sports classes were among peers in the school seen as more highly valued than others" (ibid). Such a mentality inflicts unnecessary pressure on the already-high expectations that many

adolescents may experience (Municipality of Oslo, 2015), and they can be driven to compulsively exercise, in order become more "like their peers", and develop unhealthy relationships to food and physical activity. It also deprives one of social support and creates competition instead; though support from close peers is otherwise favored in health-promoting activities. Finally; a high number of likes can make any information seem more reputable and credible (Goodyear & Armour, 2018, a), and mobilize "common sense assumptions about health" (ibid).

Viewing fitness posts has been positively associated with negative body talk; "a social process whereby individuals make self-focused and negatively valanced comments about their own body and appearance" (Arroyo & Brunner, 2016), and it is believed that such talk stems from constant online social comparison to one another *(ibid*, *see: k)*. Peers have been previously found to "provide more important appearance-comparison targets than models or celebrities" (Tiggemann & Zaccardo, 2015). An explanation is that close peers are usually people of similar demographics and socio-economic situation; which makes comparison more natural. "Through social comparison with someone who is perceived to be more active, healthy, and fit, one's intention may be to increase his/her fitness levels (i.e. self-improvement)" (Arroyo & Brunner, 2016). Social appearance comparison becomes practically unavoidable online, due to the high prevalence of selfies, which are photos depicting users themselves; usually taken with the phone´s frontal camera. Seeing others´ selfies, one can begin questioning one´s own body and appearance (Goodyear & Armour, 2018, a); some participants wondered about changing their health-related behavior (ibid).

5.1.3 Social media: the trends of body ideals

In the earlier heydays of traditional media; TV and magazines, and supermodels, the ideal female body was "just" thin (as the models). There exist entire communities with likeminded peers, who still support and promote the thin ideal, which is believed to be further reinforced because valued by peers and close relatives (Eckler et. al., 2017). In online communities, praise of thin ideals is commonly referred to as *thinspiration*; an amalgam of "thin" and "inspiration". Thinspiration tends to reject larger bodies (Wick & Harriger, 2018) while idealizing bodies that have been described as "ultra-thin" (Pila et. al., 2017), "extremely thin or underweight" (Alberga et. al., 2018), and even "extremely skinny or skeletal" (Harris et. al., 2018). The fact that such body types depend on genetic factors is acknowledged (Raggatt

et. al., 2018), but thinspiration still remains infamous for its "unrealistic" extreme regimes" in terms of diet and exercise (Raggatt et. al., 2018. *See also: l)*, and is therefore frequently connected with eating disorders *(m)*. Moreover, thinspiration contributes to body objectification, self-objectification (Carrotte et. al., 2017), and sexualization (Alberga et. al., 2018; Wick & Harriger, 2018), which can make young women think that looks are of critical importance *(for additional comment and quote, see: n)*. Though, summing up correlational research on social media and body image concerns, Fardouly & Vartanian (2016) found Facebook-users of both genders to engage in self-objectification *(o)*.

Fitspiration, appearing in the late 2000s (Twenge et. al., 2018), was first seen as a positive shift away from thinspiration; a healthier "happier" trend, since it shifts focus from thinness to strength and removes stigma weight lifting for females (Raggatt et. al., 2018). One content analysis found fitspiration to promote "weight management standards and behaviors as a way to be thin, fit, sexy, or beautiful" (Simpson & Mazzeo, 2017). However, the new ideal body was quickly recognized as a physiological paradox; as it is supposed to have perfect ratios of muscles, slenderness *and* curves (Arroyo & Brunner, 2016. *For detailed description, see: p)*. While the "ideal" body composition seems more achievable for boys (Wiklund et. al., 2017), for young girls it becomes almost "unattainable" and "unrealistic" (Deighton-Smith & Bell, 2018; Simpson & Mazzeo, 2017; Tiggemann & Zaccardo, 2015; Easton et. al., 2018), due to their physiology. Despite fitspiration´s focus on vigorous and consistent exercising to achieve the ideal body, the trend actually encourages strict determination to both exercise *and* diet, and is therefore much like thinspiration. Although differences between the two trends were found by Harris et. al. (2018), a later analysis across three SOME sites (Instagram, Twitter, Tumblr) found no differences between the two (Alberga et. al., 2018; *see: q)*. The latter also incorporated a bigger variety of hashtags in their analysis. It is therefore argued that both trends can be equally unhealthy, and that fitspiration is simply a "less extreme" trend than thinspiration (ibid; *see also quote r*). Already back in 2012, Homan et. al. concluded that: "viewing toned and muscular images does not produce negative feelings about the body unless paired with thinness". It seems that the desire to increase appearance is still driving the actions of both diet *(s)* and exercise *(t)*. "Researchers have posited that while the shift from a focus on thinness to fitness may outwardly seem positive, the healthy looking ideal is still underpinned by aesthetic perfection" (Raggatt et. al., 2018). And much like the previous trend; fitspiration continues to contribute to social appearance comparison online (Simpson & Mazzeo, 2017; Lambert et. al., 2018; Deighton-smith & Bell, 2018).

When body goals are not achieved, youth can experience food and body guilt (Raggatt et. al., 2018; Simpson & Mazzeo, 2017; Wick & Harriger, 2018). This is problematic, as *guilt* can be enhanced online. For example, viewing others´ *food* posts could lead to eating restraint (Vaterlaus et. al. (2015), while thinspiration communities actually used "guilt as a motivator to lose extreme amounts of weight" (Wick & Harriger, 2018). Even the practice of cheat-meals; which has become quite popular among males who want to build muscle (Pila et. al., 2017) is characterized by alternate episodes of taking in large amounts of food (usually unhealthy foods), and "subsequent attempts to compensate via restrictive dietary practices" (ibid). There seems, however, to be a general food hype going on that would make it difficult for *anyone* to be consistent in their diets and exercising. An entire scale of food variations can be found online; from vegan trends; which tend to exclude entire food groups (Ramachandran et. al., 2018), to pizza and hamburgers; perhaps as a part of the cheat meal practice. And adolescents themselves are contributing to this hype, because food is a part of the adolescent expression (Holmberg et. al., 2016).

5.2 Interview study: barriers and facilitators

5.2.1 System characteristics

Number

Shortage of health staff was widely experienced as a barrier to access. It was argued that additional workers that are necessary to deal with the high demands, are not in place:

"We need to have the leaders with us (to hire staff)." (Participant 6); *"But it comes down to money."* (Participant 7)

Several of the participants referred to a particularly immense workload in AHCs, mentioning waiting time in these. There was also consensus that male workers, and workers with foreign ethnicities, were missing; though these were thought to facilitate access for young males, and users with foreign ethnical backgrounds. Interestingly, a general shortage of male PHNs was reported regardless of whether participants experienced staff shortage at their particular work place or not. It was in fact argued that more men would be of great benefit for the entire Agency of Health; and society, in general. There was also demand for psychologists; which revealed inconsistencies in how Project *"Low Threshold"* is implemented. According to the project; psychologists are supposed to be provided by CAPP; and be present in schools as an

easily accessible specialist care service. Such an arrangement was, however, not in place in about half of the interviewed districts. For instance:

«Additionally, there should be a psychologist present; which there is not at the moment, as the previous psychologist resigned. They have not hired a new psychologist, but there should be a psychologist there full-time." (Participant 12)

Participants assumed that a general lack of resources in the health care sector was the real reason for why psychologists were missing. This was evident; as some districts were trying to take the matter in their own hands, but were still not getting necessary financial support:

«Because we have previously had (psychologist) through CAPP, but... they are struggling to get ahold of a psychologist they can send to us. So we had to hire on our own, to have that in place and avoid too much absence by the psychologist (...) Because they have some... pressures/issues themselves, within CAPP, from my understanding. But why it has taken so long, that we do not know. So, we have had to take things into our own hands. We have had to hire someone ourselves." (Participant 11)

"...Now and then; as one has money. Because now there are some resources we have gotten from the Directorate of Health. It is a consistent job; getting resources for the psychologist. But right now, there is a psychologist here, until Christmas. Then we will not have any more resources." (Participant 13)

Listening to participants´ responses and witnessing their calm demeanours, it was understood that many of them had come to terms with the barriers. For instance; *«If you ask me; it is what it is. (...) You take what you get; and try to make the best out of it."* (Participant 4).

Despite the situation with resources, participants found great aid in other staff, such as community workers, student advisors, and even teachers, and were convinced that the most important is to simply be there for the users; and be ready to listen:

«Sometimes... it can help just by having someone see you. That someone asks you: "what is this about?"." (Participant 4)

Access to care could thus still be facilitated by any adult; as long as the person appeared safe and relatable to the users:

"When they´ve opened up, I feel like it really doesn't matter who we are; as long as we are safe, kind of." (Participant 7)

In terms of body image concerns, one participant pinpointed that; *"Being able to normalize* that*, and trigger joy and acceptance of ones´ own body, is something that many are capable of doing. One does not have to be a psychologist."* (Participant 1).

Volume/size

This construct was interpreted as: volume of clinical activity and where this activity finds place; based on a systematic review by Sowden et. al. (1997). In about half of the interviews, participants felt that volume of activity in AHCs is not optimal, and has too much of a clinical perspective. It was in fact said that:

"In terms of counseling and regular conversations, we´d like to have it a little bit less clinical. Especially when it comes to boys." (As later explained): *"I was talking about the surroundings. Sterile, if you wish."* (Participant 1)

AHCs do not focus on body image concerns and regular talking. Staff shortage was again believed to be the cause, and the resulting waiting time. One interview was particularly fruitful, with an accurate description of the current situation in AHCs:

"Regarding body image and stuff like that; there is more room for those things to be handled by AHCs. There should be. But if you consider the numbers, and how many one is supposed to - you have ten-fifteen minutes for each; it just does not cover it. Unfortunately, I think there are a lot of people who are not able to open up about such topics, because they see the long line of people waiting outside." (Participant 11)

The problem is also that AHCs operate during specific days and working hours, which causes trouble for those users who live far away or attend high schools in other districts:

"...on Mondays; because then we are open until 19. But on Wednesdays, we are only open till 16. Which means; at least for the people that live here, but study in different parts of town; that they do not make it here in time." (Participant 14).

Spread of information

Thanks to modern technology; distribution of health-related information does not have to be limited to office location, or other spatial factors. Spread of information was therefore regarded as a basic health-promoting activity, that would facilitate access to public health services. This facilitator was discussed in all eleven interviews. To begin with, providing *correctly tailored* information reduces the risk of getting exposed to, and internalize, online information that can be biased:

"And generally speaking, I try to encourage them not to soak everything in that they find on the internet." (Participant 3)

Further on, informing users about the health care system, and its services, would make the services seem safer to use. Some information was thought to be particularly important to distribute. This included: when, where, and *how* health care services can be obtained;

opening hours, telephone numbers and/or e-mails. Adolescents were at times said to be oblivious of such information:

"But I believe we need to improve on enlightening information. Starting with students beginning secondary school; that they can go to AHCs. Mm…Because not all 8th graders know they can attend here. So I am trying to inform them of that." (Participant 14)

"We try to be…try to inform them as much as possible, with address and opening hours, and so on. Of course, there are always some that make an error regarding what health clinic or health clinic for adolescence, and think that "the health clinic nine to five" is the same, and come, around ten and then we work from three thirty." (Participant 1)

Information could be found on posters in high schools; official web pages, and was otherwise always provided to students whenever PHN was out in classes. School official web pages were though thought to be seldom checked by youth and therefore not considered appealing:

(Laughs): *"We only have a boring website."* (Participant 14)

Digital distribution via online channels was stated to be much more practical, and also more preferable. Several AHCs; as well as some high schools, were using Snapchat:

"Yes! The other girl does it! Yes, she´s been using Snapchat a lot!" (Participant 13)

Snapchat is a SOME platform that is popular among Norwegian youth. PHNs updated youth through so-called "snap-stories"; including hot topics about health, and inviting users to make contact if they have more questions. This practice facilitated access for many hesitant users; young males, for instance:

"They might ask me a question, on Snapchat, which they might avoid asking someone face to face." (Participant 5)

Whenever youth tried to use Snapchat for extended health consultations, participants encouraged them to show up at the office or clinic, for a proper evaluation:

"We are not going to conduct health counseling over snapchat. We are not allowed – it´s illegal." (Participant 11)

Snapchat is primarily used as an outgoing channel; also because the exchanged information must be documented, which is time consuming.

The volume of activity can be extended even further; via the School-Based Healthcare Services (SBS). Compared to AHCs, high schools were seen as more suitable arenas for efficient care, due to their greater potential of providing comprehensive care:

"Body image pressure is a topic that´s rather brought up in the school sector, than AHC; where one has a lot less time for each consultation. And it must be followed up over

time. It´s also possible for us here to confer with a counselor; if there´s anything the person can contribute with. So there´s probably a more comprehensive offer that can be given in schools. It´s even easier to do it over time, as we are in the school several times a week! While in AHCs there are employees working once every other week, right?" (Participant 11)
Unlike AHCs, where waiting time created a barrier to access, sms communication was used I high schools to schedule appointments with PHN, and thus avoid much of the waiting time. Half of the schools visited were able to give appointment the same, or the following day.
Three distinct groups of health-promoting activities were identified in SBS. These were: (1) establishing relations and trust, by showing face; (2) having normalizing talks with users; and (3) offering classes and education in relevant topics. All activities could nudge users to contact the health care sector, and were therefore believed to facilitate access.

Establishing relations and trust by showing face
By simply making an appearance, PHNs could establish relations believed to be necessary for future use of the health care sector, and prevention of potential struggles:

"I think the school system does a lot, in a way. Because the school nurse, or health nurse, is available from the first year (of upper secondary school). I think that is where one needs to go. Eh because... Just to show that there is a safe environment to go to. Right? When things get hard in high school/upper secondary school, when one enters puberty and start having draining thoughts and all of that; that they then know there is something here. That it is available (to them)." (Participant 7)

The earlier the contact; the better. Which is why participants always held presentations for all new students during their first year of high school, and then continued showing face:

"I believe safety is important. And relation; that one can feel safe and have relations with them, at least when it regards mental health. And that we do not judge. That we are somewhat open, I guess. That we use time on establishing during our visits to the classes as well. It is not supposed to be difficult; we do not judge anyone, everyone is welcome! They are teenagers and experiencing life´s ups and downs. So, I believe that just the fact that we say this in our introduction, when we walk around in the classes for them that are new; we show face, I believe that maybe that can grab some of their attention; make them want to come here, and think "Maybe I should go talk to them?". We are here to, like, help them feel better." (Participant 6)

Normalizing talks

(*Nor.)* "Normaliserende samtale" refers to conversations between user and provider, where the former often talks while the latter listens and shows support:

"It is what one would call the professional conversation with teenagers, or a conversation promoting development with teenagers, a term they use here. That it is allowed to talk about anything at all and we show that we are open to talking about anything and everything." (Participant 8)

My participants were convinced that such talks do help and are appreciated by youth. Adolescence is a turbulent time. But a small reminder about that ones´ feelings; thoughts; and appearance, are perfectly normal, can often help:

"There is a lot they have to stand in and handle. So; help them see that. That they are not sick. So that they do not use too much energy on believing there is something wrong with them! Or that they are not good enough." (Participant 14).

Classes/courses in relevant topics

High schools can hold their own courses, or invite guest lecturers to talk about relevant subjects. Sex-education was confirmed to be something organized by each individual high school (Participant 12). This education usually included topics like "personal limits" (Participant 2), was often arranged according to gender (ibid, 4, 6), and adjusted to minorities (ibid, 4). Strengthening students´ mental health was, too, a priority among health practitioners (ibid, 2; 5, 6, 9). The latter could be discussed in the context of drugs (ibid, 5; 6), and sexuality (ibid, 5). Stepping up education about media literacy, was considered to be one of the most important things to do in the school. The main argument was that there is not enough guidance from parents and other authorities. This is turn leaves many young users prone to unhealthy (social media) influence; without them being aware of this influence:

"You see, it is children, and I mean children; they are as young as 9-10 years old, that watch porn for example." (Participant 14)

"Now there are 12 – 13- year old age limits on most of them (SOME sites), but you can meet those that have had Facebook since they were 8... Snapchat since they were 10 and all kinds of things like that." (Participant 1)

Several areas were also concerned with raising awareness about all the "bullshit" that is found online. Participants referred to Oda Faremo Lindholm; originally a Norwegian journalist; who "*has done research regarding teenagers, the media and cellphones"* (Participant 11) and written a book called "Bullshitfilteret", where she brings up this

subject in the context of body image; and peer pressure:

«...talking about this "bullshit filter". That bullshit exists everywhere; in online newspapers, magazines, social media, bloggers; everywhere! Because I recently had this lecture in a tenth grade, and it is amazing when we come up with these things! They become so involved!" (Participant 7)

"(Oda F. Lindholm) has had lectures for all the grades here at school (...) she is having a lecture this autumn. And we think it is very useful, these lectures she has. So we send tasks for them to work with in the aftermath. Which is very good. Because we think it strengthens it moreso than just listening to a lecture." (Participant 11).

Temporal and financial resource constraints were though identified as barriers that hinder necessary education to be provided. One participant specifically wished there was more time for educating foreign ethnical students, as these could have incomplete knowledge about body and sexuality, compared to Norwegian adolescents:

"I wish I had more time with them; to clog these holes, that I experience are lacking. With knowledge, about ones own body and sexuality. I wish I had more time for that." (Participant 2)

"We consistently try to come in with lectures, but it is a battle. Because we´ve tried to get the school to set off time, but they do not seem interested in doing so. I think that is very sad. Because I know that 25% of teenagers deal with mental problems." (Participant 13).

Distribution/location

In addition to the limited opening hours in AHCs; their remote location created barriers to access, especially for the young male users; who only have one AHC specifically for them:

"They wouldn't bother travelling that far." (Participant 9)

"And many of them are so young! As young as 13 – 14 years old; and then it is far to travel." (Participant 13)

When it comes to the high school offices; central versus "hidden" location of these could be seen both as a barrier *and* facilitator; simultaneously, depending on the perspective. The location was a barrier in those cases, when the office was tricky to find:

"I´ve gotten some feedback that it is difficult and there are not enough signs." (Participant 12)

"*My office is at the end of the corridor. So I can say that, I notice that students that have their classrooms nearby, come more often."* (Participant 13)

At the same time; a central location worked also as a barrier; experienced as too exposing by some users. Oftentimes, these were adolescents of foreign cultural backgrounds:

"I do remember; when (different high school) was here, some students literally threw themselves through the door. Checked in all directions; "Is there anyone there who might see that I walk in?!" and then boom! Nearly threw themselves through the door; because they were so afraid of being seen." (Participant 11)

On the other hand, a hidden office location was believed to retain the anonymity of many users, and therefore worked as a facilitator. However; a visible office was easier to find, and also allowed for more cooperation with other staff; especially in those cases where it was centrally put within the school building´s infrastructure:

"I lean towards the belief that our central location is good. So that we can cooperate well with the other school staff. We are right next to the administration; and we have the student advisors right next to us. So we sit a bit better than many other places. Because often one sits a little bit hidden." (Participant 12)

Organization

The entire sample of high schools chosen for this interview study was supposed to have Project *Low Threshold* implemented (Municipality of Oslo, 2019, c). However, two of the interviewed participants had never heard of the project. One PHN laughed when (s)he heard about how updated *I* was on this matter, and pointed to poor coordination of information flow between health authorities and health care providers:

"That´s how it is! I think this is fairly descriptive, really. Because, well, there are a few... What should we say? Like senior things, that get decided, and that are not as implemented in areas where it maybe should be. (...) there is a lot happening higher up in the hierarchy system (...) One isn´t able to follow (the information), in a way. (...) I think it is really weird though. (...) I think it contributes to some alienation in relation to what one really ... wants. That; if you want something implemented in a good way, then you have to involve the others (who work with it)." (Participant 13)

Poor implementation of the project was thus recognized as a major barrier in some districts; as it also hindered presence of psychologists in schools. One of the interviewed PHNs, was also the team leader for the Project, in the district. (S)he could, however, not tell for sure about the future of the Project; nor about the psychologist vacancy:

"I don't know. We were kind of just told that the agreement is being cancelled. But…yeah. But I would imagine that the psychologist services will be continued…" (Participant 12)

Participants were expressing grief, as many knew about how well the Project was functioning in other districts:

"Some districts have an agreement with specialist care, but in (the current district) we don´t have it. That´s a pity. We´d like to have it though. (…) I know that district (name) has it; and many other districts. District (name) has it, uhm, where it actually works really well." (Participant 2)

Half of the remaining eight high schools were familiar with the project, and were cooperating with specialist health services. One area proudly confirmed perfect implementation of the project, describing their unique level of cooperation:

"It´s a cooperation between Agency of Health agency, Agency of Education; and specialist care. (ref. Colleague) is employed in the Agency of health, or; in the district. And I represent the specialist unit. And we both have offices. The school has to make sure we have offices. And this is an agreement that has been signed by the heads of all these agencies in Oslo." (Participant 8)

"What´s unique about our model, is that those who are employed through CAPP, contribute equally as much as the public health nurses in schools. They (CAPP) too, work with whoever that comes through their doors." (Participant 9)

These participants actually shared patient journals with specialist care, and saw this as a key tool for successful health care:

"And then we enter the same journals. Eh, that´s pretty unique (…); that we can read each other´s notes. And that´s very important, I believe. So that if (name) has been doing some follow-up, and then goes on vacation for a week, I can easily read up." (Participant 9).

Preferences/prejudices

There was no doubt among participants; that males are being discriminated, as a user group; and that this discrimination is particularly evident in AHCs:

"…nearly no boys visit the AHCs. So there is a big difference; boys utilize school-based health services a lot, but they very seldom go to AHCs." (Participant 2)

The discrimination was explained by the fact that females traditionally utilize health care services more often, than males do:

"Traditionally; if we were to generalize and be very normative; young boys- males in general; make less frequent contact with health care services, than women do. So that´s one way to look at it." (Participant 4)

It was also argued that it is also more socially acceptable for females to utilize health care services, in general:

"I do also believe, traditionally, perhaps; that it is easier for girls to visit a public health nurse. Or health care services in general. Because in a way, there´s a much bigger acceptance when girls utilize these services." (Participant 5)

The discrimination connected to the limited preferences for care/treatment in AHCs; as the focus of these clinics is to prevent STDs and provide contraception. There exists more contraception for females, than it does for males. Also; females; more than males; were said to be more preoccupied with testing for STDs. There were, however, also temporal constraints and insufficient human resources, that made health challenges associated with social media influence, too badly targeted in AHCs. As participant #1 concluded about body image concerns: *«I don´t think that many (users) feel like they can come here with these sorts of questions".* This is both sad and concerning, considering the fact that also adolescent males struggle with body image:

"I mean, I´ve been working as a PHN for 10 years. I can see that there are more boys now." (Participant 11)

"And I feel like many of them come for more than just to test for STDs; they come to talk…" (Participant 5).

Price

Participants were not asked about *price,* because public adolescent health care services are free of charge. Price could nevertheless become a barrier. As there is a price for *secondary care,* it can hinder users from seeking contact with *primary care;* if the users were to be referred at a later point:

"Starting the age of 16, they must pay for care, and that´s a challenge too." (Participant 6)

Because families of ethnical minorities were said to experience more financial difficulties than families of Norwegian youth, the barrier of *price* was believed to be a bigger challenge for users from foreign ethnical backgrounds.

Quality

Complexities of users´ health conditions/issues were creating trouble for quality of care, in terms of creating ambivalence around referrals to specialist care. *Complexity of issues* was therefore seen as a barrier to access. Body image and eating disorders were particularly tricky issues to deal with. These were often conglomerating of many things at once; the transitions from regular to disturbed health-behaviour in users could be subtle; and the real problems could surface after a while:

"I was about to say; "What comes first: the chicken or the egg?" The picture is so complex! It´s hard to kind of just check off stuff from a list. (…) It is a bit difficult to know the difference between (healthy adolescents) and those who are really headed towards real mental illnesses. It is somewhat difficult to know when I should refer." (Participant 14)

Paying close attention to what could be early signs of illnesses, and being curious, was believed to be a facilitator:

«I´m not afraid, to sort of lead the conversation; I´m not afraid to ask questions. And stand in it." (Participant 5)

At the same time, some PHNs intentionally chose to avoid sensitive topics, and acted as listeners instead. Such a technique was also believed to facilitate access to services:

*"We might appear a bit threatening if we ask directly about sensitive stuff. So I try to be noncommittal**;** thinking that letting them define their own problems would be wise. It also makes them readier for potential guidance, help and treatment."* (Participant 10)

"We can´t force someone to come. Because if you push them too much; especially those who are *slightly ill, they won´t come."* (Participant 7)

In terms of other facilitators; participants told about the "AHC-School"; a concept that started in 2019; organized and led by the Centre for Sexual and Reproductive Health *(Nor. Sex og Samfunn)*:

"A very good introduction for us who work in AHCs." (Participant 11)

This "School" is actually comprised of five weeks of courses. Those participants who had completed the courses; and were assured that these had raised their knowledge, saw the AHC-school as a facilitator.

"The focus (in AHC-school) has been different, depending on the week. One week was dedicated to contraception. Another week focused on genital plagues. And then, one week dealt with different types of minorities. For instance; teenagers with impairments; boys in the health care sector, which we know are in a minority (…) so; how can we meet everyone in the best possible ways. And communication has been a topic." (Participant 11)

Still; it costs to arrange courses, and the problem of resources was, again, brought up:

"You gotta set off time for such things; and it costs money." (Participant 14)

Whenever transition from primary to specialist care was necessary to consider, participants spent time and effort on softening out such transitions, making care seem less fragmented:

"I´ve dialed to hospitals; on speaker, and with the student present, saying like: "So, how do you proceed? I´ve got one here, who´s wondering if she should consider your services." Right? "How can you help?" And things like that; also to make it seem less scary." (Participant 6).

5.2.2 User characteristics

Number

There were no specific factors in this particular construct, that would explain why so relatively few adolescents access the public services with questions of body image, diet and exercise. Participants just assumed that the real number of users, eligible for care, is higher than the tip of the iceberg they were seeing:

"Though, of course; I believe it is like that with many things, at one only sees the tip of the iceberg kind of." (Participant 11)

It was believed that perhaps simply talking with health personnel could be a barrier:

"I believe it can be problematic for many to come and talk, I really do. I believe that there are plenty of those who could have made contact, but don't." (Participant 12).

Distribution/location

Apart from remotely located AHC that have already been discussed, there were no direct barriers or facilitators identified in this domain.

Need for service

"The need for care may be either that perceived by the individual or that evaluated by the delivery system" (Aday & Andersen, 1974) and "refers to illness level, which is the most immediate cause of health service use" (ibid). In other words, when/if adolescents feel they are ill and need help, they reach out. However, according to my participants, others expressed the need for care more than the users themselves. Youth´s level of "need" was thus found to be negative, and identified in four stages, which will now be outlined.

Stage 1: health problem not recognized

To begin with, the influence of social media may go unnoticed and may not be comprehended by the youth:

"Many of those that might not be aware of what influence social media has on them." (Participant 1)

The importance of being extra attentive to youth´s dietary habits and thoughts was highlighted:

«When it comes to eating disorders, I believe that numerous teenagers think that they themselves do not have any issues with such." (Participant 12)

If the user is unable to see the problem; involving parents might become necessary. But such a procedure cannot be an option when the child is of legal age, 16:

"They are over 16 years old. In other words; they are authorized for health services. And if they themselves do not see that they are struggling or having problems, then I do not have... I do not have much to work with. That´s quite frustrating, actually. Because...it´s like; what if they are in the very start phase; of developing an eating disorder, for example." (Participant 5).

Stage 2: understatement of potential problem

At this stage, youth may sense that something is wrong. Even so; users were said to experience a lot of pressure in all aspects of their lives. It was therefore said that they are internalizing pressure and stress as natural parts of life. And instead of reaching out for help, they might be telling themselves that they will be fine; that they just have to deal with it; instead of labeling themselves as "sick":

"Right? That denial in the beginning, perhaps especially in the beginning, that: "I don't have any problem." (Participant 4)

It was thought that longer periods of denial and suppressing ones´ problems could lead to overall decrease in wellbeing:

"But, obviously; if all the small things are constantly being ignored; if one kind of just continues to give the impression that everything´s under control, then…I mean; it must be tiring in the long run." (Participant 2).

Stage 3: eating as control mechanism

This type of behavior was referred to as "mechanisms for mastering" *(Nor. Mestringsmekanisme)* by most participants. It encompassed all types of behaviors youth can

engage in to deal with stress; parental divorces; cohabitational difficulties, insecurities, fears or depressions; and so on. In other words: mechanisms that help youth organizing their lives:

"It can be a way to control other things that are difficult in life. It´s something that makes life function, sort of." (Participant 11)

Adolescents could, in fact, intentionally put themselves in situations referred to as a "win-win situation" (Participant 5), in which they would willingly take risks, due to the experience reward no matter the outcome:

"Sort of: «If I get good results on this test…then I can allow myself an extra treat." And if not then… "If not, then I am going to…" then it becomes the stick, sort of; "then I am going to go and exercise". And stuff like that. (...) So, in one way or another; they win: «And if I don´t get good results, then at least I´ll get thinner."." (Participant 5)

Participants imagined that it can become very difficult to quit eating disorders or disturbed eating habits, due to the sense of control associated with these.

Stage 4: health services denied

Again; in terms of eating disorders, a very logical explanation was offered by participant #12 for why teenagers sometimes do not wish to be helped. Comparison was made between eating disorders and depression. And it seemed more sensible, to want help with the latter:

"And I´ve been previously working a lot with eating disorders, and I see that…those individuals probably have a higher threshold to ask for help. Perhaps one doesn´t want help. The same way one would want…Because that´s *what they want, right? Someone that´s been desiring a thinner body;* that´s *what they want. And not someone else to come and help them stop it."* (Participant 12).

The need for care may be expressed by others than users; on behalf of the users:

"Many who got girl friends; or someone else they are worried about; siblings, who come to talk." (Participant 5)

Participants described adolescents as caring individuals who pay attention to the health of their peers. When it comes to teachers, it was again pointed to the benefit of providing care in high schools, where contact is made on a daily basis:

"The teacher is, after all, the one who sees them every day. So it happens that (teachers) invite (adolescents) for a talk. And then manages to pull out of them that they´re struggling and…and asks: "you wouldn't wanna talk to a nurse?" (Participant 14)

In any case; whenever concerns for others´ health are present, there is a certain sense of responsibility automatically ascribed to the individual expressing these:

"To me, it is important that the one who senses concern, is also the one that addresses this concern." (Participant 4).

Ability to avail service

"Ability is modulated by the various barriers that a person must overcome before obtaining services or gaining access" (Khan & Bhardwaj, 1994). Users were believed to have many personal, and mental, barriers:

"I definitely believe they experience some sort of threshold! And many can have a go first; they come to get plasters; or inspect wounds. Their inquiries can be numerous and very simple in the beginning; and only afterwards they might disclose what´s really bothering them." (Participant 13)

This threshold can further be elevated by adolescents´ perceptions about them being the only ones struggling with problems:

"I imagine that everyone, especially in their teens; can be like: "Everything is wrong with me." They live in their own bubble; thinking that something is wrong only *with themselves."* (Participant 14)

Which leads to a conglomerate of negative emotions in youth, associated with seeking help. It can be regarded as weak, embarrassing; shameful, and otherwise not "socially-acceptable" to seek out contact with health care providers:

"It´s sort of a sign of weakness. Or; yeah; it´s hard to expose such delicate matters. I think it´s the same for all such mental things that one is struggling with. And I believe that many adolescents think that they shouldn't have had those struggles. And that they are ashamed of it, and therefore do not want to talk about it. And that´s a pity!" (Participant 13).

There was a definite surplus of personal barriers reported in boys, and in adolescents with foreign cultural background. Male users were said to feel awkward, and *"refuse to take advantage of the services, because it´s women they meet."* (Participant 1)

Adhering to the male gender roles, and the cultural masculinity associated with…

"It´s not that easy to bring up feelings and stuff, for example. To just come out of the blue and say: "I feel like crap."" (Participant 5)

Families that are non-Norwegian, seem to express a particular stigma towards mental health care, and towards contacting the health care sector, in general:

"The threshold for turning to our sector for health care, seems to be a bit higher for the girls and the boys. For girls; oftentimes because of some social control perhaps, or the fear of being caught for using contraceptives. (…) And the guys too, right? Those coming from…also the African and Arabic countries; they oftentimes live under an extreme masculinity, which implies that asking for mental care or advice in topics that are sexually oriented…is probably more embarrassing; than it would be for ethnical Norwegians." (Participant 1)

It was also believed, by some, that due to different cultural backgrounds, many families instructed their children not to reach out, or trust health care personnel:

"Mm, yes. And we´ve heard that too; that…one shouldn't always trust…right? And: "hush, hush, we´ll take care of it at home". It is a bit like that. So yeah; we´re trying to work on it." (Participant 7)

This particular finding was of concern, and was also reported in "western homes":

"I mean; we are on The West-Side*. There´s so much façade. A lot of stuff is going on within the thousand homes. Things that not everyone wants everyone to know."* (Participant 5)

On the other hand, findings also show that some adolescents do come, even with sensitive questions, and despite social norms and stigma:

"There are several of those who´ve come on their own and said: "you know what? I would actually like to cut down my hash smoking." (Participant 4)

"We meet plenty of boys, too! It´s kind of socially accepted; visiting school-based health services. It´s not a big deal. It feels like they see us as halfway old, dispensable mothers." (Participant 9)

(Colleague continues): *"And there´s no difference between boys and girls. or Pakistanis, Somalis and Norwegians, for that matter. It´s exactly the same."* (Participant 8).

But another frequently recurring topic was depression and anxiety in youth, which was said to be a far more serious problem than body image disorders:

"We do get some youth here, with questions about diet and exercise, though, of course; not that *many. Versus those who for instance come because of anxiety and depression, and those kinds of things. Unhappiness in their homes and in school...»* (Participant 12)

In about every interview, participants spoke about a natural presence of anxiety in youth, often caused by self-inflicted stress (i.e. academical performance) as well as societal pressure (i.e. peer pressure to look good, family expectations):

"You must work out a lot; eat healthy, and get top grades. It´s kind of this external and internal pressure, right? When I was young in the 80s, it was kind of enough to just be good-looking, if you know what I mean (laughs)." (Participant 4)

Some students were even said to be anxious about attending their own high schools:

«To take one example: if you arrive school, and stand there looking at the door without entering, and then go home instead, then *you need help."* (Participant 4)

The biggest challenge may therefore be trying to help these kids. As it was clear; one cannot help those who do not show up, at all.

Effective demand

Refers to the economic concept, coined by John M. Keynes (1883 – 1946). Demand is said to be effective when consumers have both willingness and ability to pay (Pettinger, T. 2016). Factors affecting demand are price (of service) and income (of users), (ibid). As already discussed, with regards to *price (see: System characteristics, Price)*; the demand *can* be said to be ineffective, as willingness and ability to pay (for specialist care) are not always present. There was however, a high demand among users for specialist treatment; but at a primary level. Participants were aware of this, but worried about not meeting this demand. "Supply creates its own demand", according to Keynesian theory (Pettinger, T. 2016), and this was evident in high schools. Several participants had noticed that increased supply was leading to an even greater demand. There was also a common assumption that human resources need to be increased to deal with the high demand. Because currently, there are too few workers in both high schools and AHCs:

«So I could absolutely have had one more (PHN) here. Like, at least in a part-time position! But it´s like; plenty wants more. So there´s always a demand for more. Once a need (for care) *is established…it fills up quickly. (…) The more visible one is; the more one promotes oneself, the higher is the demand."* (Participant 5).

Preferences/prejudices

There were some reports of fragmented, or even unsatisfactory specialist care:

"Numerous teenagers wish not to attend the specialist services. Both because it´s cumbersome and…I don't know." (Sounding like (s)he is about to cry): *«I often see that they*

come back here, and aren´t satisfied, eh, for some reason. That they feel it´s difficult to be honest and open there." (Participant 2)

Therefore, there was a preference for adequate services and care in high schools. User satisfaction; and the obvious practicalities of such care *(See: System, Volume/size)* spoke for this identified facilitator:

"I believe that if students would've got what they wanted, they would rather wish for services to be available here*."* (Participant 2).

Users were, however, experiencing some waiting time; which was in fact present in high schools, but to a much smaller degree than in AHCs. And even so, waiting time became a barrier, much because adolescents prefer *not* to wait. They prefer care when it is needed:

"Those kids are very much like: it must happen yesterday! *(...) Like, even if we put…When I am alone (in the office); busy with a student, I often put "occupied" on the door. But they (students) burst in, regardless! Without paying any attention to it.»* (Participant 8)

Scheduling appointments via sms facilitated access, by minimizing waiting time. Fewer user were also believed to be lost:

"If they drop in, they sit and wait, right? And hope to get in. And if there´s a queue, they might leave. Which is why it´s a little important that we get a grip on them; or they might not show up again." (Participant 6)

In some high-school cases, youth was said to be quite patient and understanding:

"They understand if it´s really chaotic here. "But I can rather return tomorrow…", right? If I happen to talk to someone that can wait. In my opinion, they are quite agreeable. » (Participant 10)

Assumingly because of their spontaneous nature, users could sometimes schedule, but then miss their appointments. One participant (though understanding their reasons) expressed that this type of behavior can make it difficult to provide continuous care, even in schools:

"Because they are completely free to choose, whether they are going to show up or not. Oftentimes, they come when things are really bad, and when things get better, they stop coming. The work with each and every isn´t always...well, it´s not linear. It´s more like: starting and quitting, and now and then…that is so *typical youth!"* (Participant 13)

According to findings, adolescents can have major prejudices towards the health care system, in terms of their doubt in professional confidentiality:

"I´d think (users) are afraid of others also…that we don´t stick to our duty. It might *be there; the fact that (users) are not sure whether or not we tell the teachers. Or others in school. Or the police. (...) that might a barrier. For some. »* (Participant 9)

This is the reason why cooperation in high schools can actually become both a facilitator, and a barrier. On the system side, it is a facilitator because it provides opportunities for discussions with regards to what is best for the user. On the user side, however, too much of an "open" communication between staff members is seen as a barrier. Adolescents do not want *everyone* to know about their struggles:

"Now, there are *many community workers here. And, being able to separate* our *services from theirs, is somewhat challenging. (…) And I also believe that it´s important that we are something completely different from the rest of school. Right? You know, with regards to the duty of confidentiality."* (Participant 13)

Parents should also, preferably remain uninformed. Some PHNs reported that their users were very well informed about the duty of confidentiality. However, users´ doubt was mentioned in about half of all interviews, suggesting that this can be a considerable barrier for many.

Barriers can potentially be minimized, as long as trust is established between PHNs and their users. The PHN must be very clear about his/her duty of confidentiality, making sure adolescents understand it. Any other actors should also be discussed and evaluated; with the user, before they become involved:

«If the student opens up and tells a whole lot, I ask: «may I...is this maybe something that I can talk about to your teacher? To adjust things a little bit better for you". And then we can reach consensus on what I can tell the teacher." (Participant 14).

Attitudes/values

One attitude youth seems to have internalized, and holds against the health care sector, is the attitude that once closed, equals always closed. It was reported in about half of the interviews, and is regarded as a barrier for access. Even though some PHNs were seldom absent, they were deeply missed whenever their door was closed:

(Collectively imitating disappointed voices): *"You guys are never here!"* (Participant 8 and 9). Participant 8 and 9, in fact; provided exceptionally good descriptions of high schools (i) and AHCs (ii), and explained what the barrier could mean for access (iii):

(i): *"Being here alone all year long, just won´t do. It results in less capacity for follow-up, and less of an open door."*

(ii): (Describing the logic of adolescents): "*«They work Tuesdays and Thursdays; therefore, I go also; Tuesdays and Thursdays." If (users) are instead met by a closed door, which says «I´ll be here tomorrow"; that´s unacceptable! (…) simply; VERY unfortunate. And if that´s the case; it is better to stick to the few office hours, than be available "now and then"."*

(iii) (Defining access): *«That the capacity is high enough, so that you don't go goose chase one and two, and three times. Because then you just don't bother anymore."*

When it comes to values, adolescents were said to value the School-Based Services; perhaps not always in terms of (help with) body image problems; but generally speaking. PHNs´ high school offices often included facilities that made the office seem like a haven; a place for comfort and care:

«…And (colleague) is excellent at making them a cup of tea when they feel sick! So that they feel they are being noticed, and cared for. So that, maybe they come back." (Participant 7)

And the interview participants expressed equal gratitude, as they were happy to be of use:

"(The adolescents) are content and grateful, and; yeah. You feel like you´re doing something useful for somebody." (Participant 11).

No value whatsoever, was seen in AHCs with regards to questions on body image, diet, and exercise:

«No, I believe that there are rather few, who are thinking that they can use this service for that; or for those challenges." (Participant 1)

This was though more of a systematic barrier, as it was explained by AHCs´ clinical perspectives; discrimination of male users; limited preferences for care/treatment; limited opening hours; and insufficient temporal- and human resources.

6 Discussion

Illustrative interview quotes for this chapter can be found in Appendix X, and are marked with numbers (1 – 40) in the text.

6.1 The influence of social media

Although not necessarily recognizing social media as the biggest influencing factor; my participant confirmed its influence on health. Some commented that social appearance comparison probably happens more in real life (i.e. in schools), but added that peers see each other online, so it might as well happen there. Interview findings corresponded with several findings from the scoping review. In lines with (Wiklund et. al., 2017); where the young Swedish participants expressed that there is a certain social value connected to good looks, my participants acknowledged the pressure of looking a certain way, to fit in. They also believed that adolescents in Oslo are internalizing certain ideals. A lot of the influence can be explained with the fact that youth is constantly online, and because the content they are exposed to is edited and driven by market forces. The explanation is also supported by scoping review, as media "can exert an influence on a person's values and beliefs (Arroyo & Brunner, 2016). "Even what appears to be modest effects can be consequential over time" (ibid). These cumulative processes were believed to affect body image over time. Therefore; the earlier the influence is acknowledged and targeted, the better. It worried my participants that younger and younger teenagers are trying to correspond to the difficult body ideals. Young males are preoccupied with getting enough protein and going to the gym to build muscles; and gym is also the place to "blow off some steam" and regulate emotions. Participants commented that this is not really a problem; since gym peers provide social support, but it is still unfortunate that systematic and personal barriers push adolescent males away from primary care. *Porn* and mass marketing of fitness products were seen as a much bigger sources of influence on young males. Participants expressed worry and believed that targeting these topics in schools is necessary; to normalize perceptions among both males and females. When it comes to young females, a shift from *thinspiration* to *fitspiration* was apparent. Also; young girls do strive for "unattainable" body ideals, but do not understand the physiological paradoxes of these. Females were generally more preoccupied with diet and weight loss; could engage in negative body talk (Arroyo & Brunner, 2016); and tended to judge by appearance. In terms of disordered eating behaviour; it seemed though that both

genders are prone to such, and would restrict their caloric intake, while exercising excessively. Comparing Norwegian and foreign youth; it was said that the latter might have more "real problems"; in terms of worry for the family income and such, and that having the "perfect looks" matter more for the former adolesncents. An assumption is therefore that Norwegian youth have internalized Western ideals and are more preoccupied with body image. Although; most participants reported a preoccupation with "thin *and* fit" body ideals; also in adolescents with other ethnical backgrounds.

In terms of technology "in itself", it can be speculated that a combination of smartphones, and the option to digitally retouch pictures, is contributing to youth´s obsession with appearance. Smartphones led to exceptionally good frontal cameras, which again might have given rise to the selfie-culture. Taking selfies has become a regular practice to report eating (Holmberg et. al., 2016), and exercise activities (Vaterlaus et. al., 2015). Though *attractiveness* has been previously found a motivation to exercise (Simpson & Mazzeo, 2017). A combination like this is likely to distort youth´s perceptions of reality and what is normal; making them question their own appearance**.** It has also become common to track exercise and diet activity, using health apps. Although health apps were not discussed in the interviews, and are not interactive social media per definition; it is possible that youth can become obsessed with recording and monitoring their health behaviour, chasing their body ideals. Adolescents might turn to health apps if they have "particular body image concerns or desires" (Goodyear & Armour, 2018, b). Though they might disregard the apps afterwards; having extracted relevant information (ibid), such apps can become addicting. Presenting weight reduction over time in fancy diagrams, they can make weight loss seem more tempting and increase chances of developing eating disorders. Health apps might thus be health-harming; when used by healthy teenagers with normal weight, to lose weight. In fact; scoping review tended to report normal BMI; and still a desire to lose weight, among the participants.

Another challenge is that social media provides both healthy, *and* unhealthy contents; often in the same context. This may further confuse the youth, and for instance make weight loss more difficult. An example is the practice of cheat meals (Pila et. al., 2017), which can potentially trap adolescents in unhealthy binging and purging-patterns. Moreover; viewing online food posts can provoke feelings of hunger "even when not hungry" (Vaterlaus et. al., 2015), or make users opt out for fast-foods instead of their planned meals (ibid). Unhealthy

food temptations become more available during high school; and more affordable, as adolescents start having their own money. Youth were said to vary in their diets. but expressed regret and even fear; and saw it as a necessity to compensate whenever they had eaten something "bad". The fear of *fat* gain, in particular, was mentioned. It might explain why it has been hard to reduce, rather than raise; levels of exercise activity in adolescents in some districts of Oslo (Municipality of Oslo, 2015). A fat-phobia has been previously reported in kids as young as 6 or 7-years-old in Sweden (*ref.* Wiklund et. al., 2016). It may well be that adolescents of Oslo share some of the same fears.

Adolescence is a turbulent time, during which their physical and mental health may be easily destabilized by mundane factors. In addition to irregular diets; adolescents´ sleep was also believed to fluctuate heavily and affect their health. In lines with Kelly et. al. (2018) and Twenge et. al. (2018), it is likely that there is a connection between irregular sleep and social media use among adolescents in Oslo. Although it would be difficult; to affect youth´s online activities, controlled access to certain social media sites through schools´ Wi-Fis might be a good idea. This is also possible. Perhaps such a measure would hinder teenagers from going online during school-time and be tempted by food pictures. It would also reduce the levels of exposure to unrealistic body ideals and fitness adds; and engagement in social appearance comparison online.

6.2 Experienced barriers and facilitators

Barriers to access were recognized in both domains (*System, Users*) and their constructs. Some barriers were obviously interconnected. This was particularly evident between *Number, Volume,* and *Organization* (System), and between *Need for service* and *Ability to avail service* (Users). On the system side, a lack of financial, temporal and human resources seems to hinder services provision overall. Shortage in staff was experienced as a major barrier. In fact; it was felt that the initial decided quantum of students per PHN, established by health authorities, was incorrect. Shortage in staff led to waiting time and low volumes of activity; psychologists were particularly demanded. Temporal and financial barriers were also hindering relevant education. For instance; PHNs wished their high schools would set off more time for educating young adults in relevant topics. Moreover; the 5-week courses, provided by AHC-schools, were seen as facilitating the improvement of primary care, but participants mentioned that also *these* require money; and take time. Volume of activity

was not found to be optimal; especially not in AHCs, which tend to focus on females and prevention of STDs. They do not, however, allocate enough time for regular conversations; even though there should be time for this, according to participants. AHCs can also appear discriminating towards young males. There are mostly female PHNs working, and only one AHC for boys. In addition, young males can experience personal barriers; in terms of associated gender roles, social acceptance and stigma. Judging by the assumption that young males are also testing themselves less for STDs that females do, made by one of the participants, males have even less reason to go to AHCs, and the chance for detecting possible disorders among males decreases further. Males are probably still having a hard time dealing with body image-related issues; they just do not talk about it. As Easton et. al. (2018) pointed out; "males may well be negatively affected but might not express their feelings because of gender norms". It would why so many young boys go to the gym instead.

Extended health care services in schools

In terms of the extended School-Based Healthcare Services (SBSH) it was clear that these had not been extended enough. The fact that Project *Low Threshold* is not properly implemented, affected the number of providers; and their activities. In order for care takers to cooperate in lines with the Coordination reform (2012), and in lines with the PLIS-model; a specialist from CAPP must be present in high schools *to a certain degree* (Municipality of Oslo, 2009, d). This; together with several others measures (ibid), would ensure seamless coordination, in terms of referrals to specialist care, and otherwise; proper preventive care in schools. However; the project had been cancelled in several of the districts; psychologists were often missing, and participants expressed dismay about not being able to follow the measures.

Participants suspected general financial constraints; also within CAPP itself, but could also complain about poor coordination of information flow. It was difficult to provide adequate preventive care in schools, despite a mutual wish between students and PHNs. But referring to specialist care could also be complicated, often due to the inherent complex nature of body image disturbance and eating disorders. It was believed that proper implementation of the Project would solve many barriers. For example: there seems to be an experienced price for specialist care that nudges some families to stay away from the health care sector all together. But if adolescents are not being heard by their parents (Municipality of Oslo, 2015), who otherwise instruct them not to contact primary care *(See: 5.2.2, Ability to avail service),*

it can add to adolescents´ mental health struggles. It was believed by the participants that some parents "talk *to* their children, not *with* their children" (Participant 9). Such alienation would explain why adolescents turn to social media for health information.
The best practice SBSH, was found in the district that also shared patient journals with CAPP. Perhaps this is a facilitator that should be considered closer by health care authorities, as also other participants expressed a wish for shared journals.

Understanding the ways of adolescents

Moving to the experienced barriers in the user-domain; it was felt that adolescents might not want help, or not recognize the need for help. Allegedly; because they are unaware of potential problems with social media influence. Or; because they are internalizing that in order to be good enough; they have to be successful in all aspects; as indeed was believed by the participants. It can be moreover hard to define a complex issue such as body image, during a complicated lifetime period. Though it *is* peculiar how adolescents seem to notice others´ deteriorating health; just not their own. Much like the Swedish adolescents, who "at times suspected damaging changes among their classmates" (Wiklund et. al., 2016), adolescents of the current study were said to care about each other. In fact; they expressed worry because they were witnessing frequent comments about classmates´ appearance. Another fact is that adolescents use eating as a way to control life. Interview participants mentioned divorces, cohabitational challenges, and the pressure of expectations as factors that can contribute to formation of disordered eating habits. This would explain the difficulty of quitting eating disorders *(See: 5.2.2, Need for help)*. It also proves that there can be specific mechanisms triggering youth´s health-harming behaviour, but understanding such might be difficult for PHNs Relying on Health apps, instead of authorized health care personnel for fitness advise, may too be a reason for why users do not see the need in accessing health care services.

Another barrier might be an adolescent´s own attitude, that "once closed" means "always closed"; as it sends out a certain message that the user is quick to internalize. In terms of office location; especially users with foreign cultural backgrounds may avoid going to the PHN, if there is a risk of being seen by others. For these; hidden locations would be of benefit. However; "there is evidence of a reduction in access with distance (distance decay), particularly in areas where perceptions of need and importance may be low" (Sowden et. al., 1997). Judging by this, *and* by the fact the many adolescents may perceive need as low, a

visible office could serve as a reminded, in case need for care would appear. In sum, as no definite factors were identified; for why the number of users is so low, all identifying factors can be affecting, in theory.

Media literacy, education, and information

The scoping review found both knowledge and level of critical awareness to vary in youth. As the review included mostly college-aged participants; while the focus group of the current study is younger, the latter are allegedly in more need of education. Similar to a general consensus about increased education about from the scoping review, my participants also talked positively about health-promoting activities. Class discussions were believed to increase youth´s awareness about body ideals, mass marketing and photo editing. It might also be wise to address the problem of drug-use among adolescents, as for instance marijuana is popular among adolescents in Oslo, and they might also have access to drugs in their homes (Municipality of Oslo, 2015). Even though current studies on how smoking marijuana might affect adolescents in development, are ambivalent, drugs should not become another brick in the wall; there are already enough factors affecting youth´s mentality, and Based on the overall findings, it is felt that youth will appreciate in-school education. In lines with the reported "enjoyment of learning about health and fitness" (Ragatt et. al., 2018), my participants also reported that: "and it is amazing when we come up with these things! They become so involved! » (Participant 7).

The fact that some users were mistaking regular health clinics for AHCs, while others did not even know about AHCs offer, tells that many relevant services might be currently poorly promoted. Previous research and the current study recognized adolescents´ preferences for online information seeking; and communication. Snapchat was particularly mentioned, in the case of Oslo. Which is why using SOME, preferably framing the information as "visual rather than textual" (Holmberg et. al., 2016), is believed to work for promoting public adolescent health care services.

Further research

Most studies were either American or British. It appears that the connection between social media influence and negative health outcomes in youth has not been studied in Norway. This paper encourages to further research in Norwegian contexts. In addition, very little research has been conducted on males. Although fitspiration can lead to muscle dissatisfaction in men (Carrotte et. al., 2017). Allegedly, these use different SOME sites; hashtags; and engage in

different health-related content, that what has been analyzed. Further research must be done, to investigate what type of health-related information young males access; *why*, and on which platforms. Participants of my interview study said males for instance enjoy online gaming. Gaming can be addictive (Hurley, K., 2018), and has been associated with disturbed sleep (Twenge et. al., 2018; Kelly et. al., 2018; Cain & Gradisar, 2010). Online gaming is often filled with violence and inappropriate language, and violent gaming has been associated with aggression in adolescents (Shao & Wang, 2019). It would be interesting to investigate whether there is any connection between online gaming, aggression, and young males´ gym visits. Interestingly; Holmberg et. al. (2016) also found gaming nights to be special occasions in which adolescents indulge in, and present online; high calorie low nutrient (HCLN) foods. In their online presentations, text captions were mostly positively loaded; which suggests that young males enjoy combining late night gaming with "junk" food binging. Gaming nights can thus potentially enhance the practice of cheat meals, which has been associated with food binge (Pila et. al., 2017). Since gaming is popular, it would be good to know whether or not teenage boys who game are at risk for developing disturbed eating habits. Youth is known for using several platforms simultaneously, and Snapchat is one of them. But neither Snapchat nor its content have been analyzed – this is difficult as Snapchat content is per definition not saved on any site (users can choose if they want to save text/image in the chat, or not). So there is for instance no one database from which to extract content to make a content analysis. It would be possible, however, to do survey studies, asking adolescents about which "snaps" they send and receive, and if these are health-related (something I believe they are). Another possible way would be to analyze the content of snap-stories, which are active and visible for up to 24hours, unless the uploader deletes it. Exploring the influence of Snapchat would in any case be a good idea, because this platform is used for selfies. As shown; selfies can contribute to social appearance comparison.

Strengths and limitations

The framework used for the analysis in this study was originally developed in an American context. Its constructs might not be perfectly applicable to the Norwegian health care system. In addition; constructs that were not explained by the framework might have been misinterpreted. Social media influence; as well as the adequacy of access, was discussed in the context of Oslo. Oslo is a capital city; its youth might be preoccupied with body ideals that have not been normalized to the same degree in other parts of Norway. Also, Project "Low Threshold" is Oslo-specific, and its malfunctioning cannot explain potential unrealized

access to health care in other towns. Generalizability can also be a potential limitation with regards to the scoping review. As this review included foreign studies, it is impossible to say anything about the actual influence of SOME, without exploring a representative sample of Norwegian youth first. However, it could be argued that because social media is used globally, its trends and contents spread and affect world´s teenage populations evenly. As the scoping review used mostly college-aged participants, findings may not be applicable to the younger teenagers of Oslo. However, as only a minority of those participants were "selective and deliberately avoiding content" (Ragatt et. al., 2018), it is believed that younger teenagers would definitely not demonstrate equal critical abilities with regards to online messages. This would in turn support the assumption that these are more prone to influence than older individuals. Data was collected using qualitative semi-structured interviews and questions were posed as they seemed fitting; a uniform degree of elaboration on each topic was thus not achieved. Most participants were interviewed in school-based contexts and the focus might have been slightly lesser on AHCs. But about half of the participants worked in both high schools and the clinics, so data is still assumed to be sufficient. Participants were also highly opinionated about the topics and gave the impression that challenges were present in both arenas. Their opinions were subjective and might have been framed in ways that could affect the results. For instance; even though the interviews with two participants simultaneously resulted in fruitful discussions, a fear of being "too honest" in front of colleague might have been present. In addition; because colleagues differed in their levels of working experiences, one could have possibly overrun the other, although this is not seen as a big complication. Some of the context might have been lost in the translations of the interview quotes; also because these were sent to my American friends in an online chat. However; translations were read, and compared carefully against the Norwegian extracts. Original quotes were also kept and can be found in the appendixes, for those who understand Norwegian. Time constraints did not allow for a second search of the four databases; after the inclusion criteria were in place. This might have left out more recent studies. A thorough scoping review usually requires searching more databases (than the 4 that were searched here), but the time constraints did not allow for this. Time constraints also hindered searching reference lists, although it was the original idea. Finally, each article in the review was objectively evaluated; as I wrote down what I felt was of particular interest/importance. Data might have been left out. Although I had a pretty good sense of which direction the review was going in, towards the end.

7 Conclusion

This study investigated whether or not social media was believed to influence body image perceptions, diet; and exercise behaviours of adolescents, and explored perceived potential barriers and facilitators for access to relevant public adolescent health care services. In order to answer study´s two research questions, a scoping review was first conducted on the topic of influence, after which public health care workers in Oslo were asked for their opinions; using semi-structured qualitative interviews. The interview participants were also asked about what they perceived as barriers and facilitators to access.

The study can confirm social media´s influences on adolescent health, suggesting that the influence on body image perceptions is mediating influence on diet and exercise behaviours of adolescents. The influence is a continuous process; catalysed by social media´s ability to reach many, as well as users´ own online activities.
This study identified a total of 23 barriers, that hinder access to relevant public adolescent health care services, and 12 facilitators that favour the access. A majority of both barriers and facilitators are aspatial; meaning that geographical (spatial) factors are of little importance for the current access, and the current health problem. This is true; as spatial factors matter mostly for acute health conditions that require immediate treatment. Spatial barriers could though be remote location of AHCs, or hidden office locations in high schools. In terms of the latter; future infrastructural building plans should still consider a central, visible location against users´ wish for privacy and anonymity.

In the case of this study, SOME affected through cumulative processes, and conditions such as eating disorders and body image dissatisfaction could surface after a while. A slight majority of barriers (B = 13) exist in the Users-domain. Four of these were identified in adolescents´ *Need for service*, and three in adolescents´ *Ability to avail service.* Findings here suggest that adolescents do not see a need for help, because they are internalizing body ideals (found online) that would go against this need. A certain social value of particular body ideals has found its ways from traditional media to social media, and is being promoted online. Even though body ideals were found to vary across the districts of Oslo, it is evident that there has been a shift from thinness to fitness, and that teenagers now are trying to correspond to even harder body ideals. In addition, adolescents experience a social pressure to correspond to such ideals as normalized. This can make turning to public health care

services seem weak; or otherwise undesirable, and also negatively affect adolescents *Ability to avail services*. And when services *are* sought after, barriers, such as experienced waiting time and an often-closed door to PHNs office; still hinder adolescents to access the services. This study however, strongly suggests targeting the health care system (System-domain); believing that it would facilitate improvements in the Users-domain. Adolescents were found to value School-Based Health Care Services (SBHS). This study therefore encourages investing more resources into facilitating factors in high schools. Users (i.e. high school students) already regard high schools as arenas fit for providing relevant care; and they also prefer these arenas for care. In addition, SBHS already have advantage, over for instance AHCs, in terms of comprehensive care. Without saying that AHCs should shift their focus from their clinical activities, it is important to make these more oriented towards male users; include more regular talking with adolescents, and possibly also extend opening hours.

A general lack of relevant staff in high schools, PHNs; but also psychologists; and at times male health care workers; was though a major systematic barrier. Having a health professional in office at all times would eliminate the barrier of *"Once closed = always closed»* in the Users-domain, and keep potential users from being lost to the system. Always-present health staff; and always kept opening hours, would also ensure more time for regular talks; normalizing talks, as participants of this study were referring to. Such talks facilitate access to care because they normalize users´ perceptions that it is okay to reach out for help (fixing barriers in *Ability to avail service*), and that it is okay not to correspond to body ideals. More time for regular conversations with users establishes relations and builds trust; which can be crusial in those cases where users´ complex or very personal problems surface only after a while. In lines with the preventive health care focus of public health care; the earlier adolescents are screened for potential problems, the better. Generally speaking; having someone to talk to; someone who can listen, while perhaps also making you a cup of tea, is a level of comfort and quality of care that everyone would appreciate! This study strongly recommends to implement The Project as it was intended to be implemented. As the Project depends on established guidelines; these should perhaps be revised, and made more binding, to ensure that measures are met. Unhampered information flow from health authorities to public health care workers, and seamless coordination of both public and specialist care; are both asked for. The interplay between primary and secondary care must improve, so that the latter assist the former; and the former is able to provide more comprehensive preventive care. A suggestion for this is to make sure that specialist care (i.e. psychologists) are

represented in high schools; as it was meant with The Project. Such a measure would moreover reduce the ambivalence of referring to specialist care; if the complexity of particular health issues can be discussed with specialists, in high schools. Proper implementation of The Project would also solve issues with experiences price for care; facilitating access for user group minorities.

SBHS reported exceptional education, targeting the topics of media literacy, body image and peer/social pressure. As said; adolescence is a turbulent time, during which users are vulnerable and prone to influence. As SOME was found to influence with unrealistic ideals, which were often also digitally altered; it would be good if SBHS continuously strengthened adolescent mental health; proactively fighting depression/anxiety and body image dissatisfaction, triggering acceptance of one´s own appearance. It is important here, to set off financial and temporal resources; not only for the health-promoting activities through SBHS, but also to raise the levels of knowledge among PHNs. The AHC-School was mentioned as a facilitator in this context.

Finally; active distribution of health-related information; especially through online social media channels, was found to facilitate access. Findings from scoping review suggest that turning to SOME for health-information can be easier for users, than turning to PHNs. Due to experienced barriers, SOME works as a barrier-free source of information that is also less time-consuming and retains full anonymity. Which is why this study suggests public health care providers to use online platforms for information spread and communication with users. A lot of health-promoting outward work can be incorporated into online communication. It is also a subtle way to establish contact, and has the ability to invite more users in; instead of working with only a “tip of the iceberg” of users.

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Appendix I. Explanation of the PLIS-model

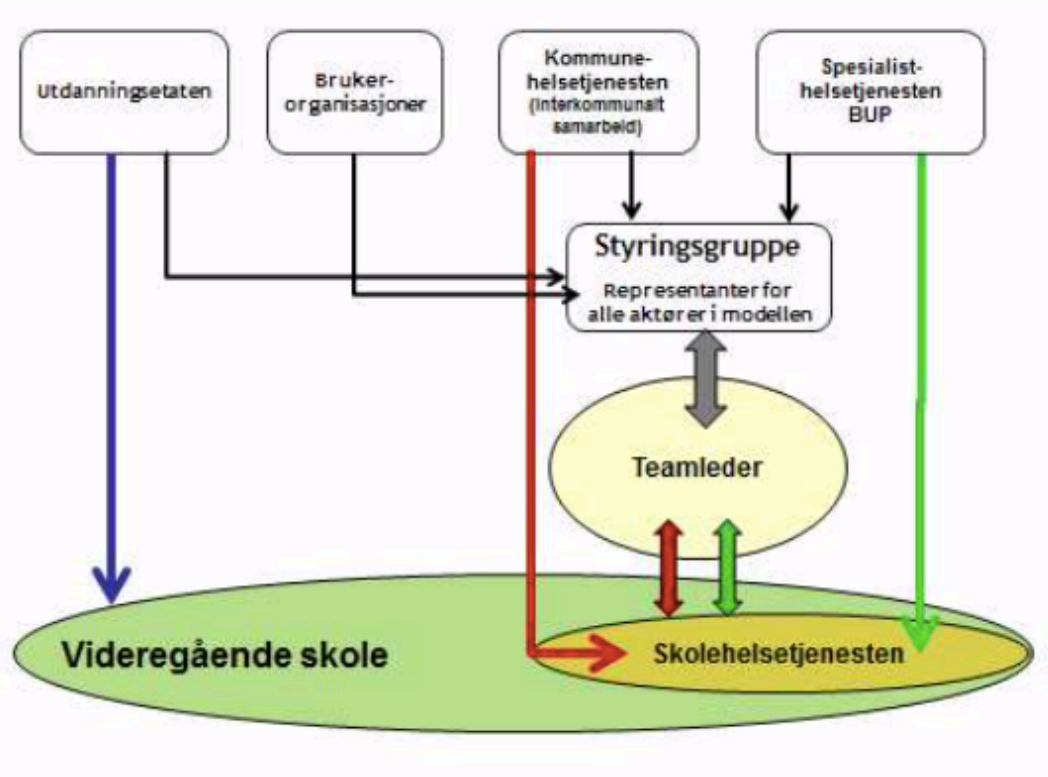
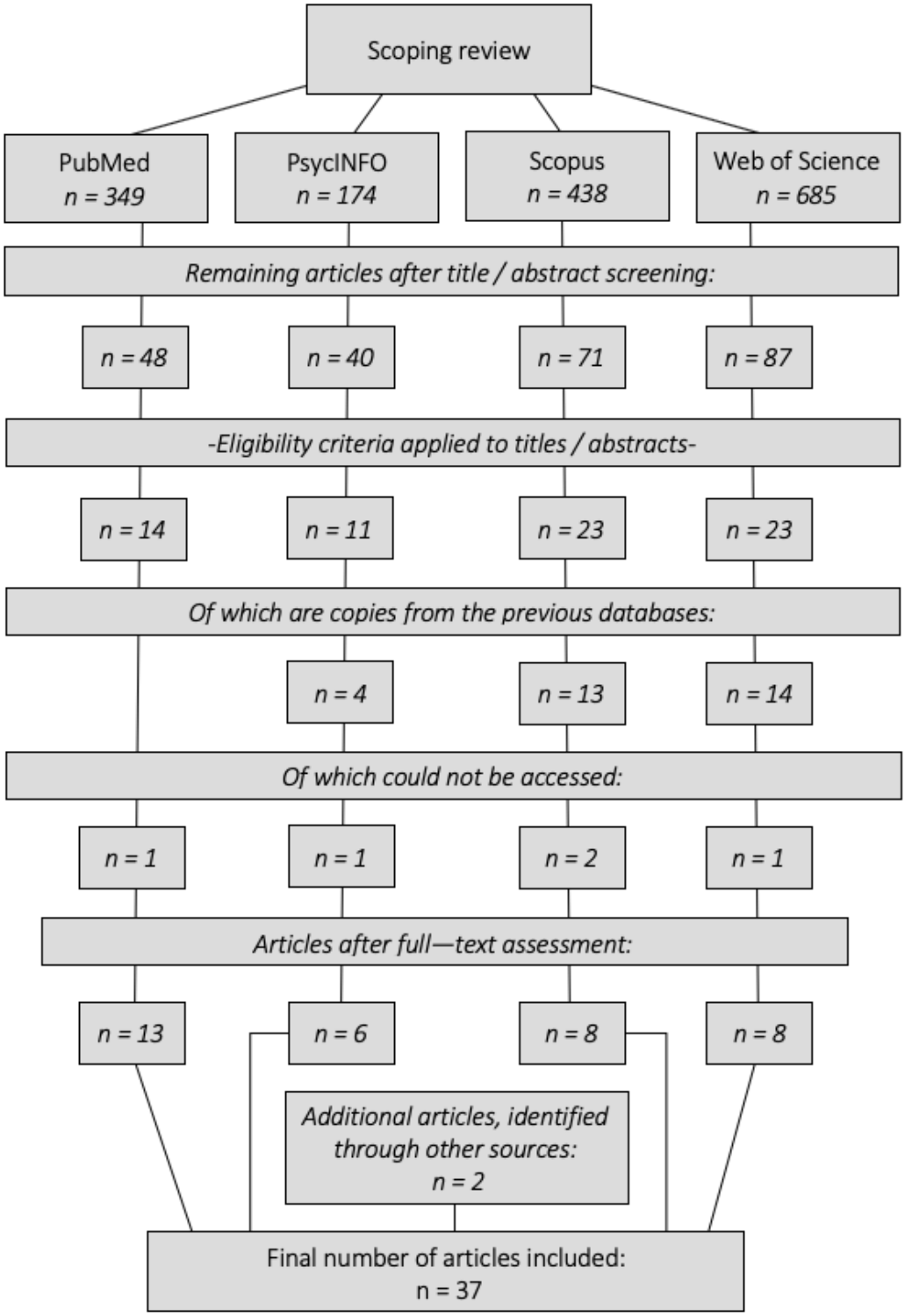


Figure 1: PLIS-model. Source: Municipality of Oslo.

The green and yellow ellipses illustrate, respectively, high schools and SBSs. Inputs come from Education Agency (blue arrow), municipal services (red arrow), and specialists/CAPP) the green arrow. The thick red and green arrows symbolize instruction and information flow between SBSs and team leader for the project in a given district. Finally, the gray arrow connects team leader with a superior executive leader group (pale yellow ellipse). The model was developed some years prior to the project (starting 2002), after which the leader group started gathering every half-year to discuss the project and negotiate its alterations (Municipality of Oslo, 2009, d).

Appendix II. Illustrated process of selected articles for review



Appendix III. Scoping review: inclusion criteria and data charting

	Inclusion criteria	Exclusion criteria
Setting	Any country Publication date from 2010	 Studies published before 2010
Participants	Males and females, Age 15 – 25, also including mean/median age within this range. Participants with self-diagnosed health conditions (including eating disorders, malnutrition, overweight, and addictive exercise behavior).	Age/mean/median below or above 15 – 25- Participants with clinically diagnosed pre-existing health condition (including eating disorders, malnutrition, obesity, addictive exercise behavior), pregnancy, or professional background as athlete
Outcomes	-Studies exploring impacts on health behavior (diet and exercise) from SOME influence and usage. -Studies exploring impacts on psychological constructs and perceptions of individuals (including self-esteem, body image, body satisfaction or dissatisfaction) from SOME influence and usage. -Content analyses of food, exercise and body-related contents on SOME (and how it can impact health behavior, psychological constructs, or perceptions of individuals	-Studies exploring impacts on health behavior from other media influence (including TV, online mass media, magazines, adds, etc). -Studies exploring impacts on psychological constructs and perceptions of individuals from other media´s influence. -Content analysis of other contents on social media. -Studies exploring interventions made through, or with the help of, SOME, with specific goals to improve health-related behavior (including education, psychological interventions and peer support programs, to fight eating disorders, poor diet, obesity, malnutrition, sedentary lifestyles.)
Study type	Content analysis studies Qualitative studies Explorative studies Intervention studies	Book reviews Product marketing and/or management studies (including medicine, sport attire and dietary products)
Publication type	Published article	All other published literature
Language	English	All other languages

Table 1: Inclusion criteria

Year:	Authors:		
Title:			
Type of study:			
Methods:			
Study location:		Studied sample:	
N =	Mean/median age:	Gender:	Mean BMI:
Aim:			
Type of SOME investigated:			
Main findings:			
Limitations:			

Table 2: general data charting

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Appendix V. Description of interview participants

Participant number	Job title	Works in both school and AHC (yes/no)	Area	Education/work experience, additional to the basic PHN education:
1	PHN	Yes	1	Project leader in AHC
2	PHN	No	2	11-year practice
3	Clinical social worker	No	3	1,5-year practical work. Participant currently substitutes the local psychologist
4	PHN	Yes	4	Experience from the field of psychiatry
5	PHN	Yes	5	9-year practice
6	PHN	Yes	6	10-year practical work, (of which) 5 years in high school
7	PHN	No	-	2-year practical work, (of which) 1 year in district and 1 in high school
8	Clinical pedagogue, Team coordinator	No	7	Works in high school
9	PHN	Yes	-	Previous work experience from two other high schools.
10	PHN	No	8	1-year practice in current high school. Previous work experience from other high schools.
11	PHN	Yes	-	«Technical manager» in the district *(Nor. Fagleder)*
12	PHN, Team leader for Project *Low Threshold* in the district	No	9	14-year practice. Currently works in high school. additional education: 1-year study in adolescent sociology
13	PHN	Yes	10	Obtained degree as psychiatric nurse, and Master degree in "Health and fat"
14	PHN	Yes	11	5-year practice from current area. Works also 50% in junior high school

Appendix VI. Interview guide

Anonymitet av informant, VG skole og HFU - oversikt føres kun av meg.
Informasjonsinnhenting om erfaringer og refleksjoner, ikke vurderinger.
Spille inn på mobil, ta notater for hånd ved siden av, slette all data etter endt prosjekt.
Samtykke signeres, egne sitater leses gjennom og godkjennes før publisering. Ved spørsmål kan kontakt gjenopptas

1. introdusere meg selv (master UiO) og min oppgave.
2. definere og presentere brukergruppen av helsetjenester: unge i Oslo med tilgang til gratis skolehelsetjeneste via videregående skoler og/eller helsestasjoner for ungdom.
3. spør deltakere hvordan de hadde definert «tilgang»

generelle/oppvarmingsspørsmål:

**hvilken stilling har du?*
**hva slags bakgrunn har du? utdannelse, praksis (plass? antall år totalt?)*
**siden du begynte på denne skolen; har du merket noe endring i tematikken som ungdommen kommer med? Eller har det vært de samme henvendelsene hele veien? (i så fall: hvilke?)*

Hvordan hadde du definert «adekvat tilgang» *(Synonym: tilstrekkelig)*?

System descriptors (healthcare system, personnel, facilities)

Number:

**(VG) hvor mange av fem arbeidsdager er helsesøster på kontor på gjeldende VG?*
**(HFU) føler du at det er tilstrekkelig med, eller mangel på, helsepersonell på denne helsestasjonen?*
** det kan tenke seg at gutter ikke synes noe om å snakke med kvinnelige helsepersonell og vice versa; finnes det både tilgjengelige kvinnelige og mannlige helsesykepleiere her? Eventuelt andre relevante representanter av det mannlige kjønn?*

Volume/size (str. på lokaler, omfang av tjenester, plass):

**HFU: er det nok oppholdsplass til ungdommen som kommer hit?*
**Er lokalene tilpasset slik at det ikke er fysisk vanskelig for ungdommen å oppholde seg her?*

Distribution/location:

**Er helsesøsters kontor/HFUen enkel å finne, f.eks. er lokalene godt synlige?*

Organization (solo, group practice, hospital, urgent care center):

**Ved noen helsestasjoner jobber også psykolog i tillegg til lege og helsesykepleier (tidligere helsesøster): finnes psykolog på denne helsestasjonen?*
(dersom nei): føler du at ungdommen du kommer i kontakt med har behov for hjelp/veiledning fra psykolog?
(dersom ja): er det lett å komme i kontakt med denne? hvordan er rutinene her?

**Er du kjent med prosjektet lavterskel: utvidet skolehelsetilbud? («Hovedmålet med prosjektet er å utvikle gode, fleksible og lett tilgjengelige psykiske helsetilbud til ungdom» oslokommune.no)*

Preferences/prejudices (e.g. towards racial and ethnic minorities and the poor)

**(jeg antar at unge som tar kontakt kommer fra ulik etnisk bakgrunn): opplever du at det er lettere for noen grupper å ta kontakt?*
**føler du at dagens system for kontakt med helsesøster på VG eller i HFU kan gjøre det vanskelig for unge med minoritetsbakgrunn å ta kontakt?*

Quality:

**er arbeids/åpningstidene kompatible med de unges timeplan?*
**er det lang ventetid for å få time?*
**er chatting med helsepersonell et tilbud dere har? benyttes dette?*
**Når det kommer til unges henvendelser ifm. Selvbilde, kroppsfokus - føler du at du har nok kunnskap til å kunne veilede slike, uten å måtte henvise til andre instanser?*
**Dersom du føler at henvendelsen er utenfor ditt fag/kompetanseområde – er det tydelig for deg hva du da må gjøre, f.eks. er retningslinjene/pakkeforløp godt definert?*
(dersom nei/uklart): hva mener du skal til for at <u>du</u> skal kunne gi ungdommen bedre hjelp på dette området?
**når ungdommen er i kontakt med deg angående temaet vi snakker om; mens du er i samtale med dem, pleier du å se etter symptomer som vanligvis er tegn på spiseforstyrrelser og den slags?*
**føler du at dagens system for kontakt med helsesøster på VG eller i HFU kan gjøre det vanskelig for unge med minoritetsbakgrunn å ta kontakt?*

Ekstra spørsmål:
*Har du vært på HFU-skole, eller tilsvarende kurs?

Population descriptors (potential users, individuals or whole communities)

Number:

**Kommer du i kontakt med ungdom som nevner at de har vansker med aksept av egen kropp, sliter med selvbilde, og er generelt kroppsfokuserte?*
**Hva med henvendelser rundt spising eller trening? Opplever du at ungdommen har behov for veiledning på disse områdene?*
**Hvor mange snakker om at blir påvirket av SOME? Dersom de ikke nevner det: får du inntrykk av at de blir påvirket?*
Hvor tenker du de ellers får sine kroppsidealer og inspirasjon fra?

*Distribution/location (of the users - where they live related to services)

**Hva med HFUen da; hører du fra ungdommen at de har vansker med å finne fram?*
(Eller finne tid til å dra bort?)

Need for service (nåværende helsestatus og symptomer på lidelser/sykdom):

**hvilken alvorlighetsgrad vil du tilskrive ungdom som er i kontakt med deg ifm. kroppsfokus, kosthold og trening?*

**føler du at unge som kommer med henvendelser ifm. kroppsfokus, kosthold og trening har ytterligere behov for helsehjelp, eller føler du at det holder med veiledende samtaler for disse?*

Ability to avail service ("ability is modulated by the various barriers that a person must overcome before obtaining services or gaining access." - Khan, 1994)

**kan du tenke deg noen (andre) personlige barrierer som unge må overkomme før de tar kontakt med helsefagarbeidere ifm. kroppsfokus, kosthold og trening?*
**tenker du det er noe forskjell på jenter og gutter her?*

Preferences/prejudices (unges preferanser, samt fordommer til helsesektoren)

**kroppsfokus, selvbilde, slanking og eventuelt trening, kan være sårbare tema for mange unge. får du inntrykk av dette? Får du inntrykk av at noe er helt tabu?*
**henvendelser ifm. kroppsfokus, kosthold og trening, samt påvirkning fra sosiale medier kan være vanskelige å behandle fordi disse er tverrfaglige, og ikke "sykdommer" i seg selv - føler du at ungdommen kan tenke slik og derfor unnlate å ta kontakt?*
**Når de unge likevel da tar kontakt, hvordan opplever du at de foretrekker å gå fram? Dvs om de først tekster, og så kommer innom, eller ringer...*

Attitudes/values:

fordi tjenestene som tilbys er tverrfaglige og ofte går ut på samtaler med unge om "det de har på hjertet" - tenker du at unge ser verdien i (det gratis) tjenestetilbudet?

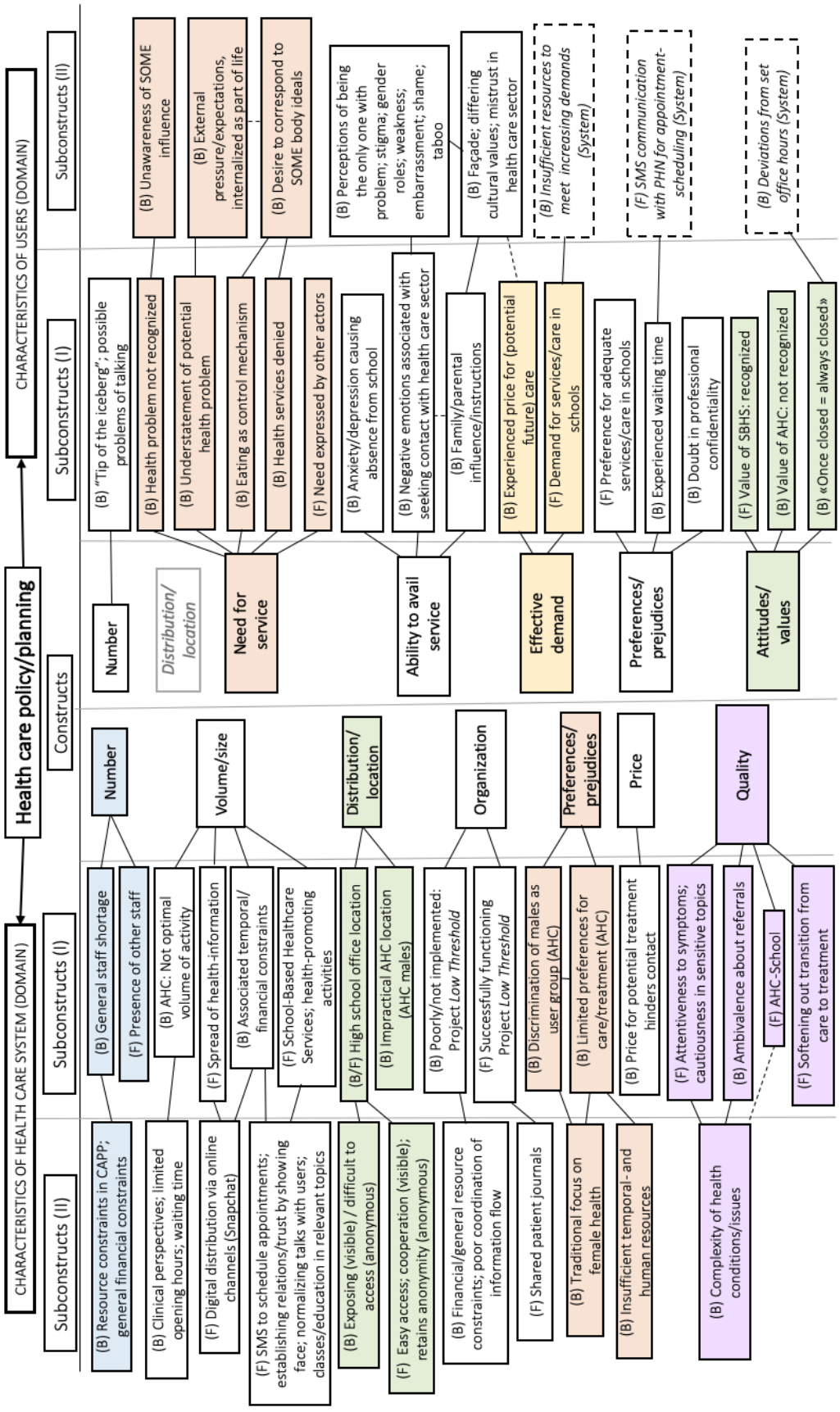
Appendix VII. Illustrative scoping review quotes, Ch. 5.1

Quote	Extract
a	To evaluate psychological wellbeing, the study measured "self-esteem, self-satisfaction, domain satisfaction, life satisfaction, and happiness" (Twenge et. al., 2018)
b	"Adolescents who spent more time on electronic communication and screens (e.g., social media, texting, electronic games, Internet) were less happy, less satisfied with their lives, and had lower self-esteem" (Twenge et. al., 2018)
c	"Exercise and nutrition has spread within society, while knowledge is simultaneously lacking" (Wiklund et. al., 2017)
d	"Personal information transmitted online can quickly be shared with a wider audience than was anticipated by the uploader (Fritz, 2014)" (Holmberg et. al., 2016).
e	A majority of participants indicated "that they do not search for nutrition information but they are exposed to it constantly" (Lambert et. al., 2018)
f	"Automatically sourced content refers to the health-related information that social media sites pre-select and promote to young people" (Goodyear & Armour, 2018, a)
g	"Within the search and explore feature, young people reported that they saw health-related information posted by people they didn't follow and/or commercial companies" (Goodyear & Armour, 2018, a)
h	"Social media provides a digital platform for users to present the version of themselves they want their social network to see (Zhao et al., 2008)" *ref.* Crossman, 2017.
i	Young people access and use "a range of health-related information on body transformations, diet/nutritional supplements or recipes and workouts/exercises" (Goodyear & Armour, 2018, a)
j	"For example, when individuals witness someone who compulsively exercises, posts images looking fit and receives positive feedback from others, this reinforces pre-existing attitudes and behaviors both for the poster and the viewer of that post" (Hefner et. al., 2016)
k	"Individuals who reported higher levels of social comparison and reported higher levels of exposure to friends' fitness posts reported engaging in the most negative body talk, whereas individuals who reported lower levels of social comparison and reported lower levels of exposure to friends' fitness posts reported engaging in negative body talk the least» (Arroyo & Brunner, 2016)
l	"Explicit encouragement of restrictive eating" (Pila et. al., 2017)
m	Thinspiration: "A confluence of images depicting emaciated women accompanied by quotes designed to inspire weight loss and promote an eating-disordered lifestyle (Borzekowski, Schenk, Wilson, & Peebles 2010; Ghaznavi & Taylor, 2015)." *ref.* Crossman, 2017
n	"the more sexually suggestive the image, the more social endorsement it receives" (Wick & Harriger, 2018). In this particular content analysis, about every fifth depicted person posed in underwear, yet about one third of all images were coded as sexually objectifying.
o	"Facebook users report more drive for thinness, internalization of the thin-ideal, body surveillance, self-objectification, and appearance comparisons than do non-users" (Fardouly & Vartanian, 2016)
p	The ideal female body is expected to be thin (Carrotte et. al., 2017; Deighton-Smith & Bell, 2018; Robinson et. al., 2017), toned (ibid; Raggatt et. al., 2018) and strong (Raggatt et. al., 2018). In addition, girls must have little body fat (Robinson et. al., 2017) but still a "curvaceous body shape" (Deighton-Smith & Bell, 2018), while boys must have "a muscular, yet lean body shape" (ibid).
q	"No differences were found between fitspiration and thinspiration posts with regard to sexual suggestiveness, appearance comparison, and messages encouraging restrictive eating. Fitspiration and thinspiration posts included similar images across the three

	SNS—focusing on appearance, sexually suggestive images, and restrictive eating" (Alberga et. al., 2018)
r	"Fitspiration endorses problematic attitudes towards fitness, body image, and restrictive eating" (Alberga et. al., 2018)
s	"Social media was also a major influence on food choice due to its impact on body ideals" (Lambert et. al., 2018)
t	"Physical activity is often presented as means to an attractive body, rather than a fit and healthy one" (Deighton-Smith & Bell, 2018)

Appendix VIII. Identified barriers and facilitators (Khan & Bhardwaj, 1994)

framework is colour-coordinated only for the sake of a better overview



Appendix IX. Illustrative interview quotes, Ch. 5.2

Domain: System

Table 3a, *Number*

Languages: English	**Norwegian**
“We need to have the leaders with us (to hire staff).” (Participant 6); “But it comes down to money.” (Participant 7).	«Da må vi ha lederne med.» (Deltaker 6); «Men det er penger som rår i de tilfellene.» (Deltaker 7)
«Additionally, there should be a psychologist present; which there is not at the moment, as the previous psychologist resigned. They have not hired a new psychologist, but there should be a psychologist there full-time.” (Participant 12).	"I tillegg så skal det være en psykolog; det har vi ikke nå, for hun har sagt opp. Og så har de ikke ansatt ny. Men det skal jo være en 100% psykolog."
«Because we have previously had (psychologist) through CAPP, but... they are struggling to get ahold of a psychologist they can send to us. So we had to hire on our own, to have that in place and avoid too much absence by the psychologist (...) Because they have some... pressures/issues themselves, within CAPP, from my understanding. But why it has taken so long, that we do not know. So, we have had to take things into our own hands. We have had to hire someone ourselves.” (Participant 11).	"For vi har tidligere hatt via BUP, men...de strever med å få tak i psykolog som de kan sende ut til oss. Så vi har måttet ansette selv. For å ha det på plass og ikke ha masse fravær her, av psykolog (...) "Fordi at de har noen...trykk selv, inne på BUP, ettersom jeg har skjønt. Men hvorfor det har tatt så lang tid, det vet vi ikke. Men vi har da måttet ta litt grep. Vi har måttet ansette selv da. "
"…Now and then; as one has money. Because now there are some resources we have gotten from the Directorate of Health. It is a consistent job; getting resources for the psychologist. But right now, there is a psychologist here, until Christmas. Then we will not have any more resources." (Participant 13).	«av og til; ettersom man har penger. Fordi nå er det noen sånne midler man har fått fra Helsedirektoratet. Så det er en sånn stadig jobb, å få midler til psykolog. Men akkurat nå er det psykolog her. Frem til jul. Og da er det ingen flere midler».
«If you ask me; it is what it is. (…) You take what you get; and try to make the best out of it.” (Participant 4).	«Men jeg tenker at det er som det er (...) sånn at man må gjøre det beste ut av det som er»
«Sometimes... it can help just by having someone see you. That someone asks you: "what is this about?".” (Participant 4).	"Noen ganger så kan det også...bare hjelpe at noen ser deg. At noen...spør deg, altså: «hva handler dette her om?»."
“When they´ve opened up, I feel like it really doesn’t matter who we are; as long as we are safe, kind of.” (Participant 7).	"Når de først åpner seg, så føler jeg at det er litt samme hvem vi er, så lenge vi er trygge, på en måte."
“Being able to normalize that, and trigger joy and acceptance of ones´ own body, is something that many are capable of doing. One does not have to be a psychologist.” (Participant 1).	«Og dei kjenner alle misnøyen; den tror jeg vi alle har, av og til. Og så, kunne normalisere det, og trigge dem på – prøve å skape heller en aksept og glede over egen kropp, er noe veldig mange kan gjøre, som ikke må være en psykolog.»

Table 3b, *Volume/size*

Languages: English	**Norwegian**

“In terms of counselling and regular conversations, we´d like to have it a little bit less clinical. Especially when it comes to boys.” (As later explained): “I was talking about the surroundings. Sterile, if you wish.” (Participant 1).	"I form av veiledning og samtale, så skulle vi gjerne hatt litte granne mindre klinisk. Spesielt gjerne i mot gutter.» (Som senere forklart): "Her mente jeg at omgivelsene er veldig kliniske. Sterilt om du vil)»
“Regarding body image and stuff like that; there is more room for those things to be handled by AHCs. There should be. But if you consider the numbers, and how many one is supposed to - you have ten-fifteen minutes for each; it just does not cover it. Unfortunately, I think there are a lot of people who are not able to open up about such topics, because they see the long line of people waiting outside." (Participant 11).	«Det med kroppspress og sånne ting; det er det egentlig rom for å ta opp sånne ting på HFU. Det skal være det. Men hvis du tenker på tallene; og hvor mange man skal, -du har ti, femten minutt på hver, så de dekker ikke det. Dessverre så tror jeg det er mange som ikke klarer å åpne seg på sånne ting. For at de ser det sitter lang kø på utsiden».
"...on Mondays; because then we are open until 19. But on Wednesdays, we are only open till 16. Which means; at least for the people that live here, but study in different parts of town; that they do not make it here in time.” (Participant 14).	«Ja, i alle fall på mandager. For da har vi åpent til 19. men på onsdager har vi åpent bare til 16. og da, hvert fall de som bor her, men som går på skole i andre bydeler, de rekker ikke hit til 16. Så...så det burde kanskje vært andre åpningstider på onsdager óg da.»
“And generally speaking, I try to encourage them not to soak everything in that they find on the internet.” (Participant 3).	"Og generelt sett så prøver jo jeg å oppfordre dem til å ikke sluke rått alt dei finner på nettet"
"But I believe we need to improve on enlightening information. Starting with students beginning secondary school; that they can go to AHCs. Mm…Because not all 8th graders know they can attend here. So I am trying to inform them of that." (Participant 14).	"Men jeg tror at vi må bli enda flinkere til å opplyse. Helt fra elevene begynner på ungdomsskolen, at de kan gå på HFU. Mm...For det er ikke alle i 8. klasse som vet at de kan gå hit. Så jeg prøver å informere dem om det".
“We try to be…try to inform them as much as possible, with address and opening hours, and so on. Of course, there are always some that make an error regarding what health clinic or health clinic for adolescence, and think that "the health clinic nine to five" is the same, and come, around ten and then we work from three thirty.” (Participant 1)	«Vi prøver å være...å opplyse de så mye som mulig, med adresse og åpningstider og så videre. Selvfølgelig er det alltid noen som tar feil av helsestasjon og helsestasjon for ungdom, og tror at «helsestasjon ni til fem» er det samme, og kommer da rundt kl 10; og så jobber vi fra halv fire.»
(Laughs): "We only have a boring website." (Participant 14)	(Ler) "Nei, vi har bare en sånn vanlig kjedelig internettside»
“Yes! The other girl does it! Yes, she´s using Snapchat a lot!” (Participant 13).	"Ja! hun andre gjør det! Ja, hun har brukt Snapchat masse!»
“They might ask me a question, on Snapchat, which they might avoid asking someone face to face.” (Participant 5).	"de stiller kanskje et spørsmål på snap, til meg, som de kanskje vegrer seg for å spørre noen om sånn face to face"
“We are not going to conduct health counseling over snapchat. We are not allowed – it´s illegal.” (Participant 11).	«Vi skal ikke drive med helserådgivning på snap. Det har vi ikke lov, -det er ikke lovlig»
“Body image pressure is a topic that´s rather brought up in the school sector, than AHC; where one has a lot less time for each consultation. And it must be followed up over time. It´s also possible for us here to confer with a counselor; if there´s anything the person can	"kroppspress ofte kanskje er tema som heller kommer inn i skolehelsetjenesten, enn på HFU, der man har mye mindre tid til hver konsultasjon. Det også må følges opp mer over tid. (…) Og snakke med rådgiver; hvis det er noe rådgiver kan bidra med. Så vi kan nok gi

contribute with. So there´s probably a more comprehensive offer that can be given in schools. It´s even easier to do it over time, as we are in the school several times a week! While in AHCs there are employees working once every other week, right?" (Participant 11).	et litt mer helhetlig tilbud til elevene på skolen. Selv lettere å gjøre det over tid; for at vi er jo på skolen flere ganger i uka! Mens på HFU så er det noen som jobber annen hver uke en gang, ikke sant?»
“I think the school system does a lot, in a way. Because the school nurse, or health nurse, is available from the first year (of upper secondary school). I think that is where one needs to go. Eh because... Just to show that there is a safe environment to go to. Right? When things get hard in high school/upper secondary school, when one enters puberty and start having draining thoughts and all of that; that they then know there is something here. That it is available (to them).” (Participant 7)	«Jeg synes jo på en måte skolehelsetjenesten gjør mye. Fordi helsesøster, eller helsesykepleier, er tilgjengelig fra første klasse. Jeg tenker det er der man må gå. Eh fordi...Bare vise at det er en trygg arena å komme til. Ikke sant? Når det blir vanskelig på videregående; når man kommer i puberteten og får disse vanskelige tankene og alt det der; at de da vet at det er noe her. At det er tilgjengelig.»
"I believe safety is important. And relation; that one can feel safe and have relations with them, at least when it regards mental health. And that we do not judge. That we are somewhat open, I guess. That we use time on establishing during our visits to the classes as well. It is not supposed to be difficult; we do not judge anyone, everyone is welcome! They are teenagers and experiencing life´s ups and downs. So, I believe that just the fact that we say this in our introduction, when we walk around in the classes for them that are new; we show face, I believe that maybe that can grab some of their attention; make them want to come here, and think "Maybe I should go talk to them?". We are here to, like, help them feel better.” (Participant 6).	«jeg tror trygghet er viktig. Og relasjon; at man kan føle seg trygg på det og ha relasjon med dem, hvert fall når det gjelder psykisk helse. (...) Og at vi ikke dømmer. At vi er litt sånn åpne da. Og det bruker vi litt tid på når vi går rundt i klassene og. Det skal ikke være vanskelig; vi dømmer ingen, og det er bare å komme til oss! Dem er ungdommer og erfarer at livet går opp og ned. Så jeg tror at bare det at vi sier det på introen, når vi går rundt i klassene for de som er nye; og viser ansikt, så tror jeg kanskje det kan være litt napp der, som gjør at de kanskje kommer hit, og tenker «kanskje jeg skal snakke med dem?» (...) Vi er liksom her for at de skal ha det bedre. "
“It is what one would call the professional conversation with teenagers, or a conversation promoting development with teenagers, a term they use here. That it is allowed to talk about anything at all and we show that we are open to talking about anything and everything.” (Participant 8).	"Det er det som er den profesjonelle samtalen med ungdom, eller utviklingsfremmende samtaler med ungdom, som de bruker som begrep her. At det er lov på en måte å snakke om absolutt hva som helst, og at vi viser at vi er åpne for å snakke om absolutt hva som helst».
“There is a lot they have to stand in and handle. So; help them see that. That they are not sick. So that they do not use too much energy on believing there is something wrong with them! Or that they are not good enough.” (Participant 14).	"det er veldig mye de skal stå i, og håndtere. Så: hjelpe dem å se det. At de er ikke syke. " (...) "sånn at de ikke bruker så mye energi på å tro at det er noe gærent med dem! Eller at de ikke er bra nok»
“You see, it is children, and I mean children; they are as young as 9-10 years old, that watch porn for example.” (Participant 14)	«Du ser jo, -det er jo barn, og da sier jeg barn; dem er jo helt nede i sånn 9 – 10 års alder, som ser på porno f.eks. Mhm (...) Så mer informasjon tror jeg hadde vært fint.»
“Now there are 12 – 13- year old age limits on most of them (SOME sites), but you can meet those that have had Facebook since they were	" Nå er det 12 – 13 års aldersgrense på de fleste (SOME sites), men du møter jo de som har fått

8... Snapchat since they were 10 and all kinds of things like that." (Participant 1).	– hatt Facebooken sin de var 8...Snapchat siden de var 10 og alt mulig sånt.»
"…has done research regarding teenagers, the media and cellphones" (Participant 11)	«...Oda Faremo Lindholm; hun har jo skrevet «bullshit filteret», og har forsket på det med ungdom og press og mobiltelefon.»
«...talking about this "bullshit filter". That bullshit exists everywhere; in online newspapers, magazines, social media, bloggers; everywhere! Because I recently had this lecture in a tenth grade, and it is amazing when we come up with these things! They become so involved!» (Participant 7).	«...så snakker vi om det bullshit-filteret. At bullshit finnes over alt; i nettaviser, magasiner, sosiale medier, blogger; over alt! For jeg hadde denne undervisningen i 10. klasse nå, og det var helt fantastisk når vi kommer på de tingene her! De blir jo kjempeengasjerte!»
"(Oda F. Lindholm) has had lectures for all the grades here at school (...) she is having a lecture this autumn. And we think it is very useful, these lectures she has. So we send tasks for them to work with in the aftermath. Which is very good. Because we think it strengthens it moreso than just listening to a lecture." (Participant 11)	«Så hun har jo hatt foredrag på alle trinnene her på skolen (...) hun skal ha foredrag nå til høsten. Og vi synes det er veldig nyttig da, foredragene hun har. Og så sender vi jo med sånne oppgaver som de kan jobbe med i etterkant. Og det er jo veldig bra. For at da tenker man at det kan forsterkes mer, enn å bare høre foredrag.»
"I wish I had more time with them; to clog these holes, that I experience are lacking. With knowledge, about ones own body and sexuality. I wish I had more time for that." (Participant 2)	«De kunne jeg ønske meg å ha mer tid til; nettopp for å tette igjen de herre hullene, som jeg opplever at kanskje mangler da. Med kunnskap, om egen kropp og seksualitet. Det kunne jeg gjerne hatt mere tid til.»
"We consistently try to come in with lectures, but it is a battle. Because we´ve tried to get the school to set off time, but they do not seem interested in doing so. I think that is very sad. Because I know that 25% of teenagers deal with mental problems." (Participant 13).	"Vi prøver stadig å komme inn, i forhold til undervisning, men det er litt kamp... " (..) "for vi har prøvd å få skolen til sette av tid, men det vil de ikke. " (...) "Men jeg synes jo det er veldig dumt. For jeg vet jo at 25% av ungdommen sliter med psykiske problemer. Og det å da bruke litt tid på mestring i forhold til det, tenker jeg er viktig. "

Table 3c, *Distribution/location*

Languages: English	**Norwegian**
"They wouldn't bother travelling that far." (Participant 9)	"De gidder ikke dra så langt"
"And many of them are so young! As young as 13 – 14 years old; and then it is far to travel." (Participant 13)	"Og mange er jo unge! De er jo nede i 13 – 14 år, og da er det langt å reise."
"I´ve gotten some feedback that it is difficult and there are not enough signs." (Participant 12)	"Jeg har fått noen tilbakemeldinger at det er litt sånn vanskelig og dårlig skiltet"
"My office is at the end of the corridor. So I can say that, I notice that students that have their classrooms nearby, come more often." (Participant 13)	"Jeg sitter jo helt innerst i en korridor. Så kan si at, -merker jo at de elevene som har klasserom i nærheten, de kommer oftere."
"I do remember; when (different high school) was here, some students literally threw themselves through the door. Checked in all directions; "Is there anyone there who might see that I walk in?!" and then boom! Nearly threw	«Jeg husker jo at når det var (other high school) her, da var det noen som liksom kastet seg inn døra. Sjekket i alle retninger: «er det noen som ser at jeg går en inn der nå?» og så bare bom! Kaster seg inn nærmest, for de var kjempe redde for å bli sett».

themselves through the door; because they were so afraid of being seen." (Participant 11)	
"I lean towards the belief that our central location is good. So that we can cooperate well with the other school staff. We are right next to the administration; and we have the student advisors right next to us. So we sit a bit better than many other places. Because often one sits a little bit hidden." (Participant 12)	«Jeg faller på at jeg synes det er bra at vi sitter så sentralt. Sånn at vi kan få til et godt samarbeid med de andre på skolen da (...) vi ligger rett ved administrasjonen, og så har vi rådgiverne rett ved siden av oss. Sånn at vi sitter litt mer bedre, enn mange andre steder. For ofte så sitter man litt bortgjemt.»

In text: "see Appendix: Table 1c, *Distribution/location*"

Table 3d, *Organization*

Languages: English	**Norwegian**
"That´s how it is! I think this is fairly descriptive, really. Because, well, there are a few... What should we say? Like senior things, that get decided, and that are not as implemented in areas where it maybe should be. (…) there is a lot happening higher up in the hierarchy system (...) One isn´t able to follow (the information), in a way. (…) I think it is really weird though. (...) I think it contributes to some alienation in relation to what one really ... wants. That; if you want something implemented in a good way, then you have to involve the others (who work with it)." (Participant 13)	"Ja, det er litt sånn det er. Det synes jeg er ganske beskrivende egentlig. For, altså, det er en del sånne... Hva skal vi si? Sånne honør greier, som blir vedtatt, og som er lite implementert der det kanskje burde være da. (...) det er mye som skjer høyere oppe i systemet (...) Man er liksom ikke helt med. (...) Jeg synes det er veldig rart da. (...) Jeg tenker at det bidrar til litt sånn fremmedgjøring i forhold til hva man egentlig...ønsker da. At, hvis man ønsker noe implementert på en god måte, så er man nødt til å involvere de som (jobber med det)»
"I don't know. We were kind of just told that the agreement is being cancelled. But…yeah. But I would imagine that the psychologist services will be continued…" (Participant 12)	«Jeg vet ikke. Vi har på en måte fått beskjeden at den avtalen blir sagt opp. Men at man...ja. Jeg tror jo at psykologtjenesten kommer til å bli videreført.»
"Some districts have an agreement with specialist care, but in (the current district) we don´t have it. That´s a pity. We´d like to have it though. (…) I know that district (name) has it; and many other districts. District (name) has it, uhm, where it actually works really well." (Participant 2)	«Noen bydeler har en avtale med sin spesialisthelsetjeneste, men i bydel (navn), som hører da til (spesialistenheten), så har vi det ikke. Dessverre. Skulle gjerne hatt det (...) Jeg vet at bydel (navn) har det, og mange andre bydeler. Og bydel (navn) har det, eh, hvor det fungerer egentlig veldig godt.»
"It´s a cooperation between Agency of Health agency, Agency of Education; and specialist care. (ref. Colleague) is employed in the Agency of health, or; in the district. And I represent the specialist unit. And we both have offices. The school has to make sure we have offices. And this is an agreement that has been signed by the heads of all these agencies in Oslo." (Participant 8)	"det er et samarbeid mellom helseetaten, skoleetaten og spesialisthelsetjenesten. (ref. Kollega) er ansatt i helseetaten, -i bydelen. Og jeg spesialisthelsetjenesten. Og så har vi kontorer; skolen må på en måte passe på at vi har kontorer. Og det er en samarbeidsavtale som har blitt skrevet under av toppene i alle disse etatene i Oslo."
"What´s unique about our model, is that those who are employed through CAPP, contribute equally as much as the public health nurses in schools. They (CAPP) too, work with whoever that comes through their doors." (Participant 9)	«det som er unikt for vår modell da, det er at BUPP-erne, de stiller på lik linje som helsesykepleierne i skolehelsetjenesten. Eh, de tar i mot det som ramler inn døra de også.»

“And then we enter the same journals. Eh, that´s pretty unique (…); that we can read each other´s notes. And that´s very important, I believe. So that if (name) has been doing some follow-up, and then goes on vacation for a week, I can easily read up.” (Participant 9)	“Og så skriver vi samme journalsystem. Eh, det er jo også ganske unikt (...); At vi kan lese hverandres notater. Og det er veldig viktig, tenker jeg også. Sånn at hvis (navn) har fulgt opp en (bruker) over tid, og så kommer dem og så har (navn) ferie i en uke, så da kan jeg bare lese meg opp kjapt.»

Table 3e, *Preferences/prejudices*

Languages: English	**Norwegian**
“…nearly no boys visit the AHCs. So there is a big difference; boys utilize school-based health services a lot, but they very seldom go to AHCs.” (Participant 2)	"...Mens på helsestasjon for ungdom, så har vi nesten ikke gutter innom (...) Så det er stor forskjell. Guttene bruker mye skolehelsetjenesten, men veldig lite helsestasjon for ungdom.»
“Traditionally; if we were to generalize and be very normative; young boys- males in general; make less frequent contact with health care services, than women do. So that´s one way to look at it.” (Participant 4)	"Sånn tradisjonelt; og hvis man er veldig hetero og normative nå, så er det jo sånn at gutter oppsøk, -og menn; generelt oppsøker helsetjenestene mer sjeldent, enn det kvinner gjør. Så, det er jo et perspektiv her, det også.»
“I do also believe, traditionally, perhaps; that it is easier for girls to visit a public health nurse. Or health care services in general. Because in a way, there´s a much bigger acceptance when girls utilize these services.” (Participant 5)	"jeg tror jo sånn at, kanskje tradisjonelt, at det er lettere for jenter å oppsøke helsesykepleier, eller helsetjenester i det hele tatt. Fordi at det er større aksept, på et vis; at jenter benytter det.»
«I don´t think that many (users) feel like they can come here with these sorts of questions.” (Participant 1)	"Jeg tror ikke det er mange som tenker at de kan gå hit med den tematikken»
“I mean, I´ve been working as a PHN for 10 years. I can see that there are more boys now.” (Participant 11)	"Altså nå har jeg jo jobbet som helsesøster i 10 år. Jeg ser det er flere gutter nå.»
“And I feel like many of them come for more than just to test for STDs; they come to talk…” (Participant 5)	"Og jeg synes at mange kommer for mer enn liksom bare det å teste seg for skjønnssykdommer. De kommer for å snakke..."

In text: “see Appendix: Table 1e, *Preferences/prejudices*”

Table 3f, *Price*

Languages: English	**Norwegian**
“Starting the age of 16, they must pay for care, and that´s a challenge too.” (Participant 6)	"Når de kommer over 16 år, så må de betale selv, og det er også en utfordring.»

In text: “see Appendix: Table 1f, *Price*”

Table 3g, *Quality*

Languages: English	**Norwegian**
“I was about to say; “What comes first: the chicken or the egg?” The picture is so complex! It´s hard to kind of just check off stuff from a list. (…) It is a bit difficult to know the difference between (healthy adolescents) and those who are really headed towards real mental illnesses. It is somewhat difficult to know when I should refer.” (Participant 14)	"Og det er jo litt vanskelig å si, hva som kommer først; høna eller egget, holdt jeg på å si. (...) bildet er så komplekst! Så det er vanskelig å ha sånn lister å krysse av etter. (...) Det er vanskelig å skille litt mellom (friske unge), og de som virkelig er på vei inn i en ordentlig psykisk uhelse da. Det er litt vanskelig å vite når jeg skal henvise videre. "

«I´m not afraid, to sort of lead the conversation; I´m not afraid to ask questions. And stand in it." (Participant 5)	«Jeg er ikke redd for å på en måte ta den samtalen; jeg er ikke redd for å stille spørsmål. Og stå i det, på en måte."
"We might appear a bit threatening if we ask directly about sensitive stuff. So I try to be noncommittal**;** thinking that letting them define their own problems would be wise. It also makes them readier for potential guidance, help and treatment." (Participant 10)	"Det kan være litt sånn truende hvis vi spør direkte om litt sånne vanskelige ting. Så jeg prøver å være litt avventende, og tenker at det er lurt at de selv setter ord på det. For da er jo man klar for veiledning, eventuelt hjelp og behandling."
"We can´t force someone to come. Coz if you push them too much; especially those who are slightly ill, they won´t come." (Participant 7)	"Vi kan ikke presse noen til å komme. For hvis man pusher de for mye, gjerne de som er litt syke, så vil de jo ikke komme"
"A very good introduction for us who work in AHCs." (Participant 11)	"En veldig god innføring for oss som jobber for helsestasjon for ungdom.»
"The focus (in AHC-school) has been different, depending on the week. One week was dedicated to contraception. Another week focused on genital plagues. And then, one week dealt with different types of minorities. For instance; teenagers with impairments; boys in the health care sector, which we know are in a minority (…) so; how can we meet everyone in the best possible ways. And communication has been a topic." (Participant 11)	«Det har vært forskjellig fokus for hver uke. Det har vært en prevensjonsuke. En underlivsuke, med fokus på plager i underlivet. Og så har det vært en minoritetsuke, med på forskjellige typer minoriteter. Ungdom med funksjonsnedsettelse, gutter i helsevesenet; som vi ser jo er en minoritet (...), hvordan møter vi alle på en best mulig måte. Og kommunikasjon har vært tema en uke.»
"You gotta set off time for such things; and it costs money." (Participant 14)	"Det må jo settes av tid til det og det koster jo penger."
"I´ve dialed to hospitals; on speaker, and with the student present, saying like: "So, how do you proceed? I´ve got one here, who´s wondering if she should consider your services." Right? "How can you help?" And things like that; also to make it seem less scary." (Participant 6)	«Jeg har også ringt på høyttaler, ned til...ja, på sykehus, med eleven til stedet, for å fortelle: «ja, hvordan jobber dere? Jeg har en her som da lurer på om hun skal ta i mot hjelpen deres». Ikke sant? Og: «Hva kan dere gjøre?». Og litt sånn for å ufarliggjøre det.»

Domain: Users

Table 4a, ***Number***

Languages: English	**Norwegian**
"Though, of course; I believe it is like that with many things, at one only sees the tip of the iceberg kind of." (Participant 11)	"Det er klart at; jeg tror det er sånn med mange ting, at man ser kanskje toppen av et isfjell da.»
"I believe it can be problematic for many to come and talk, I really do. I believe that there are plenty of those who could have made contact, but just don´t it." (Participant 12)	"Jeg tror det er mange som synes at det er et problem å komme og snakke. Det tror jeg. Jeg tror det er mange som ikke tar kontakt, som kunne ha tatt kontakt. "

Table 4b, ***Need for service***

Languages: English	**Norwegian**
"Many of those that might not be aware of what influence social media has on them." (Participant 1)	"Mange som ikke er gjerne bevisste på hvilken innflytelse sosiale medier har på de"
"When it comes to eating disorders, I believe that numerous teenagers think that they	"I forhold til det med spiseforstyrrelser, så tror jeg at det er veldig mange som tenker at de selv ikke har vansker med det. "

themselves do not have any issues with such." (Participant 12)	
"They are over 16 years old. In other words; they are authorized for health services. And if they themselves do not see that they are struggling or having problems, then I do not have... I do not have much to work with. That´s quite frustrating, actually. Because...it´s like; what if they are in the very start phase; of developing an eating disorder, for example." (Participant 5).	"de er over 16 år. Med andre ord: de er helserettslig myndige. Og hvis de selv ikke ser at de har noen utfordringer eller problemer med det, så kan ikke jeg på en måte...da har jeg ikke så mye å spille på. Det er ganske frustrerende, faktisk. For at...det er sånn; kanskje er de ganske tidlig ute i løpet da, med å utvikle en spiseforstyrrelse, for eksempel..."
"Right? That denial in the beginning, perhaps especially in the beginning, that: "I don't have any problem." (Participant 4).	«ikke sant; denne fornektelsen i starten, kanskje særlig i starten, at «jeg har ikke noe problem»»
"But, obviously; if all the small things are constantly being ignored; if one kind of just continues to give the impression that everything´s under control, then…I mean; it must be tiring in the long run." (Participant 2).	"og det er klart at hvis på en måte sånne småting blir hele tiden lagt lokk på; man bare skal på en måte vise at man fikser det meste, så...så blir det jo litt slitsomt i lengden da. "
"It can be a way to control other things that are difficult in life. It´s something that makes life function, sort of." (Participant 11).	"At det kan være en måte å ta kontroll på noen andre ting som er vanskelige i livet (...) at det er noe som gjør at livet fungerer litt for de da"
"Sort of: «If I get good results on this test…then I can allow myself an extra treat." And if not then… "If not, then I am going to…" then it becomes the stick, sort of; "then I am going to go and exercise". And stuff like that. (...) So, in one way or another; they win: «And if I don´t get good results, then at least I´ll get thinner."." (Participant 5).	««Hvis jeg får god karakter på denne prøven...så kan jeg liksom unne meg selv litt ekstra» liksom. Men hvis ikke så...«Hvis ikke, så skal jeg...» så blir det typ straff da; «Da må jeg trene litt» og sånt. (...) Så på en eller annen måte så vinner man litt: «Hvis jeg ikke får god karakter, så blir jeg i alle fall tynnere.»»
"And I´ve been previously working a lot with eating disorders, and I see that…those individuals probably have a higher threshold to ask for help. Perhaps one doesn´t want help. The same way one would want…Because that´s what they want, right? Someone that´s been desiring a thinner body; that´s what they want. And not someone else to come and help them stop it." (Participant 12).	"og jeg jobbet mye med spiseforstyrrelser før, og jeg ser jo at...de har nok mye høyere terskel for å be om hjelp. Kanskje fordi man ikke ønsker hjelp til det. På samme måte som man ønsker..." (...) "det er jo noe man ønsker. For eksempel, noen som har ettertraktet en tynnere kropp; så er det jo noe man ønsker. Ikke noe man ønsker at noen skal komme og hjelpe deg med å stoppe. "
"Many who got girl friends; or someone else they are worried about; siblings, who come to talk." (Participant 5).	"Mange som har venninner, eller noen de er bekymret for; søsken, som kommer hit og snakker da.»
"The teacher is, after all, the one who sees them every day. So it happens that (teachers) invite (adolescents) for a talk. And then manages to pull out of them that they´re struggling and…and asks: "you wouldn't wanna talk to a nurse?" (Participant 14).	«læreren er jo den som ser dem hver dag, så det hender at de tar dem med til en prat. Og så klarer å lirke ut av dem at de strever og...spør: «du vil ikke snakke med helsesykepleier?»»
"To me, it is important that the one who senses concern, is also the one that addresses this concern." (Participant 4).	«jeg er jo opptatt av at den som på en måte kjenner på noe uro, er den som skal adressere uroen"

Table 4c, ***Ability to avail service***

Languages: English	**Norwegian**
“I definitely believe they experience some sort of threshold! And many can have a go first; they come to get plasters; or inspect wounds. Their inquiries can be numerous and very simple in the beginning; and only afterwards they might disclose what´s really bothering them.” (Participant 13).	"jeg tror de synes at det er absolutt en sånn terskel! Mange prøver seg; de kommer for å få plaster, se på et sår; at de kommer mange ganger først med veldig sånne ufarlige ting, før de kanskje lufter det som er vanskelig da.»
“I imagine that everyone, especially in their teens; can be like: “Everything is wrong with me.” They live in their own bubble; thinking that something is wrong only with themselves.” (Participant 14).	"jeg tror at alle føler litt på, spesielt sånn i tenårene, at «alt er feil med meg»." og "Det er jo det at de er i sin egen boble. De føler at det er bare de som har det sånn. Og at det er bare de det er noe gærent med.»
“It´s sort of a sign of weakness. Or; yeah; it´s hard to expose such delicate matters. I think it´s the same for all such mental things that one is struggling with. And I believe that many adolescents think that they shouldn’t have had those struggles. And that they are ashamed of it, and therefore do not want to talk about it. And that´s a pity!” (Participant 13).	«det er på en måte tegn på svakhet. Eller ja; at man blottlegger noe som er veldig sårbart til en selv, og at det er vanskelig. (...) Jeg tror det gjelder alle sånne psykiske ting man sliter med. At man på en måte tenker først, -jeg tror mange ungdom tenker at de ikke skulle ha det. At de skammer seg over det, og derfor ikke vil prate om det. Og det er jo; det er veldig synd! "
“…refuse to take advantage of the services, because it´s women they meet.” (Participant 1).	"de vegrer seg for å benytte tjenester, fordi at det er damer de møter. "
“It´s not that easy to bring up feelings and stuff, for example. To just come out of the blue and say: “I feel like crap.”” (Participant 5).	"Det er ikke så lett å ta opp, for eksempel, følelser eller sånt, bare sånn; komme helt ut av det blå og si sånn: «jeg har det skikkelig dritt» liksom."
“The threshold for turning to our sector for health care, seems to be a bit higher for the girls and the boys. For girls; oftentimes because of some social control perhaps, or the fear of being caught for using contraceptives. (…) And the guys too, right? Those coming from…also the African and Arabic countries; they oftentimes live under an extreme masculinity, which implies that asking for mental care or advice in topics that are sexually oriented…is probably more embarrassing; than it would be for ethnical Norwegians.” (Participant 1).	«Det virker til å være litt høyere terskel, både jenter og gutter, til at de oppsøker helsehjelp i denne sektoren. For jenter gjerne på bakgrunn av eventuelt en sosial kontroll, eller en frykt for at noen skal oppdage at de bruker prevensjon eventuelt. (...) For gutter og, ikke sant. Gutter i fra...også afrikanske og arabiske land; lever gjerne under en veldig voldsom maskulinitet som tilsier at det å be om hjelp rundt tematikk som er psykisk eller seksuell helserettet...er mer flaut enn for kanskje etnisk norske."
“Mm, yes. And we´ve heard that too; that…one shouldn’t always trust…right? And: “hush, hush, we´ll take care of it at home”. It is a bit like that. So yeah; we´re trying to work on it.” (Participant 7).	"Mhm. Ja. Og det har vi jo fått høre og. På en måte at...man skal ikke alltid stole på...Og ikke sant; «hysj-hysj, vi ordner det hjemme i familien» Det er jo litt sånn. Så vi prøver jo å jobbe med det."
“I mean; we are on The West-Side. There´s so much façade. A lot of stuff is going on within the thousand homes. Things that not everyone wants everyone to know.” (Participant 5).	«vi er jo liksom på vestkanten da. Det er mye fasade. Ehm, så det skjer mye i de tusen hjem, som, som ikke alle vil at alle skal vite om.»
“There are several of those who´ve come on their own and said: “you know what? I would actually like to cut down my hash smoking.” (Participant 4),	" det er flere som har kommet; har kommet på egenhånd, og sagt at: «vet du hva? Jeg ønsker faktisk å redusere hasjrøykingen min». "

“We meet plenty of boys, too! It´s kind of socially accepted; visiting school-based health services. It´s not a big deal. It feels like they see us as halfway old, dispensable mothers.” (Participant 9). (Colleague continues): “And there´s no difference between boys and girls. or Pakistanis, Somalis and Norwegians, for that matter. It´s exactly the same.” (Participant 8).	"Vi har veldig mange gutter og! Det er liksom sosialt akseptert; det å gå til skolehelsetjenesten. Det er ikke noe big deal (…) Det virker som om de ser på oss som sånn dere halvgamle reserve-mammaer" (9) «Og det er ikke forskjell på gutter og jenter. Eller pakistanere eller somaliere, eller norske nordmenn fra Norge liksom. Det er helt likt. " (8)
“We do get some youth here, with questions about diet and exercise, though, of course; not that many. Versus those who for instance come because of anxiety and depression, and those kinds of things. Unhappiness in their homes and in school...» (Participant 12).	«Det kommer en del ungdom, med spørsmål om kosthold, og trening. Men det er klart at; det er ikke veldig mange som kommer; kontra dem som kommer med angst og depresjon, og den type problematikk. Samt mistrivsel; på skolen, mistrivsel hjemme...»
“You must work out a lot; eat healthy, and get top grades. It´s kind of this external and internal pressure, right? When I was young in the 80s, it was kind of enough to just be good-looking, if you know what I mean (laughs).” (Participant 4).	"du skal trene mye; du skal spise riktig, og du skal få toppkarakterer; ikke sant, at man på en måte har et ytre og indre press (...) Da jeg var ungdom på 80-tallet, da holdt det på en måte å være pen (siste ord nærmest ledd ut), hvis du skjønner.»
«To take one example: if you arrive school, and stand there looking at the door without entering, and then go home instead, then you need help.” (Participant 4).	«hvis du, for eksempel da, kommer til skolen, og da står og ser på skoledøra og ikke går inn; og går hjem, ikke sant; da trenger du hjelp.»

Table 4d, *Effective demand*

Languages: English	**Norwegian**
«So I could absolutely have had one more (PHN) here. Like, at least in a part-time position! But it´s like; plenty wants more. So there´s always a demand for more. Once a need (for care) is established…it fills up quickly. (…) The more visible one is; the more one promotes oneself, the higher is the demand.” (Participant 5).	«Så jeg kunne helt fint hatt en til her. I hvert fall i halvt stilling liksom!» (..) «Men det er litt sånn; Mye – vil ha mer. Så; alltid behov for mer. Med en gang man etablerer et behov liksom, så...så er det fort at det fylles opp da.» og: «jo mere synlig man er; jo mere man reklamerer for seg selv, jo større pågang får man jo».

Table 4e, *Preferences/prejudices*

Languages: English	**Norwegian**
“Numerous teenagers wish not to attend the specialist services. Both because it´s cumbersome and…I don’t know.” (Sounding like (s)he is about to cry): «I often see that they come back here, and aren´t satisfied, eh, for some reason. That they feel it´s difficult to be honest and open there.” (Participant 2)	"Veldig mange ungdom ønsker ikke å gå til spesialisthelsetjenesten. Både fordi det er tungvint og...jeg vet ikke.» (Med nesten gråtende stemme): «Jeg opplever veldig ofte at de kommer tilbake hit, og ikke er fornøyd da. Eh...av en eller annen grunn. At de føler at det er vanskelig å være ærlig og åpen der..."
“I believe that if students would’ve got what they wanted, they would rather wish for services to be available here.” (Participant 2)	«Jeg tror at hvis elevene hadde fått det som de ønska, så skulle de ønske heller at det var tilgengelig her da.»
“Those kids are very much like: it must happen yesterday! (…) Like, even if we put…When I	“Den ungdom er veldig sånn: det må skje i går! (...) Sånn; selv om vi setter, -hvis jeg er alene; så

am alone (in the office); busy with a student, I often put "occupied" on the door. But they (students) burst in, regardless! Without paying any attention to it.» (Participant 8).	setter jeg ofte «opptatt» på døra, når jeg sitter opptatt med en ungdom. Men dem raser jo inn for det! Og tar ikke hensyn til det liksom.»
"If they drop in, they sit and wait, right? And hope to get in. And if there´s a queue, they might leave. Which is why it´s a little important that we get a grip on them; or they might not show up again." (Participant 6).	"Så da, er de på drop-in, så sitter de gjerne og venter, ikke sant? Og håper på å komme inn. Og hvis det da er kø, så kan det hende at de går ut igjen. (...) derfor er det litt viktig at vi tar tak i dem. Fordi det kan godt hende at de plutselig ikke dukker opp tilbake igjen.»
"They understand if it´s really chaotic here. "But I can rather return tomorrow…", right? If I happen to talk to someone that can wait. In my opinion, they are quite agreeable. » (Participant 10).	"De skjønner det, hvis det er veldig kaotisk, typ; «men jeg kan heller komme tilbake i morgen». Ikke sant? Hvis jeg snakker med noen som kan vente. Og det synes jeg de er ganske forståelsesfulle på.»
"Because they are completely free to choose, whether they are going to show up or not. Oftentimes, they come when things are really bad, and when things get better, they stop coming. The work with each and every isn´t always...well, it´s not linear. It´s more like: starting and quitting, and now and then…that is so typical youth!" (Participant 13).	«For de kan jo helt velge selv, om de kommer eller ikke. Ofte så kommer de en periode når de har de skikkelig dårlig, og så når det blir litt bedre så slutter de å komme. Det er ikke alltid at arbeidet med hver enkelt, -det er ikke helt lineært da. Det er litt mer sånn: start og stopp og...og av og til...(...) det er veldig typisk ungdom!»
"I´d think (users) are afraid of others also…that we don´t stick to our duty. It might be there; the fact that (users) are not sure whether or not we tell the teachers. Or others in school. Or the police. (...) that might a barrier. For some. » (Participant 9).	«Eh da tenker jeg at dem er redde for at andre også skal, -at vi ikke overholder taushetsplikten vår. Den kan ligge der. Det at de ikke er sikre på om vi forteller ting til lærerne på skolen. Eller andre på skolen. ikke sant? Eller til politiet. Eller sånne ting. Det kan være en barriere. For noen.»
"Now, there are many community workers here. And, being able to separate our services from theirs, is somewhat challenging. (…) And I also believe that it´s important that we are something completely different from the rest of school. Right? You know, with regards to the duty of confidentiality." (Participant 13).	"nå er det jo mange miljøarbeidere her. Og det å klare å skille vår tjeneste fra de, det er en liten utfordring da. (...) Jeg tror det er viktig. Og jeg tror også det er viktig at vi er på en måte noe helt annet enn skolen da. Ikke sant? Ja, sånn i forhold til dette her med taushetsplikt."
«If the student opens up and tells a whole lot, I ask: «may I...is this maybe something that I can talk about to your teacher? To adjust things a little bit better for you". And then we can reach consensus on what I can tell the teacher." (Participant 14).	"hvis eleven åpner seg og forteller masse, så spør jeg «kan jeg, -er dette kanskje noe jeg kan snakke litt med læreren din om? For å få tilrettelagt for deg». Og da kan vi bli enige om hva jeg kan si til læreren.»

Table 4f, *Attitudes/values*

Languages: English	**Norwegian**
(Collectively imitating disappointed voices): "You guys are never here!" (Participant 8 and 9).	(Sammen; mens de imiterer elevenes skuffelse): «dere er aldri her!»
(i): "Being here alone all year long, just won´t do. It results in less capacity for follow-up, and less of an open door." (ii): (Describing the logic of adolescents): "«They work Tuesdays and Thursdays;	(i): "det å være alene her hele året; det er for lite. Det gir mindre kapasitet til oppfølging, og mindre åpen dør." (ii): "«det er folk der på tirsdag og torsdag, da går jeg tirsdag og torsdag»». Hvis dem da

therefore, I go also; Tuesdays and Thursdays." If (users) are instead met by a closed door, which says «I´ll be here tomorrow"; that´s unacceptable! (…) simply; VERY unfortunate. And if that´s the case; it is better to stick to the few office hours, than be available "now and then"." (iii) (Defining access): «That the capacity is high enough, so that you don't go goose chase one and two, and three times. Because then you just don't bother anymore."	liksom kommer til lukket dør og så står det «jeg kommer i morgen» i stedet; det går ikke! " (...) "Det er VELDIG uheldig, rett og slett. Da er det bedre at man er det lite men fast, enn veldig ustabilt og «av og til». " (iii) "at det er såpass stor kapasitet at du ikke går bomturer en og to og tre ganger. For da gidder du ikke.»
«…And (colleague) is excellent at making them a cup of tea when they feel sick! So that they feel they are being noticed, and cared for. So that, maybe they come back." (Participant 7).	«...Og (kollega) er jo kjempe flink til å lage en kopp te når de er litt syke og liksom...ja. Sånn at de liksom føler seg sett og ivaretatt, så kanskje de kommer tilbake da.»
"(The adolescents) are content and grateful, and; yeah. You feel like you´re doing something useful for somebody." (Participant 11).	"de er fornøyde og takknemlige, og, ja. Man føler at man gjør noe som er nyttig for noen da."
«No, I believe that there are rather few, who are thinking that they can use this service for that; or for those challenges." (Participant 1).	"nei, jeg tror nok det at det ikke er mange som tenker at de kan bruke den tjenesten til det, eller til de utfordringene." (#1).

Appendix X. NSD approval for research project

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Sosiale mediers innflytelse på unges helse og mulige barrierer for tilgangen til skolehelsetjenesten i Oslo: Hva hvis begge oppfattes som et problem? – En kvalitativ studie

Referansenummer

764568

Registrert

05.05.2019 av Elizaveta Mouratkina Haukedal - elizavem@uio.no

Behandlingsansvarlig institusjon

Universitetet i Oslo / Det medisinske fakultet / Institutt for helse og samfunn

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

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Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

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Prosjektperiode

27.05.2019 - 31.12.2019

Status

22.05.2019 - Vurdert

Vurdering (1)

22.05.2019 - Vurdert

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet den 22.05.2019 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde: