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EMPIRICAL STUDIES

Parents' experiences with public health nursing during the postnatal period: A reflective lifeworld research study

Bente Kristin Høgmo MSc, RN, PHN, PhD student | **Terese Bondas PhD, LicHSc, MNSc, RN, PHN, Professor** | **Marit Alstveit PhD, MHSc, RN, PHN, Associate Professor**

Faculty of Health Sciences, University of Stavanger, Stavanger, Norway

Correspondence
Bente Kristin Høgmo, Faculty of Health Sciences, University of Stavanger, Stavanger, Norway.
Email: bente.k.hogmo@uis.no

Funding information
Universitetet i Stavanger

Abstract

Aim: To describe mothers' and fathers' experiences with public health nursing and child and family health centre services in the postnatal period, both as a couple and as individuals.

Method: A phenomenological reflective lifeworld research approach with a descriptive design was chosen. A purposive sample of 10 mothers and 10 fathers were interviewed twice, 1–2 and 6–8 weeks postpartum, using joint and individual interviews. By focusing on being open and flexible, the data were analyzed to elucidate a meaningful structure of the phenomenon.

Results: The findings revealed that parents' experiences with public health nurse (PHN) and Child and Family Health Centre (CFHC) services in the postnatal period are characterised by a longing to be seen and confirmed both as unique individuals and as a family by the PHN. Although an increased need for both lay and professional care is prominent during the postnatal period, the parents drew a varied picture of their experiences demonstrating that the CFHC services are focussing almost exclusively on mother and child.

Conclusion: A public health nurse can contribute to strengthen parenthood and promote the family's health when the focus is on the new baby. Being cared for while learning to care for the baby is pivotal in a phase that involves both joy and vulnerability. This study adds knowledge concerning the importance of both parents being seen and confirmed by the PHN as unique individuals and a family unit in the postnatal period.

KEYWORDS

Child and Family Health Centre, parents, phenomenological, postnatal care, public health nursing, reflective lifeworld research

INTRODUCTION

The focus of this study is parents' experiences of postnatal care provided by the public health nurse (PHN) and Child and Family Health Centre (CFHC) services. An early postnatal discharge of healthy mothers and term babies has become common in many western countries, and the duration of hospital stay after birth is now around 2–3 days or less [1, 2]. A shorter length of stay at the hospital marks a shift from an illness orientation in maternity care to what has been claimed to be a more family-centred approach where all family members can be together, contributing to improved involvement and bonding between father and child [2]. According to the World Health Organisation, a positive postnatal experience is recognised as a goal and defined as one in which women, newborns, partners, parents, caregivers and families receive information, reassurance and support from motivated health workers [3]. In most high-income countries postnatal healthcare services are offered at the hospital of birth and in municipalities. In the Nordic welfare state context, parents are offered parental leave, which also facilitates the participation of both parents in caregiving and taking part in the postnatal healthcare services provided [4]. The services aim to give parents support in their new role, introduce and support breastfeeding and facilitate the parent–child attachment relationships [5, 6]. The present study is part of a larger Norwegian research project investigating parents' experiences with municipal postnatal healthcare services [7].

BACKGROUND

Having a child is a major life event with several consequences for the new mothers and fathers, both as individuals and as a couple. Giving birth is characterised as something normal, and postpartum strain and exhaustion are not unusual [8, 9]. Being together as a family and receiving follow-up care from health professionals, is described important for parents [10–12]. Good parental support from health care professionals is linked to continuity of care, parent participation, individually adapted care and receiving sufficient information [13–15]. The results of a meta-synthesis [16] show that achieving positive motherhood, being seen as individuals and having their own and their baby's needs recognised and met are considered important for woman in the postnatal period. Because the transition to parenthood might have a significant impact on the couple's relationship, relationship quality is important for the well-being of both partners and their children [17]. Living in an emotionally supportive relationship may protect a persons' psychological and physical health and well-being in demanding situations [18]. Despite strong evidence for the importance of fathers' involvement in their children's care from birth [19, 20], fathers report a lack of information and support from health professionals in the postnatal period [21–23]. A synthesis of previous research on father's encounters with pregnancy, birth and maternity care [24] found that most fathers desired supporting their partners and engaging fully with the process of becoming a father. As shown by Wells [25] if the fathers do not receive support in the postnatal period, they are in danger of being estranged from their parental role; this is unfortunate for them as individuals and for the outcomes of the children, families and society. A meta-synthesis of parental experiences of early postnatal discharge concluded that early postnatal discharge might influence the initial process of feeling secure and confident, as parents depend positively or negatively on the postnatal care [10]. However, the majority of previous research is about women's experiences [26–28] and there is a scarcity of knowledge regarding mothers' and fathers' shared and individual experiences of municipal healthcare in the postnatal period.

THE STUDY

Aim

The study aims to describe mothers' and fathers' experiences with the public health nursing and Child and Family Health Centre services in the postnatal period, both as a couple and as an individual.

Design

The research design is qualitative and phenomenological, using individual and couple interviews as a data collection method.

Method

This study is based on a descriptive reflective lifeworld research (RLR) approach [29]. In RLR the focus is on meaning as the essential structure and the methodological principles are openness, flexibility and 'bridling' [29, 30]. Bridling means to slow down the process of understanding, focussing on not making definite what is still indefinite [29]. An open stance is crucial and implies having the capacity to be surprised and sensitive to the unpredicted and unexpected [29]. The data were collected and transcribed

by the first author (BKH) and the two co-authors (TB and MA), who are well-experienced qualitative researchers, fostered and took part in the reflective process of analyzing the data. Critical reading and discussions have been of crucial importance, and the researchers have problematised and reflected on taken-for-granted assumptions in order to allow the phenomenon to present itself more fully [29, 30]. This included following the Consolidated Criteria for Reporting Qualitative Research [31].

Study setting and participants

The study setting is Norwegian public health nursing. In Norway, children have the right to essential medical care and check-ups in the municipality where they live [6]. CFHCs provide free of charge, low-threshold and universal health services for children from 0 to 5 years and their families, following a standardised programme with regular consultations. The parents are offered a home visit 7–10 days after birth by a PHN, group consultation at 4 weeks of age and individual consultation when the child is 6 weeks old, both at the CFHC. In Norway, the Edinburgh Postnatal Depression Scale (EPDS) [32] is used by many CFHCs as a method for mapping mothers' mental health and well-being during the 6-week consultation. Although the primary caregivers at the CFHCs are PHNs, an early home visit by a midwife is also recommended. The aim of postnatal healthcare aims to support the parents and facilitate early parent–child attachment and mastery of the parental role. In addition, emphasis is placed on the child's development and the parents' mental health and well-being [6, 33]. In Norway, CFHCs have daytime opening hours and are closed on weekends.

Ten couples (10 mothers and 10 fathers) participated in the study. Two of the parents came from another Nordic country, and the rest of the parents came from Norway. Inclusion criteria were parents with different sexes who had recently become parents, with the mother discharged from the hospital within 3 days after birth with a healthy baby and no need for additional follow-up from health care professionals. Both parents were required to have mastered a Scandinavian language and planned to utilise CFHC services (see Table 1 for the characteristics of the participants). The recruitment of participants was done with the help of midwives at one hospital, and from midwives at a CFHC in one county in the southwestern region of Norway. In addition, two couples were recruited by snowball sampling. The participants had different occupational backgrounds and worked in health and social care, the oil industry, in kindergartens, as mechanics, electricians, craftsmen and in research.

TABLE 1 Characteristics of the participants ($n = 20$)

Gender	**Women**	**Men**	
	10	10	
Age			
Min-Max	24–33	24–33	
Living status			
Living with the mother/father of the child	10	10	
Children			
First child	6	6	
Second child	4	4	
Home visit			
Public health nurse	10	9	
Midwife	6	6	
Four-week check-up at CFHC	8	0	
Group	5	0	
Individual	3	0	
Six-week check-up at CFHC	10	3	
EPDS-mapping	8	0	
Family place of residence			
Urban area (100,000 +/−)			Three families
Rural area (20,000 +/−)			Seven families

Data collection—joint and individual interviews

As lifeworld research does not seek preconceived answers [29], the interview was carried out with a focus on establishing a dialogue that enabled a common reflection on the parents' experiences. The parents were interviewed twice, and the data consist of verbatim transcriptions from semi-structured interviews with ten couples. The joint interviews give the parents the opportunity to negotiate and jointly construct their responses [34], although in some cases one partner might dominate the interview and silence the other [35]. As researchers, it is important to be reflexive during the research process and be aware of potential risks to respondents and consider how our choice of data collection method may affect both the interpretation and analysis of the data, and the well-being of the participants and their relationships. By using this multi-level approach, we incorporated a form of triangulation where the individual interviews gave an opportunity to follow up on topics discussed in the joint interview and create a room for reflection between the joint and individual interviews. By looking at both dyadic and individual perspectives as units of analysis, there is a potential to gain a rich picture of the phenomenon under inquiry [36, 37].

The first interview was a joint interview conducted shortly after returning home from the hospital after birth, and the second was an individual interview at the end of the postnatal period. In the joint interviews, some questions were for common reflection, like: 'can you please describe how you have experienced the postnatal period so far' and 'what do you know about the CFHC service and how did you get this knowledge?' and others were directed at the mother or father, like: 'if you have been in contact with the PHN or CFHC, what are your experiences with the service?'. Some of the joint interviews were characterised by the mother being the most talkative, but there were also interviews where the father's voice dominated, and in these cases, the interviewer deliberately tried to include the other informant by asking questions about his or her experiences, perspectives and opinions. The interviews were conducted and transcribed verbatim by the first author from autumn 2019 to spring 2020. All parents chose their homes as the setting for the interviews. There were in total 30 interviews lasting between 10 and 60 min, with an average length of 35 min.

Analysis

The RLR approach guided the analysis [29]. Based exclusively on the collected data, the aim was to describe the phenomenon without seeking the interpretation [38]. The first author (BKH) analyzed the data under the supervision of the co-authors (TB and MA) who read excerpts from the extracts. The focus was on being open and flexible, striving to have a bridled attitude while seeing each part of the text in terms of the whole while simultaneously understanding the whole in terms of its parts. Following the movements of the text, the first author emphasised being present with the data as given by the parents in the lifeworld interviews, aiming at understanding the text on its own terms. To be open and receptive to the phenomenon under study, we reflected upon our preunderstanding shaped by our theoretical backgrounds, international professional experiences as PHNs and being mothers. Throughout the analysis, we repeatedly discussed alternative meanings to a given meaning unit, and based on differences and similarities, meaning units were clustered together. The clusters of meaning were re-read, and the process continued through common reflection by carrying on a dialogue with the text until a pattern in the clusters appeared. Eventually, the essential meaning structure and the constituents of the phenomenon emerged. Quotes from the joint (J) and individual (I) interviews were coded with numbers and presented under each quotation. The process is illustrated in Table 2.

Ethical considerations

The Regional Committee for Medical and Health Research Ethics West (reg. no: 2019/7220) and the Norwegian Centre for Research Data (NSD) (project number: 420055) approved this study, and the ethical considerations are based on the principles in the Helsinki Declaration [39]. According to NSD's template, a data management plan was prepared [40]. Informed consent was obtained from all participants, and they received both oral and written information on the study and were ensured of their right to withdraw from the study at any time.

FINDINGS

The essential meaning structure of parent's experiences with PHN and CFHC services in the postnatal period is characterised by the parents longing to be seen and confirmed as unique individuals and as a family by the PHN when learning to care for the baby. While striving to get to know and care for the newborn, the parents simultaneously focus on taking care of their own and older children's well-being, and try to relieve and support each other. An increased need for both lay- and professional care is prominent, and the mothers and fathers want to be seen and met by the PHN, and get confirmation that they are good enough as parents. The home visit enables the PHN

TABLE 2 The three phases of the data analysis Dahlberg et al., [29]

Phase 1		Phase 2	Phase 3
Reading/rereading of transcripts		Clusters of meaning	Gathering clusters of meanings in patterns
Extract from interview	Content	Meaning unit	Constituent
'I feel that my need for security and care is much greater than usual. The vulnerability comes out very clearly [...] one is in a way a bit bare—one needs a little care' JM6	Having a baby has made the mother more vulnerable and in need of care	Experiencing increased vulnerability in the initial postnatal period	Feeling a bit skinless with an increased need of care
'The first few days after we got home, I probably stressed a little extra with breastfeeding. There was a lot of hormones and little sleep' JM9	An experience of increased stress the first days at home with a newborn baby		

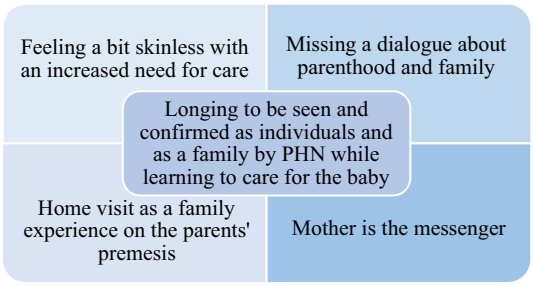

FIGURE 1 Overarching theme and constituents of parents' experiences with public health nursing and CFHC services in the postnatal period.

to become acquainted with the family and gives insight into their lifeworld. The home visit contributes to safety and lay a foundation for further collaboration between the PHN and the parents. The parents draw a varied picture of their further contact and experiences with the PHN, demonstrating a perception that the CFHC services are focussing almost exclusively on the mother and child. A further description of the phenomenon is followed by its four constituents: *Feeling a bit skinless with an increased need for care, Missing a dialogue about parenthood and family, Home visit as a family experience on the parents' premises and Mother is the messenger*. Overarching theme and constituents are illustrated in Figure 1.

Feeling a bit skinless with an increased need for care

Even though having a baby was described as a joyful experience, a vulnerability associated with establishing oneself at home as a new family was prominent in the initial postnatal phase. One mother described that she had a greater need for security and care and by using the metaphor 'skinless' she talked about the vulnerability she experienced the first days after returning home after birth. The parents emphasised that the care from family and friends was significant, and for the parents who lacked family support, CFHC played an important role in terms of providing extra professional care and being an arena contributing to establishing relationships with other parents: *'I have been there twice a week, the maternity group at the CFHC has meant a great deal to me' (JM3)*.

The interviews revealed a distinct difference between how the mothers and fathers experienced the follow-up from the PHN. One father stated: *'I haven't been in contact with the CFHC after the home visit. The mother has been there during the postnatal period, but I don't think it was expected that I should come' (IF8)*. The mother, on the other hand, said that the PHN had been essential for her during the postnatal period, especially in relation to her mental health. Several parental couples reflected on how their well-being mattered to the baby. Childbirth and postpartum were described as a journey through the physical and psychological, from chaos to stabilisation and normality. In this phase mental health was something that concerned the parents.

> The six-week check-up was in her (PHN) office where we sat down and went through this screening for postpartum depression. Then we got much more into how I actually felt, and that was perhaps why I also got a stronger feeling of making contact with her.
>
> (IM6)

The fathers were not offered a conversation about their mental health and well-being when the postnatal period was over: 'I would like to tell the PHNs that they must

invite both parents to the six-week check-up. That both parents have to come! I think it would have been good for men too, to fill out such a form about their mental health' (IF8).

Missing a dialogue about parenthood and family

Taking care of the baby, older siblings and each other was something the parents' described as particularly important. Having a child was perceived as a joint project, which creates a mutual dependency between the parents. Through the parents' reflections, a perception of a missing family perspective was revealed. This was expressed through statements related to the parents' experience that the PHN's intentionality was mainly directed at the mother and baby. Having this mother–child focus was described as natural and reassuring, but at the same time, the parents expressed that they missed being seen more as a unit in which all family members play a role in 'the becoming of a new family'.

Several parents said that even if you try to prepare as best you can, you will never fully know what it means to be a mother or father before the baby is born. In the joint interview, a parental couple had a dialogue about the change that had happened to them as individual persons when becoming parents:

> Then we became in a way two new people. Before, we were just ourselves, really ... and now we are actually parents. It's a whole new role that you suddenly have—which comes very overnight, really [...] we must get to know each other again.
>
> (JM2)

One of the fathers described how life had changed after he became a father, and while reflecting on the topic he suddenly realised that their new roles as parents had in a way displaced their previous roles as a loving couple and that it had been a bit challenging.

A longing to be confirmed as a unique individual was expressed through the parents' descriptions of a lack of focus on the father and his significance for the baby and the rest of the family in the postnatal period.

> Going from being a couple to becoming parents is a big change. And I think there are many relationships that break up because mom feels that dad is not contributing enough. So, I think it's important ... to see dad more. Perhaps several relationships could have been saved then.
>
> (IM10)

Home visit as a family experience on the parents' premises

The home visit was perceived by the parents as a family experience, and the establishment of contact with PHN in the home environment contributed to increased security. The home visit was described as concrete care and attention and experienced by the parents as being met more on their own terms. 'It has been great to get the first follow-up at home. It is very nice to have your own PHN which you are followed up by and which you can contact if there is anything, in addition to the regular checks' (JM6).

In the encounter with the health personnel at the hospital, the parents felt more like recipients while in their own home environment they experienced a shift in the balance of power and became more active participants. Information about what should happen in the future, such as which check-ups and vaccines were planned for the baby, was described as important for the parents to grasp as early as possible. Being seen, listened to and taken seriously gave the parents increased security in mastering the care and nurturing of their baby. The fact that both mother and father could ask questions and receive evidence-based answers was emphasised as important by several parents.

> She stayed here a long time and I did not feel that I delayed her. She took her time and answered all our questions. She was just really good and calm in relation to everything and ... I did not feel stupid when I asked about things.
>
> (IM2)

Support, recognition and professionalism invited a trusting relationship and helped to lay a good foundation for further cooperation between the parents and the PHN.

Mother is the messenger

Several mothers said that they had developed a trusting relationship with their PHN and experienced they were followed up systematically. At the same time, some mothers expressed that they perceived that the fathers were not given the same opportunities and were not

incorporated to the same extent in consultations with the baby.

> As a mother I have not missed anything, but I think they (PHNs) must see father to a greater extent. I've been thinking about how they can handle it when I am the one who always goes to the CFHC, and the father is at work. Then it becomes the mother's role to be a messenger.
>
> (IM3)

In the couple interviews, one mother and father became aware of some mechanisms that may have contributed to the father feeling excluded, such as the fact that the mother unconsciously viewed the contact with the PHN and CFHC as a 'mother task'. Several fathers described that they felt excluded by the PHN and the CFHC services. They experienced that the flow of information and contact solely took place between the mother and PHN, and some of them also expressed that they perceived that the CFHC was primarily a mother–child offer. One first-time father said:

> It can be a little difficult for the father as well in the beginning. All contact with PHN and CFHC goes through the mother, as a father you just have to follow. It has gone well for me, I like that the mother has some control, but the PHN and CFHC could have included me as father more.
>
> (IF5)

Accessibility, content and mandate were areas that occupied the fathers, and they shared views related to the service's opening hours, information exchange and the way PHN and CFHC communicated with the parents.

DISCUSSION

The postnatal period was experienced by the parents as both joyful and challenging. For the parents who lacked support from their families, the care from PHN was perceived as pivotal. Other studies of parents' experiences and needs postnatally have also identified the increased need for practical and professional support, information and care [8, 9]. The maternity groups offered at the CFHC contributed to build social relationships and were appreciated by the mothers. Previous studies support that maternity groups can create a basis for establishing networks for new families and facilitate PHNs to conduct health-promoting work [41, 42].

In this study, the parents reflected upon how the transition to parenthood had made visible a great responsibility to take care of themselves and each other when feeling a bit 'skinless', so that they were able to care for the baby. According to Eriksson [43], all human beings are natural caregivers. Based on a caring science perspective, providing care can be seen as an interactive process and an expression of reciprocity as described by the parents. The professional care is therefore not different from the natural one, but it is required to be not only technical but also holistic where the goal is to promote the person's overall health [43]. Our study found that establishing the new family was of major importance for the parents and they wanted to be recognised as equally important caregivers. Confirmation that they were good enough as parents and that everything was going well with the baby was essential. Even though the parents described a strong mutual dependency on each other, a missing family perspective was revealed in the encounter with the PHN. A mother–child focus dominated leaving the father in the 'shadows', which is unfortunate because individualised available support is shown to increase the parents' sense of security and parental confidence [10]. A family is a dynamic unit of unique persons in relation to each other already before the birth of the baby, thus the family in care can not be known only through one of its members [44].

Creating a family is described as demanding in terms of the baby having the main focus at the expense of the couple's relationship and PHN can play an important role in scaffolding the new family. Delicate et al. [17] describe relationship changes due to parents physically being focussed on the baby, leaving partners to feel left out or competing with the baby for affection. Transition to parenthood is a developmental transition, and the concept relates to how the individuals respond to changes they undergo and how new circumstances are incorporated and adopted into an individual's life [45]. The PHN might have an important role in contributing to preventing a relationship breakdown by having a dyadic focus in order to understand how to support the parents to identify and manage potential relational problems. This view is confirmed by Ahlborg et al. [46], who argue that by being aware of the possible strained situation of new parents, the PHN can support both on an individual and group level aimed at facilitating the parent and partner roles by focussing on communication skills and cohesion.

The parents experienced a lack of focus on the father's needs and significance for the baby and described it as adverse that the PHN's focus was only on the mother's mental health. When not feeling supported, fathers might feel unimportant, distant and helpless [25]. This finding is supported by Wiklund et al. [15] who found that a person-centred approach and empowering behaviour in the postnatal period was one of the most beneficial interventions for preventing postnatal depression. They suggest

family-centred care as a model that might improve postnatal care for mothers and fathers. In this study, becoming parents is perceived as an exciting period in life, which also represents increased vulnerability. The experience of home visits by PHN was described as a great contribution to increased security and seen by the parents as a family experience. Being able to get advice and guidance in relation to breastfeeding and other relevant issues was considered important and led to increased mastery of necessary skills. The home visit was also considered a good way to get to know each other and prepare the ground for further cooperation. These findings are supported by studies of parents' experiences of homecare, showing that mothers and fathers felt safe in their own home environment, indicating that it might be easier for health personnel to provide high-quality care that optimises the health and well-being of the whole family unit by providing home-based early postnatal care [47–49].

Several fathers described feeling excluded by the PHN and experienced that all contact and information took place between the PHN and the mother. These findings are in line with Hodgson et al. [21], who suggest that the father's needs are not being adequately met by healthcare professionals in the postnatal period. Despite a goal of providing municipal postnatal healthcare that embraces the whole family [33], change within services has been slow. As shown by Wells [25], more pressure is placed on the mothers to manage the child's health care when fathers miss the parent–child opportunities the CFHC services represent. Fathers are longing to be acknowledged as equivalent in the parenting dyad and the perception of support when becoming a father affects father–infant bonding [19]. Treating fathers as equal parents and giving them a participating role may contribute to strengthening their fatherhood identity [50]. Although the phenomenon of maternal gatekeeping may be tied to fathers' involvement and access to postnatal care [51], both fathers and mothers reflected upon how the PHN and CFHC could encourage fathers to participate by offering more flexible opening hours. This is in line with Wells & Sarkadi [52], who point to two main barriers to why CFHC still does not promote father involvement effectively. First, most CFHCs are only open during normal working hours, and second, the PHNs are not doing enough to directly encourage paternal participation.

Methodological considerations

The results in this study are based on a variety of data presented as an essence with its constituents, which is considered a core strength in phenomenological inquiry [29, 53]. The descriptions of the phenomenon have contributed to provide research findings that are generally valid for parents other than those involved in the present study [54]. Using a multi-level approach with a combination of joint and individual interviews, the mothers and fathers were given the possibility to co-create, discuss and individually reflect upon the topics raised in the interviews, which contributed to gaining a broader picture of the parents' lived experiences. Even though both joint and individual interviews have their limitations, the two approaches complement each other in elucidating different aspects of the parents' experiences [55]. One of the individual interviews lasted only for 10 min, mainly because the father had limited experiences due to minimal contact with the PHN and CFHC in the postnatal period, which on the other hand might be seen as a finding in itself. In reflective lifeworld research, even short interviews can contribute to nuances in descriptions and by interviewing the parents twice, illuminated aspects of the phenomenon in the joint interviews were further explored in the individual interviews. The findings in this study reflect a Norwegian context and a homogenous group of parents regarding education, employment and marriage or cohabitation. Future research might also include multicultural parents and parents with additional follow-up needs experiences in the encounter with the CFHC and PHN in the postnatal period.

CONCLUSION AND IMPLICATIONS

Our findings show that the PHN can contribute to strengthen parenthood and promote the whole family's health when the new baby is in focus. In a phase characterised as both joyful and vulnerable, being cared for when learning to care for the baby is pivotal. While the home visit is described by the parents as a good family experience contributing to increased security and mastery, the further contact with the PHN and CFHC is distinguished by most fathers having little or no contact with the service. Although the mothers describe postnatal care that to a large extent meets their needs, a greater family focus is required. The findings of this study expand our knowledge regarding what is important for mothers and fathers in the encounter with the CFHC services, suggesting a further development of postnatal care in order to meet the parents' unique individual needs, promote paternal participation and concurrently recognise the family as a unit where the whole family's health and well-being are important for the parents and their baby.

AUTHOR CONTRIBUTIONS

Bente Kristin Høgmo was involved in the study design, interviews, transcriptions, analyses and manuscript preparation. Terese Bondas and Marit Alstveit were involved in

designing the study and contributed to the analyses and manuscript preparation. All authors have agreed on the final version of the manuscript.

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CONFLICT OF INTEREST

The authors report no potential conflict of interest, and the authors alone are responsible for the content and the writing of the manuscript.

ETHICS STATEMENT

The Regional Committee for Medical and Health Research Ethics West (reg. no: 2019/7220) and the Norwegian Centre for Research Data (NSD) (project number: 420055) approved this study.

ORCID

Bente Kristin Høgmo https://orcid.org/0000-0003-1242-5623
Terese Bondas https://orcid.org/0000-0002-1023-6223
Marit Alstveit https://orcid.org/0000-0002-7834-6023

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