LUND UNIVERSITY

Antenatal preparation for the early parenthood period. Development and feasibility of an evidence-based programme for antenatal parental preparation

Pålsson, Petra

2020

Document Version:
Publisher's PDF, also known as Version of record

Link to publication

Citation for published version (APA):
Pålsson, P. (2020). *Antenatal preparation for the early parenthood period. Development and feasibility of an evidence-based programme for antenatal parental preparation*. [Doctoral Thesis (compilation), Department of Health Sciences]. Lund University, Faculty of Medicine.

Total number of authors:
1

General rights
Unless other specific re-use rights are stated the following general rights apply:
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.
• Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
• You may not further distribute the material or use it for any profit-making activity or commercial gain
• You may freely distribute the URL identifying the publication in the public portal

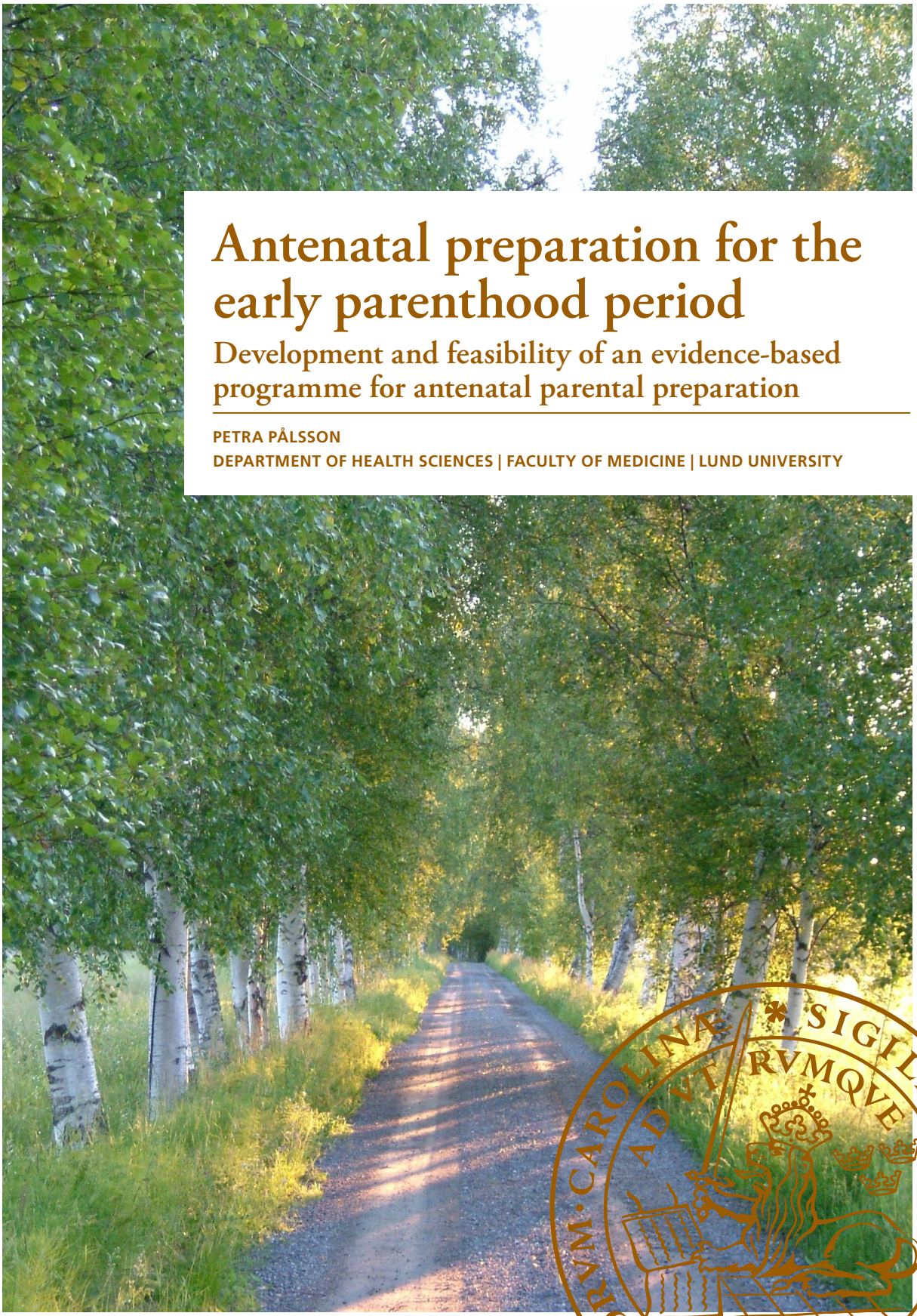
Read more about Creative commons licenses: https://creativecommons.org/licenses/

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

LUND UNIVERSITY

PO Box 117
221 00 Lund
+46 46-222 00 00

Download date: 26. Apr. 2024



Antenatal preparation for the early parenthood period

Development and feasibility of an evidence-based programme for antenatal parental preparation

PETRA PÅLSSON
DEPARTMENT OF HEALTH SCIENCES | FACULTY OF MEDICINE | LUND UNIVERSITY

Printed by Media-Tryck, Lund 2020 NORDIC SWAN ECOLABEL 3041 0903

LUND UNIVERSITY

FACULTY OF MEDICINE

Department of Health Sciences

Lund University, Faculty of Medicine
Doctoral Dissertation Series 2020:32
ISBN 978-91-7619-892-6
ISSN 1652-8220

Antenatal preparation for the early parenthood period

Development and feasibility of an evidence-based programme for antenatal parental preparation

Petra Pålsson

LUND
UNIVERSITY

DOCTORAL DISSERTATION
by due permission of the Faculty of Medicine, Lund University, Sweden.
To be defended at Health Science Centre, Lund on 27th of March 2020 at 09.00

Faculty opponent
Margareta Johansson, Associate Professor, Uppsala University

Organization	Document name
LUND UNIVERSITY	DOCTORAL DISSERTATION
Department of Health Sciences Faculty of Medicine	Date of issue 27 March 2020
Author: Petra Pålsson	

Title and subtitle: Antenatal preparation for the early parenthood period.
Development and feasibility of an evidence-based programme for antenatal parental preparation

Abstract

Parents often feel inadequately prepared for challenges of early parenthood. This thesis aimed to develop an evidence-based programme for antenatal preparation for early parenthood and to test its feasibility. The Medical Research Council's framework for development and evaluation of complex interventions was used to design the three studies.

Interviews were conducted with first-time parents; 18 mothers and 15 fathers, one month postpartum, about their experiences of preparation for parenthood. Phenomenographical analysis showed that access to support in the preparation helped parents gain knowledge and form realistic expectations. This in turn facilitated parents to strengthen their own resources and develop strategies to deal with challenges.

A cross-sectional study with questionnaires from 52 antenatal clinics and 108 midwives explored provision and experiences of antenatal parental preparation. Provision differed between clinics, web-based information was unfrequently used and midwives reported lack of skills in group-leadership and pedagogics.

Based on findings from these studies, a systematic literature review and theories related to self-efficacy and co-parenting an evidence-based programme for antenatal parental preparation was developed. Feasibility of the programme was pilot-tested in a cluster-randomised controlled trial. Three antenatal clinics with 19 first-time mothers and 14 first-time fathers formed an intervention group (IG) and four antenatal clinics with 20 first-time mothers and 18 first-time fathers the control group (CG). Data were collected with questionnaires from parents and midwives. Retention rates were 73% (IG) and 79% (CG). Significantly fewer mothers in IG than in CG reported lack of content in the programme (p=0.02). Parental self-efficacy increased more for fathers in IG (7.45; 95% CI -18.04 to 32.94) but not for mothers in IG (- 2.30; 95% CI -18.87 to 14.27) compared to counterparts in CG. More mothers in IG (75%) followed their intention to breastfeed exclusively than in CG (46%). Midwives reported sufficient training and supervision and provided the programme according to study protocol.
The programme was found to be feasible; to determine the cost-effectiveness a full-scale trial is required.

Key words: Prenatal education, parenthood, mother, father, midwife, self-efficacy, breastfeeding, antenatal care, pregnancy, complex intervention

Classification system and/or index terms (if any)

Supplementary bibliographical information		Language English
ISSN and key title 1652-8220 Lund University, Faculty of Medicine Doctoral Dissertation Series 2020:32		ISBN 978-91-7619-892-6
Recipient's notes	Number of pages 95	Price
	Security classification	

I, the undersigned, being the copyright owner of the abstract of the above-mentioned dissertation, hereby grant to all reference sources permission to publish and disseminate the abstract of the above-mentioned dissertation.

Signature Date 13th of February, 2020

Antenatal preparation for the early parenthood period

Development and feasibility of an evidence-based programme for antenatal parental preparation

Petra Pålsson

LUND
UNIVERSITY

Cover photo by Anna K Blomgren

Copyright Petra Pålsson

Lund University
Faculty of Medicine
Department of Health Sciences

Doctoral Dissertation Series 2020:32

ISBN 978-91-7619-892-6
ISSN 1652-8220

Printed in Sweden by Media-Tryck, Lund University
Lund 2020

Media-Tryck is a Nordic Swan Ecolabel
certified provider of printed material.
Read more about our environmental
work at www.mediatryck.lu.se
MADE IN SWEDEN

It takes a village to raise a child.

African proverb

Contents

Abstract 7

Abbreviations and Definitions 8

Original papers 10

Introduction 11

Background 13

- The transition to parenthood 13
  - Sense of security and postnatal depression 14
  - Attachment and child perspective 15
- Reproductive health and antenatal care 15
  - Breastfeeding 17
  - Parental support and antenatal parental preparation 17
- Frameworks 19
  - Methodological framework 19
  - Self-efficacy in Social cognitive theory 21
  - Co-parenting 22

Aims 23

Methods 25

- Design 25
- Context of the study 27
- Study populations and recruitment 27
  - Parents 27
  - Antenatal clinics and midwives 31

Randomisation 33
Regular antenatal parental preparation and design of the intervention 33
Regular antenatal parental preparation 33
The intervention 34
Data collection 36
Procedures in Study A 36
Procedures in Study B 36
Procedures in Study C 36
Interview guide 38
Questionnaires to antenatal clinics and midwives 38
Questionnaires to parents 40
Data analysis 42
Phenomenography 42
Preunderstanding 43
Statistical analyses 43
Ethical considerations 44
Beneficence and Non-maleficence 45
Autonomy 46
Justice 46
Findings 49
Development phase 49
Parental preferences and provision of antenatal parental preparation 49
A model of the intervention 52
Feasibility/piloting phase 54
Feasibility of the evidence-based programme 54
Estimated costs to provide the intervention 58
Internal consistency of measurements 59

Discussion 61
Methodological considerations 61
Trustworthiness 61
Reliability 63
Validity 63
General discussion of the findings 66
Development phase 67
Feasibility/piloting phase 69
Final remarks 72
Conclusions and clinical implications 72
Further research 73
Populärvetenskaplig sammanfattning 75
Acknowledgements 79
References 81
Paper I-IV
Appendix I-IV

Abstract

Parents often feel inadequately prepared for challenges of early parenthood. This thesis aimed to develop an evidence-based programme for antenatal preparation for early parenthood and to test its feasibility. The Medical Research Council's framework for development and evaluation of complex interventions was used to design the three studies.

Interviews were conducted with first-time parents; 18 mothers and 15 fathers, one month postpartum, about their experiences of preparation for parenthood. Phenomenographical analysis showed that access to support in the preparation helped parents gain knowledge and form realistic expectations. This in turn facilitated parents to strengthen their own resources and develop strategies to deal with challenges.

A cross-sectional study with questionnaires from 52 antenatal clinics and 108 midwives explored provision and experiences of antenatal parental preparation. Provision differed between clinics, web-based information was unfrequently used and midwives reported lack of skills in group-leadership and pedagogics.

Based on findings from these studies, a systematic literature review and theories related to self-efficacy and co-parenting an evidence-based programme for antenatal parental preparation was developed. Feasibility of the programme was pilot-tested in a cluster-randomised controlled trial. Three antenatal clinics with 19 first-time mothers and 14 first-time fathers formed an intervention group (IG) and four antenatal clinics with 20 first-time mothers and 18 first-time fathers the control group (CG). Data were collected with questionnaires from parents and midwives. Retention rates were 73% (IG) and 79% (CG). Significantly fewer mothers in IG than in CG reported lack of content in the programme (p=0.02). Parental self-efficacy increased more for fathers in IG (7.45; 95% CI -18.04 to 32.94) but not for mothers in IG (- 2.30; 95% CI -18.87 to 14.27) compared to counterparts in CG. More mothers in IG (75%) followed their intention to breastfeed exclusively than in CG (46%). Midwives reported sufficient training and supervision and provided the programme according to study protocol.

The programme was found to be feasible; to determine the cost-effectiveness a full-scale trial is required.

Abbreviations and Definitions

ANC	Antenatal clinic
CI	Confidence Interval
CNI	Care Need Index
CONSORT	Consolidated Standards of Reporting Trials
EPDS	Edinburgh Postnatal Depression Scale, instrument measuring risk for postnatal depression
MRC	Medical Research Council
PES	Parent Expectation Survey, instrument measuring parental self-efficacy.
PPSS	Parents' Postnatal Sense of Security, instrument measuring parents' sense of security the first postnatal week.
RCT	Randomised Controlled Trial
SEK	Swedish crown
UN	United Nations
WHO	World Health Organization
ANC Midwife	Midwife working in antenatal clinic.
Antenatal parental education	Term used in Paper III, corresponding to antenatal parental preparation.
Antenatal parental preparation	Measures to prepare for birth and parenthood during pregnancy.
Cluster	Group unit, in this study cluster refers to antenatal clinic.
Co-parent	Non-birthing parent.
Early parenthood period	The first month after the baby is born.

Family	A group of individuals with a continuing legal, genetic and/or emotional relationship considering themselves to be a family. (Institute for Patient- and Family-centered Care).
Family centre	Co-location and cooperation with antenatal clinic, child health services, open nursery school and social services.
Father	Male co-parent.
First-time parent	A parent who has no previous children.
Independent clinic	Antenatal clinic not co-located with child health services and open nursery school or organised in a Family centre.
Mother	In this thesis used for the birthing mother, although the fact that one in reality can be a mother without having given birth is acknowledged.
Parental group	Group of parents to whom antenatal parental preparation are provided.

Original papers

This thesis is based on the following papers:

I Pålsson, P., Persson, E.K., Ekelin, M., Hallström, I.K., & Kvist, L.J. (2017). First-time fathers' experiences of their prenatal preparation in relation to challenges met in the early parenthood period: Implications for early parenthood preparation. *Midwifery, 50*, 86-92. doi: 10.1016/j.midw.2017.03.021.

II Pålsson, P., Kvist, L.J., Ekelin, M., Hallström, I.K., & Persson, E.K. (2018). "I didn´t know what to ask about": First-time mothers' conceptions of prenatal preparation for the early parenthood period. *Journal of Perinatal Education, 27*(3),163-174. doi: 10.1891/1058-1243.27.3.163.

III Pålsson, P., Kvist, L.J., Persson, E.K., Hallström, I.K., & Ekelin, M. (2019). A survey of contemporary antenatal parental education in Sweden: What is offered to expectant parents and midwives' experiences. *Sexual & Reproductive Healthcare, 20*, 13-19. doi: 10.1016/j.srhc.2019.01.003.

IV Pålsson, P., Hallström, I.K., Persson, E.K., Ekelin, M., & Kvist, L.J. An evidence-based programme for antenatal parental preparation: A pilot study for a cluster randomised controlled trial. In manuscript.

The papers have been reprinted with permission from the publishers.

Introduction

Becoming a parent is a major life event that brings joy as well as challenges (Deave, Johnson, & Ingram, 2008; Nilsson et al., 2015; Åsenhed, Kilstam, Alehagen, & Baggens, 2014). Entering parenthood involves new roles, relationship changes and responsibilities for a new life; a baby who is dependent upon its parents or other guardians. Studies have shown that parents often feel unprepared for the challenges that parenthood brings (Buultjens, Murphy, Robinson, Milgrom, & Monfries, 2017; Entsieh & Hallström, 2016; Wells, 2016).

Lack of realistic expectations and support may inhibit transition to parenthood (Barimani, Vikström, Rosander, Forslund Frykedal, & Berlin, 2017; Harwood, McLean, & Durkin, 2007) whereas being prepared and having knowledge as well as receiving social and professional support may facilitate the transition (Bäckström, 2018; Barimani et al., 2017; Entsieh & Hallström, 2016; Meleis, Sawyer, Im, Hilfinger Messias, & Schumacher, 2000). Access to support for expectant and new parents is essential and included in the United Nations Convention on the rights of the Child, which since January 1 2020 is a Swedish law, as measures to increase children's health and development (UN, 1989; SFS 2018:1197).

Antenatal parental preparation is one way to provide support in the transition to parenthood and is often provided within antenatal care by midwives (Australian Department of Health, 2019; Gagnon & Sandall, 2007; Koushede et al., 2017; SFOG, 2016). However, parents often feel inadequately prepared, and it has been reported that focus of the preparation is rather on labour and birth than on parenthood (Barimani et al., 2017; Buultjens et al., 2017). Although there is evidence that fathers'/co-parents' involvement also has benefits for the mother and the baby (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008; Widarsson, Kerstis, Sundquist, Engström, & Sarkadi, 2012), studies have indicated shortcomings in how fathers' and co-parents' needs are met within the services providing parental support (Fenwick, Bayes, & Johansson, 2012; Steen, Downe, Bamford, & Edozien, 2012; Wells, 2016; Wells & Lang, 2016).

Previous research regarding interventions in antenatal parental preparation in Sweden has mainly focused on preparation for birth (Bergström, Kieler, & Waldenström, 2011). There is a need to develop antenatal parental preparation to correspond to parents' needs and to provide better evidence-based practice (Buultjens et al., 2017; Gilmer et al., 2016). Preparation for early parenthood tailored to the needs of expectant

parents may improve the start for the whole family and increase the child's possibilities for good health and development, which in turn could also have a positive health economic impact on society. Thus, it is important to gain knowledge of parents' needs for antenatal parental preparation and how these can be met within antenatal care in order to develop evidence-based antenatal parental preparation.

Background

The transition to parenthood

Transition means undergoing changes over time (Meleis et al., 2000). For the pregnant mother-to-be, pregnancy also involves bodily changes which makes her transition to parenthood more apparent. On the other hand, fathers-to-be may, during the pregnancy, experience feelings of unreality in relation to becoming a parent (Baldwin, Malone, Sandall, & Bick, 2019; Draper, 2003; Åsenhed et al., 2014). Engaging and being involved in the pregnancy, for example by participating in activities confirming the pregnancy, such as ultrasound examinations (Draper, 2003; Ekelin, Crang-Svalenius, & Dykes, 2004; Fenwick et al., 2012; Widarsson, Engström, Tydén, Lundberg, & Hammar, 2015) and antenatal parental preparation (Draper, 2003; Widarsson et al., 2015) help fathers in their transition to parenthood. Studies also show that being involved is just as important in transition to parenthood for co-parents who are not heterosexual fathers (Klittmark, Garzón, Andersson, & Wells, 2019; Wells & Lang, 2016; Wojnar & Katzenmeyer, 2014).

While becoming a parent involves feelings of excitement, joy and love it also can be experienced as overwhelming and stressful. The transition to parenthood is a challenging period in life for parents-to-be who strive to be confident and adapt to their new roles (Baldwin et al., 2019; Deave et al., 2008; Nilsson et al., 2015; Svensson, Barclay, & Cooke, 2006; Åsenhed et al., 2014). Preparation and knowledge facilitate the transition (Barimani et al., 2017; Meleis et al., 2000) and parents often seek information in various ways to prepare for parenthood: literature, internet, talking to friends, relatives, professionals and attending antenatal parental preparation (Entsieh & Hallström, 2016; Widarsson et al., 2012). Realistic expectations have been shown to be important for adjustment to parenthood (Barimani et al., 2017; Choi, Henshaw, Baker, & Tree, 2005; Harwood et al., 2007) and Finnish researchers have reported a discrepancy between expectations and reality in postnatally depressed mothers (Tammentie, Paavilainen, Åstedt-Kurki, & Tarkka, 2004).

Both professionals and peers have been shown to be important sources of support for parents in this transition (Bäckström, 2018; Barimani et al., 2017; Entsieh & Hallström, 2016; Meleis et al., 2000); but studies have also indicated that men may have less access to peer support (Baldwin et al., 2019; Deave & Johnson, 2008). In a

Swedish study mothers and fathers who reported lack of parental role models also reported higher parental stress (Widarsson, Engström, Berglund, Tydén, & Lundberg, 2014). Parental stress is defined as an experienced imbalance in parental demands and resources (Andersson & Hildingsson, 2016; Widarsson et al., 2014) and a recent study has indicated parental stress to be a risk factor for marital separation (Widarsson, Nohlert, Öhrvik, & Kerstis, 2019). It has been reported that both mothers and fathers consider their partner to be the most important source of support during pregnancy and early parenthood (McKellar, Pincombe, & Henderson, 2008; Widarsson et al., 2012) and that both parents want the father to be involved during pregnancy (Deave et al., 2008; Entsieh & Hallström, 2016; Wells, 2016). When parents support each other and work together in their parental roles it has been found to reduce their parental stress (Durtschi, Soloski, & Kimmes, 2017; Feinberg, Jones, Kan, & Goslin, 2010) and positively affect their relationship (Durtschi et al., 2017).

Sense of security and postnatal depression

Security is connected to one's own resources and feelings of control, comfort and confidence and may be considered a basic need. It is a central issue during childbearing, influencing parents' behaviours and decision making (Werner-Bierwisch, Pinkert, Niessen, Metzing, & Hellmers, 2018). Studies have shown that a sense of security is important for parents' experience of the first postnatal week, it affects them as individuals, as a couple, for their start as parents and for the baby's wellbeing (Fredriksson, Högberg, & Lundman, 2003; Persson & Dykes, 2009; Persson, Fridlund, & Dykes, 2007; Persson, Fridlund, Kvist, & Dykes, 2011, 2012; Werner-Bierwisch et al., 2018). Earlier Swedish research has shown that parents' postnatal sense of security can be affected by a sense of healthcare professionals' empowering behaviour, affinity within the family, a sense of general wellbeing and for mothers also a sense of breastfeeding as manageable (Persson, 2010). Fathers' participation and involvement was shown to be an important factor affecting both parents' sense of security during childbearing (Persson et al., 2011, 2012; Werner-Bierwisch et al., 2018). According to a recent review, being prepared for parenthood contributes to an increased sense of security (Wiklund, Wiklund, Pettersson, & Boström, 2018).

There is also indication of an association between higher parental postnatal sense of security and lower risk for postnatal depression; results from a study by Persson & Kvist (2014) showed a significant correlation between parents' postnatal sense of security the first postnatal week measured by the PPSS-instrument (Persson et al., 2007) and risk for postnatal depression for both mothers and fathers two months after childbirth, measured by the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987).

The prevalence of maternal postnatal depressive symptoms in general populations is 12% (Massoudi, Hwang, & Wickberg, 2016; Shorey et al., 2018). However, among immigrant mothers a prevalence of 20% has been reported (Falah-Hassani, Shiri, Vigod, & Dennis, 2015). Fathers may also experience postnatal depression and studies have shown that between 6% and 8% of fathers report postnatal depressive symptoms (Cameron, Sedov, & Tomfohr-Madsen, 2016; Carlberg, Edhborg, & Lindberg, 2018; Massoudi et al., 2016). Postnatal depression has been shown to be associated with higher parental stress (Andersson & Hildingsson, 2016; Anding, Röhrle, Grieshop, Schücking, & Christiansen, 2016). The consequences of postnatal depression are not restricted to the individual suffering from the symptoms; studies have also shown that postnatal depression in one parent is associated with an increased risk for postnatal depression in the other parent (Massoudi et al., 2016; Ramchandani et al., 2008).

Attachment and child perspective

Parents' mental well-being may affect their parenting behaviour. According to a Swedish study both mothers and fathers with depressive symptoms at six weeks postpartum, reported impaired bonding with the baby at six months postpartum (Kerstis et al., 2016). It also has been shown that both maternal and paternal postnatal depression may negatively impact on children's health and development (Ramchandani et al., 2008; Vänskä et al., 2017).

Early childhood is an important developmental phase in a human's life with impacts on health in both short- and long-term perspectives. A secure attachment between the infant and its' parents, where parents understand, interact and respond to the infant's needs, lays the foundation for the child's development (Center on the Developing Child at Harvard University, 2016; Irwin, Siddiqi, & Hertzman, 2007)

Research has shown that fathers' involvement positively influences children's development and health (Levtov, van der Gaag, Greene, Kaufman & Barker, 2015; Sarkadi et al., 2008; WHO, 2007). Although the research has been based on fathers, this conclusion may likely be assumed for all co-parents. Promoting and supporting fathers'/co-parents' involvement is therefore important from a child perspective (UN, 1989; SFS 2018:1197).

Reproductive health and antenatal care

Reproductive health is defined by the World Health Organization (WHO) as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes"*

(WHO, 2004). Further, reproductive health has clear links to human rights and sustainable development where measures to increase reproductive health world-wide are included in the UN global goals (UN, 2015). One of the WHO's standards of reproductive healthcare is that every woman and her family should be provided with emotional support that is sensitive to their needs and strengthens their capability (WHO, 2016a). Midwives have an important role in reproductive healthcare and work within a partnership with women and their families to give support, care and advice (International Confederation of Midwives, 2017). Contributions to improved reproductive health can also be made outside the healthcare system, on a societal level, for example by social security systems for parental leave benefits, acceptance for breastfeeding in public areas, access to child care and work environments which allow mothers and fathers to combine working life with being a parent. However, access to healthcare that aims to increase reproductive health is essential. Antenatal care is one example and is defined as care during pregnancy by skilled healthcare professionals and includes risk identification, prevention and management of pregnancy related or concurrent diseases and health education and promotion. A minimum of eight healthcare visits during pregnancy are recommended in international guidelines. Organisation of antenatal care differs world-wide. Although midwives are common provides of antenatal care, it may also be provided by physicians and sometimes nurses (WHO, 2016b).

In Sweden, antenatal care was developed in the 1930s based on a British model to reduce maternal and infant morbidity and mortality. Initially, pregnant women were offered two visits and given health education in hygiene and new-born care. During the years the number of midwife visits has increased, in Sweden today 8-10 visits are offered during pregnancy and one follow-up visit 6-16 weeks postnatally. Antenatal care is provided in antenatal clinics (ANC) which may be organised at primary care level or at an out-patient clinic belonging to a hospital. Although most commonly organised as an independent clinic; some antenatal clinics are co-located in a family centre in close cooperation with child health services, social services and open nursery-school. Antenatal clinics may be publicly or privately owned, however all antenatal care in Sweden is provided free of charge (SFOG, 2016) and almost all women attend antenatal care. Midwives are the primary caregiver in antenatal care, as well as in labour and postnatal care, with possibilities for referral or consultation with physicians and other healthcare professionals if complications occur. Usually care provided in antenatal clinics is given by one set of midwives, care during labour and birth by other midwives and postnatal care by further midwives. The hospital is responsible for postnatal care in the first postnatal week. After the first postnatal week, midwives at the antenatal clinics offer maternal follow up care until 16 postnatal weeks while nurses in child health services offer follow up care for the baby and parental support.

Breastfeeding

Breastfeeding has short- and long-term health benefits both for the child and for the mother; even in high and middle-income countries breastfeeding has been shown to reduce morbidity and mortality (Victora et al., 2016). The World Health Organization recommends mothers world-wide to breastfeed exclusively until the baby is six months old and to continue breastfeeding up to two years of age or beyond (WHO & UNICEF, 2003; WHO, 2017).

World-wide, approximately 40% of all infants are breastfed exclusively up to six months of age (WHO, 2018). A recent study showed that the intention to breastfeed among expectant mothers in Sweden is high (Claesson, Myrgård, Wallberg, & Blomberg, 2019) as is the initiation of breastfeeding. Of the babies born in 2017, 95% were to some extent breastfed and 75% were breastfed exclusively one week after birth. Over the last 15 years a decline in breastfeeding rates during the baby's first months has been noted. At six month of age 63% of the babies born in 2017 were to some extent breastfed; however only 13% were breastfed exclusively (The Swedish National Board of Health and Welfare, 2019a). Although being natural, breastfeeding is an act to be learned (WHO & UNICEF, 2003). Several studies have shown that the experience of difficulties in the initial phase of breastfeeding is common (Colin & Scott, 2002; Feenstra, Jorgine Kirkeby, Thygesen, Danbjorg, & Kronborg, 2018; Wagner, Chantry, Dewey, & Nommsen-Rivers, 2013). The WHO global breastfeeding strategy requires that governments and healthcare give priority to promote and support their recommendations and to provide women access to the support they require to fulfil their breastfeeding intentions (WHO & UNICEF, 2003; WHO, 2017). This is a general recommendation, and individualised care should be provided based on the mother's well-informed decisions.

Parental support and antenatal parental preparation

Parental support encompasses activities provided within society for the support of parents in their parenting role (Daly et al., 2015; Swedish Ministry of Health and Social Affairs, 2018). Supporting parents is not only a measure for the sake of the parents, it is also a measure to increase children's health and development, in line with the UN Convention on the rights of the Child which is incorporated in Swedish law (UN, 1989; SFS 2018:1197). Measures to enhance early childhood environments is one of the most important societal investments in the promotion of child health and the reduction of inequalities in health. Furthermore, it has been pointed out that early and preventive interventions are likely to be cost-effective (Doyle, Harmon, Heckman, & Tremblay, 2009; Swedish Ministry of Health and Social Affairs, 2018). One way to support parents in transition to parenthood is antenatal parental preparation, which is

offered as parental groups or as auditorium lectures in many countries world-wide, with the aim to prepare expectant parents for childbirth and early parenthood (Australian Department of Health, 2019; Gagnon & Sandall, 2007; Koushede et al., 2017; SFOG, 2016). Content and form of antenatal parental preparation may differ and has been discussed through the years; criticism has been raised that provision of the preparation is more commonly based on views of professionals rather than on the needs of expectant parents (Gagnon & Sandall, 2007; Gilmer et al., 2016).

It is important that all parents are given the possibility to access support and antenatal parental preparation (UN, 1989; SFS 2018;1197; Swedish Ministry of Health and Social Affairs, 2018). However, it has been indicated that the needs of fathers and co-parents are not met within antenatal care nor in other healthcare services directed at parents: studies have shown that fathers feel invisible and excluded by healthcare professionals (Fenwick et al., 2012; Steen et al., 2012; Wells, 2016).

Diverse interventions aimed at the preparation of parents for the early parenthood period have been evaluated in studies and while several studies have reported effects on parental or child-related outcomes, not all have shown significant effects. An Australian programme for antenatal parental preparation with increased parenting content, provided in small parental groups with up to 11 couples and based on adult learning principles with problem solving activities and peer learning resulted in a significant increase in maternal self-efficacy (Svensson, Barclay, & Cooke, 2009). An American intervention with both antenatal and postnatal sessions focused on how parents can work together in their parental roles, showed significant effects on parental self-efficacy and a reduction in parental stress (Feinberg et al., 2010). This intervention was also shown to positively affect child-related outcomes such as soothability and sleep (Feinberg et al., 2016). A UK trial by Daley-McCoy et al. (2015) evaluated an intervention, provided as a complement to regular antenatal parental preparation and aimed at enhancement of relationship functioning during transition to parenthood. The intervention included promotion of realistic expectations on becoming parents and communication skills to optimise effective problem solving. Mothers who received the intervention reported less deterioration in relationship quality and fathers reported less deterioration in couple communication and less psychological distress compared to parents in the control group. However, in a Danish trial antenatal parental preparation provided in small parental groups with up to 16 parents with focus on psychosocial aspects and parenting resources was compared to auditorium-based lectures and showed no significant effects on parenting stress or parenting alliance (Koushede et al., 2017).

Since 1978 antenatal parental preparation in Sweden has been integrated in antenatal care and offered free of charge to expectant parents. The national aim of antenatal parental preparation is "*to promote children's health and development, to strengthen parents' ability to connect with the unborn and new-born baby and physical and psychological preparation for birth"* (SFOG, 2016 p. 71). Both parents are invited to

attend and approximately 67% of all expectant first-time mothers and 60% of their partners participate in antenatal parental preparation in Sweden (The Swedish Pregnancy Register, 2019). The form of antenatal parental preparation may vary, from small parental groups with the same participants meeting in recurrent sessions to large auditorium lectures. There is no set number of sessions included, it may vary between one and six across the country (The Swedish Pregnancy Register, 2019). There are suggestions for topics to include in antenatal parental preparation, based on professional experience (SFOG, 2016), although no guidelines exist. Although a large study among expectant parents showed that their main reason for participation in antenatal parental preparation was to gain security in being a parent and taking care of a new-born baby (Ahldén, Ahlehagen, Dahlgren, & Josefsson, 2012) it has been indicated that the main focus in antenatal parental preparation is labour and birth (Barimani, Forslund Frykedal, Rosander, & Berlin, 2018; Bergström et al., 2011; Fabian, Rådestad, & Waldenström, 2005).

It is important to develop antenatal parental preparation to correspond to both mothers' and fathers'/co-parents' needs (Entsieh & Hallström, 2016; Gilmer et al., 2016). There is no consistent evidence on the best way to provide antenatal parental preparation (Gagnon & Sandall, 2007; Gilmer et al., 2016) and intervention studies regarding antenatal preparation with focus on the early parenthood period in a Swedish context are lacking. To address these gaps in research it is important to gain knowledge of parents' needs for antenatal parental preparation and how these can be met within Swedish antenatal care in order to develop evidence-based antenatal parental preparation.

Frameworks

Three frameworks have been applied to this thesis; a methodological framework which has provided guidance in the development and testing of the intervention and two theoretical frameworks that provide support for the intervention and for the understanding of the likely process of change.

Methodological framework

The Medical Research Council's (MRC) framework for development and evaluation of complex interventions (Craig et al., 2008; MRC, 2008) was used as a methodological framework in this thesis. The framework, which aims to increase the quality of intervention studies, was published in 2000 and updated and extended in 2008. A second update will be published in June 2020. The framework provides structured

guidance and consists of four main phases: development, feasibility/piloting, evaluation and implementation (Figure 1).

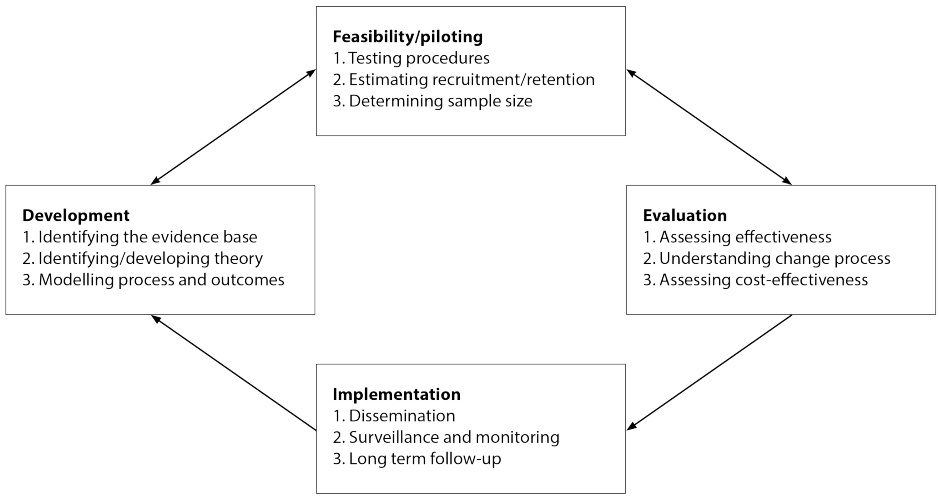


Figure 1. Phases in the MRC framework for development and evaluation of complex interventions (MRC, 2008).

In the development phase the evidence base is identified, ideally with a systematic literature review, and an appropriate theory identified or developed to underpin the intervention. It is important to consider the setting where the intervention will take place in order to increase the possibility for the intervention to be implemented in routine care in the future. When modelling the intervention, gaps in prior research and also facilitators and barriers should be identified in order to optimise the intervention. A model of the intervention should describe the active components, how they will work and what the expected outcomes are. The feasibility/piloting phase involves testing procedures for acceptability and estimating likely rates of recruitment and retention to determine sample size in an evaluation study. In this phase key uncertainties are addressed, for example: is delivery of the intervention feasible, will participants accept and adhere to the intervention and are the chosen outcome measurements appropriate? Based on the results, changes in the intervention or study procedures may need to be undertaken before proceeding to a full-scale evaluation. According to the MRC framework feasibility/piloting is an essential preparatory step, to avoid undermining an evaluation study with problems that could have been anticipated. The evaluation phase includes assessing effectiveness, understanding change process and assessing cost-effectiveness. To assess effectiveness of the intervention randomised controlled designs should be considered as this is the most robust method to minimise the risk of selection bias. Although, the framework also emphasises that randomisation is not always

possible or acceptable. A process evaluation can provide valuable insights into why an intervention may or may not work, for example by measuring concomitant treatment and intervention fidelity, i.e. were the interventions delivered according to the study protocol? Assessing cost-effectiveness will increase the usefulness of the study results and its chances of implementation. In the implementation phase, results from the evaluation and the intervention are to be disseminated and plans formed to implement the intervention on a larger scale in routine care. Implementation also involves continued evaluation with surveillance, monitoring and long-term follow-up to assess if previously shown effectiveness persists (Craig et al., 2008; MRC, 2008).

Care should be based on evidence and patients' needs and preferences, to provide the individual with best possible care. Following a framework such as the MRC framework for development and evaluation of complex interventions in healthcare is one way to systematically increase evidence-based care in clinical practice. Evidence-based implies integrating best available scientific evidence, clinical expertise and patients' perspective and preferences (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; The Swedish National Board of Health and Welfare, 2012).

Self-efficacy in Social cognitive theory

Being able to manage and adapt to the new role as a parent complies well with the concept of self-efficacy in social cognitive theory introduced by Bandura (1997). In social cognitive theory there is a triadic mutual causation between behaviour, internal personal factors and external environment. This means that behaviour is not only determined by personal factors but also by the external environment just as personal factors can be affected by behaviour and the external environment. Self-efficacy is one component of the theory and is described as a person's belief in one's own ability to perform a given activity in a certain situation. People with high self-efficacy are more likely to organise and take actions; to exercise control. Effective exercise of control is about adapting and integrating knowledge, skills and resources to manage changing situations (Bandura, 1997); in this context related to becoming a parent. For example, being able to comfort a crying baby, to maintain the relationship with one's partner or knowing where to turn for more information and support if needed. Self-efficacy can according to Bandura (1997) be attained from different sources of information where *enactive mastery experience* is considered the most influential source and is related to experiences of situations one proves to be capable of managing. Another way is by taking part in other peoples' experiences or learning from observing how others manage situations or deal with challenges, where peers may act as role models and one learns from others' mistakes as well as their success; this is called *vicarious experience*. It can also be attained by *verbal persuasion* in the sense that when other people express their faith in one's ability to manage a situation it may booster one's self-efficacy, especially

if the person giving the information is assessed as credible. On the contrary, a negative feedback may instead undermine one's belief in self-efficacy. *Physiological and affective states,* refers to how the individual perceives and interprets physical and emotional reactions in a situation and is yet another source of information in the construction of self-efficacy.

Co-parenting

Co-parenting as a concept in a framework developed by Feinberg (2002) relates to how parents work together in their parenting roles and includes four components: *support versus undermining* in the co-parental role, *differences on childrearing issues and values*, *division of parental labour* and *management of family interactions*. Support versus undermining in the parental role relates to parents' supportiveness of each other's competences, contributions and authority as parents. The component differences on childrearing issues and values involves the extent of agreement or disagreement and the importance of actively and respectfully negotiating resolutions of agreement, which may include parents being able to "agree to disagree". The division of parental labour includes duties and responsibilities related to the child and the household where the division should to be agreed on and perceived as fair and acceptable by both parents. Management of family interactions relates to resolving conflicts constructively without involving the child in the parental conflict and the aspect of balance between parents in interactions with the child when both parents are present. According to Feinberg's framework (2002), there is indication that the co-parenting relationship is more strongly related to parenting and child-related outcomes than other aspects of the couple relationship. Another advantage of the focus on co-parenting is that it has been suggested that the co-parenting relationship is generalisable to any relationship between individuals who share parenting responsibilities regardless of family structure.

Aims

The overall aim of this thesis was to develop an evidence-based programme for antenatal preparation for the early parenthood period, and to test the feasibility of the programme.

The thesis is based on four papers, each with its specific aim.

- To describe first-time fathers' experiences of their prenatal preparation in relation to challenges met in the early parenthood period (Paper I)
- To describe first-time mothers' conceptions of prenatal preparation for the early parenthood period (Paper II)
- To explore how antenatal parental education is provided in southern Sweden and midwives' experiences of working with antenatal parental education (Paper III)
- To test the feasibility of an evidence-based programme for antenatal parental preparation (Paper IV)

Methods

To explore the topic of antenatal parental preparation both qualitative and quantitative methods were used in this thesis. An overview of the designs and methods are shown in Table 1.

Design

This thesis includes three studies, described in four papers. The studies encompass the two first phases in the MRC framework for the development and evaluation of complex interventions (Craig et al., 2008; MRC, 2008); development (Study A and B) and feasibility/piloting (Study C).

Study A was designed to elucidate antenatal parental preparation from the perspectives of first-time parents with a new-born. An inductive, descriptive design with a phenomenographical approach was chosen and data were collected using individual interviews. Phenomenography was developed in Gothenburg during the 1970s, within the field of pedagogical research (Marton, 1981) and has later also been used in other research traditions such as health sciences (Sjöström & Dahlgren, 2002). A phenomenographical approach takes on a second order perspective which means that it aims to describe the world as it is experienced. Other qualitative methods assume a first order perspective and aim to describe the world as it is. Phenomenography emphasizes that different people have different ways of experiencing a phenomenon, but these variations are not endless, there seems to be a finite number in variation of conceptions (Marton, 1981; Sjöström & Dahlgren, 2002).

Study B had a cross-sectional design using questionnaires for data collection to describe how antenatal parental preparation was offered in the antenatal clinics and to elucidate midwives' views on working with antenatal parental preparation.

Table 1. Overview of the studies presented in this thesis

Study	Paper	Design	Sample	Data collection	Analysis	Time frame for recruitment and data collection
A	I+II	Inductive, descriptive	15 first-time fathers and 18 first-time mothers	Individual interviews	Phenomenography	March to June 2015
B	III	Cross-sectional	52 antenatal clinics and 108 ANC midwives	Questionnaires	Descriptive and comparative statistic Independent samples t-test, Paired samples t-test, Pearson's Chi-2 test, Cronbach's alpha	March to June 2016
C	IV	Pilot, cluster-randomised controlled trial	71 first-time parents (39 first-time mothers, 32 first-time fathers) and 6 ANC midwives	Questionnaires	Descriptive and comparative statistics Independent samples t-test, Fisher's exact test, Cronbach's alpha	September 2018 to October 2019

In Study C an intervention was developed and tested for feasibility in a pilot study designed as a cluster-randomised controlled trial following the CONSORT guidelines (Eldridge et al., 2016). Key uncertainties regarding acceptability, delivery of the intervention, recruitment and retention and responsiveness to outcome measurements were assessed and the findings present a basis for future studies.

In line with MRC's framework (Craig et al., 2008; MRC, 2008), a systematic literature review was conducted at the beginning of data collection (Entsieh & Hallström, 2016). Although the review was not included as a study in this thesis, its findings were used when modelling the intervention.

Context of the study

The studies were conducted in Skåne, a region in southern Sweden consisting of both urban and rural areas. Every year, approximately 16 000 babies are born in the region (Statistics Sweden, 2018a) and maternity healthcare is provided in a healthcare choice system with both public and private antenatal clinics. Women choose their antenatal clinic and all care is, irrespective of ownership of the clinic, publicly financed and free of charge. The antenatal clinics may be organised as independent clinics or as family centres and thereby co-located with child health services, open nursery school and social services. According to regional guidelines (Region Skåne, 2019a, 2019b) antenatal parental preparation should be offered to all expectant parents, however, no guidelines regarding form and content for antenatal parental preparation exist in the region.

Study populations and recruitment

The study populations are first-time parents, both expectant and with a new-born baby, and midwives working in antenatal clinics.

Parents

In Study A a strategic sample of 22 first-time mothers and 18 first-time fathers from three postnatal units in hospitals in southern Sweden were approached with information about the study. The recruiting units were selected based on possibilities to recruit parents from both urban and rural areas with experiences of both normal and complicated births. Inclusion criteria were first-time parent with speaking skills in Swedish or English sufficient to carry out a conversation and with an infant not cared

for on a neonatal intensive care unit (NICU). Strategic sampling aimed to optimise variation in age, education, ethnicity, place of antenatal care and mode of birth. Parents were identified and approached by midwives at the postnatal units who asked if the author of this thesis was allowed to personally provide them with information about the study. Twenty-one mothers and 18 fathers gave consent to be contacted for an interview four weeks later. When contacted again to schedule the interview two mothers and three fathers had changed their mind and one mother was not possible to contact. In total 18 first-time mothers and 15 first-time fathers participated in individual interviews. Most commonly the participating mothers and fathers were in a couple relationship. However, this was not a criterium for inclusion and the sample also includes parents where only the mother or father participated. All but one mother and one father had attended at least one group session of antenatal parental preparation.

In Study C posters about the study were displayed in the participating antenatal clinics and all expectant first-time mothers arriving for a registration visit in the first trimester and their partners received information about the study from the midwives. Cluster randomisation of antenatal clinics was used, expectant parents were not randomised, and the study information did not reveal information about intervention or control group allocation but stated that differing modes to provide antenatal parental preparation would be evaluated in the study. Inclusion criteria were first-time parents who understood spoken and written Swedish and who intended to participate in group-based antenatal parental preparation. Nineteen first-time mothers and 14 first-time fathers were recruited to the intervention group and 20 first-time mother and 18 first-time fathers to the control group. Details of recruitment and retention of the expectant parents is shown in Figure 2

A profile of the parents participating in Studies A and C is shown in Table 2. As no same-sex co-parents were among those recruited to the studies the term father is used.

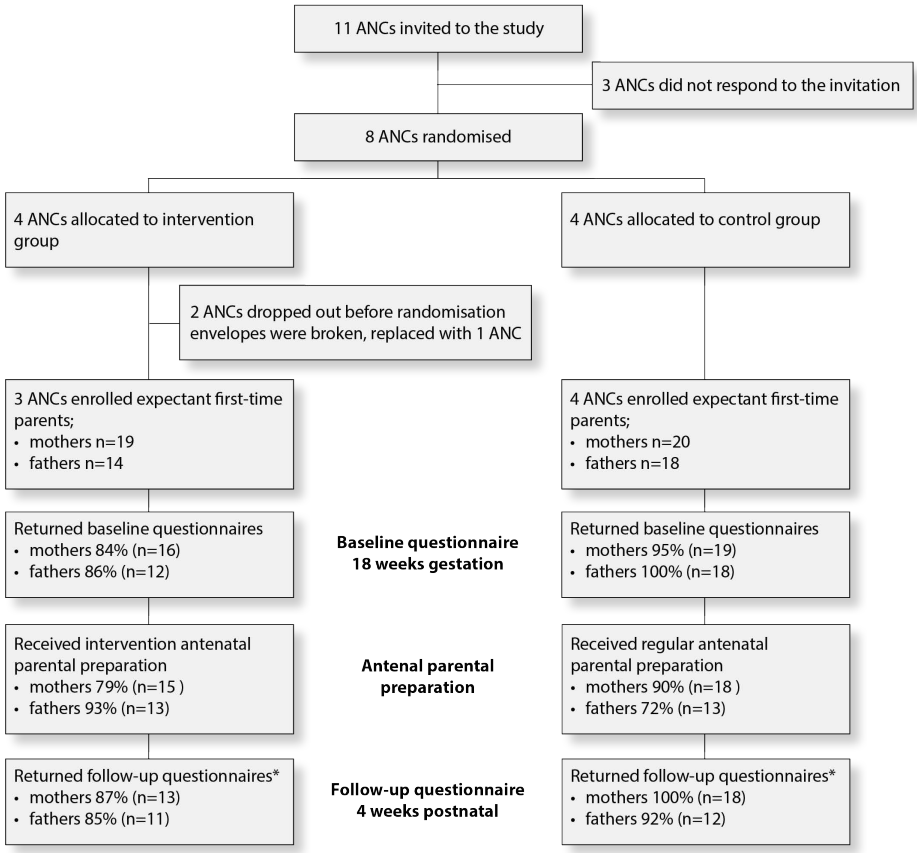


Figure 2. Flowchart of participating antenatal clinics and parents in Study C.

Table 2. Profile of the participants in Study A and C

		Study A		Study C			
		Mothers	Fathers	Mothers		Fathers	
		N=18 n	N=15 n	Intervention group N=16 n (%)	Control group N=19 n (%)	Intervention group N=12 n (%)	Control group N=17 n (%)
Age	m			29.94	31.79	31.50	33.24
	(SD)			(5.51)	(3.60)	(4.62)	(5.50)
	min – max	18-42	19-37	22-40	26-40	25-40	26-42
Country of birth	Sweden	12	9	14 (87.5)	18 (94.7)	8 (66.7)	16 (94.1)
	Other Nordic	1	1	0	0	1 (8.3)	1 (5.9)
	Europe, outside Nordic countries	3	3	1 (6.25)	1 (5.3)	1 (8.3)	0
	Middle-east	2	1	1 (6.25)	0	2 (16.7)	0
	Other Asian	0	1	0	0	0	0
Civil status	Living with partner/co-habiting	17	15	15 (93.75)	19 (100)	12 (100)	17 (100)
	Living alone/single	1	0	1 (6.25)	0	0	0
Education	Basic schooling	2	1	0	0	0	0
	Upper secondary school	4	6	6 (37.5)	3 (15.8)	2 (16.7)	6 (35.3)
	University	12	8	10 (62.5)	16 (84.2)	10 (83.3)	11 (64.7)
Occupation	Working			16 (100)	19 (100)	11 (91.7)	17 (100)
	Student			0	0	1 (8.3)	0
History of treatment for mental illness	Yes			6 (37.5)	5 (26.3)	3 (25.0)	3 (17.6)
	No			10 (62.5)	14 (73.7)	9 (75.0)	14 (82.3)

Antenatal clinics and midwives

Managers of all 82 antenatal clinics in Skåne were informed about Study B and managers of 66 clinics (80.5%) gave permission to send out questionnaires to the midwives working in the antenatal clinics. One questionnaire was addressed to the 66 antenatal clinics and one was addressed to 189 individual midwives. The questionnaire to the antenatal clinic was responded to by 52 clinics (78.8%). One hundred and eight (57.1%) midwives participated by answering the individual questionnaire. Characteristics of the participating antenatal clinics and midwives in Study B are shown in Table 3.

Table 3. Profile of antenatal clinics and midwives in Study B

		Antenatal clinics	**Midwives**
		N=52 n (%)	N=108
Type of care provider	Public Private	28 (53.8) 24 (46.2)	
Co-location with other services for families with small children	Yes, ANC with Child Health Services (CHS) Yes, ANC with CHS and open nursery school Yes, ANC with CHS, open nursery school and social services No Missing	17 (33.3) 2 (3.9) 11 (21.6) 21 (41.2) 1	
Number of midwives working in the clinic	Mean (SD) Min-Max	3 (1.7) 1-8	
Age	Mean (SD) Min-Max		50.7 (8.5) 32-66
Years of professional experience as midwife	Mean (SD) Min-Max		19.7 (10.3) 1-43
Years of experience of leading parental groups in antenatal parental preparation	Mean (SD) Min-Max		12.2 (9.4) 0-38
Experiences of type of parental groups	Small group, n (%) Large group/lecture Missing		104 (97.2) 35 (32.7) 1

In Study C, 11 antenatal clinics, identified in Study B as providing the most common programme for antenatal parental preparation (regular antenatal parental preparation) were invited to participate in the pilot study for a cluster randomised controlled trial. Eight antenatal clinics accepted the invitation, and seven participated in the study. All antenatal clinics in the study were independent clinics, three private and four public, with a good geographical distribution consisting of both urban and rural areas in Skåne, see Figure 3.

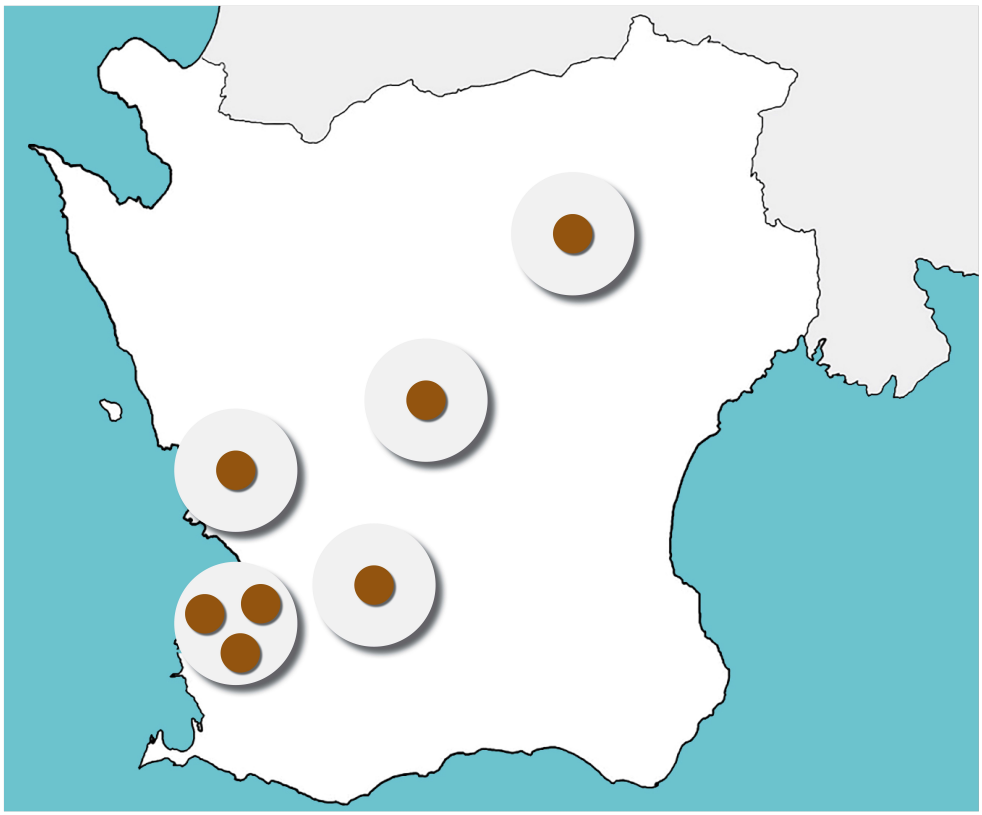


Figure 3. The locations of participating antenatal clinics in Study C.

Seven midwives working in the three antenatal clinics randomised to the intervention group received training on how to provide the intervention (further described under the intervention) and six of them were invited to respond to an evaluation form regarding the training day, all six midwives responded. The seventh midwife received her training on a separate occasion after the evaluation forms had been analysed and therefore, she was not asked to fill in an evaluation form. Due to leave of absence and work-related conditions three of the midwives who received training were not involved

in providing the intervention. Four midwives provided the intervention to expectant parents in the intervention group and were invited to participate in an evaluation of the acceptability of the intervention from a provider perspective, all four midwives responded to the questionnaire.

Randomisation

In Study C cluster randomisation of antenatal clinics was applied. Prior to randomisation; the antenatal clinics were stratified according to Care Need Index (CNI) which is based on sociodemographic variables of expectant mothers registered in the antenatal clinic (Sundquist, Malmström, Johansson, & Sundquist, 2003). Five variables are used to assess CNI for antenatal clinics in Skåne: being unemployed, born outside Europe, single parent, having moved house during the last year and low education level increases the CNI-value. Index value is 1 and higher values are related to increased risk for ill health and illness (Centre of knowledge women's health & Centre of knowledge child health services, 2019) A mean value for CNI at the participating antenatal clinics was calculated (mean 0.85; range 0.57-1.31): clinics below the mean value formed one strata and those above formed a second strata. The randomisation was performed by an external statistician using the SAS 9.4 software (SAS Institute Inc., Cary, NC, USA). Four antenatal clinics were randomised to the intervention group and four to the control group. The author of this thesis received coded, sealed and opaque envelopes to be opened in the presence of staff at the antenatal clinics. Two antenatal clinics dropped out due to staff shortages before the randomisation envelopes were opened. It was possible to replace one of the clinics by another with a similar CNI in the same geographical area.

Regular antenatal parental preparation and design of the intervention

Regular antenatal parental preparation

In regular antenatal parental preparation groups of 8-16 parents were offered two or three 2-hours-sessions. This was the most common programme for antenatal parental preparation offered in the geographical area under study (Paper III). The first session included an introduction and most often topics related to normal birth and pain relief. Most commonly, there was a continued focus on birth related topics for the second session, including birth complications and postnatal care. If a third session was offered, this generally comprised breastfeeding, early parenthood, baby's needs and care and

introduction to child health services. If only two sessions were provided, the content was compressed. A table showing a comparison between the programmes in regular antenatal parental preparation and the intervention is presented in Paper IV (page 6).

The intervention

The intervention included five 2-hour sessions in groups of 8-16 parents; an overview of the order and content of sessions given in the intervention is shown in Table 4.

Table 4. Overview of sessions in the intervention

Session	Themes	Content
1	Introduction Co-parenting	Introduction Co-parenting – short presentation and discussion, home assignment to discuss with partner expectations of oneself and ones' partner
2	Early parenthood	What is early parenthood like - discussions with new parents Home assignment related to breastfeeding challenges and web-based information
3	Breastfeeding The new-born baby Early parenthood	Breastfeeding – film Follow up of home assignment on breastfeeding and discussion Baby's needs and care – discussion from child and parental perspectives Early parenthood – discussion on emotional reactions, postnatal depression and relationship Where parents can get access to support
4	Birth	Normal birth, pain relief and birth complications
5	Birth and post-natal care	Continuation from session 4 on birth Postnatal care Physical recovery from birth Practical information – women's clinic/hospital, child health services and postnatal visit at antenatal clinic "Rounding up"

A pedagogical approach based on adult learning principles, which includes problem-solving activities and participatory learning (Entsieh & Hallström, 2016; Knowles, Swanson, & Holton, 2015), was applied in the intervention in order to increase parents' self-efficacy (Bandura, 1997). In order to create a joint focus for both parents at the beginning of the programme, topics related to parenthood were given precedence and

therefore presented first. Co-parenting (Feinberg, 2002), relating to how parents work together in their parenting roles, was central to the intervention and was introduced in a short opening presentation followed by discussion among the parents on how co-parenting can be supported. Parents were encouraged to share their expectations with their partner in a home assignment. In order to increase possibilities for peer learning (Bandura, 1997; Knowles et al., 2015) the midwife invited parents with new-borns to one of the sessions to share their experiences of early parenthood with the parents-to-be. The invited parents with new-borns had during pregnancy been cared for at the antenatal clinic. If none of the invited parents with new-born babies showed up, a written manual for the intervention provided the midwives with a second option to use. This option was for the parents to discuss in groups: "What do you most look forward to in becoming a parent?" and "Which do you think will be the greatest challenges of early parenthood?" Further, a home assignment related to finding information on causes and solutions for possible breastfeeding challenges was incorporated: guidance to knowledge-based websites was provided by the midwife (Knowles et al., 2015). Baby's needs and care were discussed from both a child perspective and a parental perspective; for example, what a crying baby might try to convey and how one can feel as a parent when it is difficult to comfort the baby. Content regarding preparations for labour and birth did not differ between regular antenatal parental preparation and the intervention but the order of topics did; in the intervention this topic was presented in the last two sessions.

Training and support to intervention providers

One to three months before the first parental group in the study, a psychologist with clinical and educational experience in maternal and child healthcare provided a full day's training (8 hours) for the midwives who were to provide the intervention. The training included group leadership skills to facilitate peer learning among parents including adult learning principles (Knowles et al., 2015), orientation to knowledge-based websites, how to introduce a framework for co-parenting and a manual for the programme. Between one and two months after the training day, the midwives had personal telephone contact with the psychologist giving them opportunities for questions to clarify their role in provision of the intervention. Further supervision was available upon request from the midwives.

Data collection

Procedures in Study A

In Study A interviews were conducted between April and June 2015. The first-time parents were interviewed individually one month after the baby was born. The parents were given the opportunity to choose time and place for the interview and all but two interviews were carried out in their homes. Two parents chose to come to a separate room at the University for the interview. Three fathers and one mother were interviewed in English, the remaining interviews were conducted in Swedish. The interviews, lasting between 21 and 90 minutes (mean 51 minutes) for fathers and between 37 and 85 minutes (mean 59 minutes) for mothers, were recorded and transcribed verbatim.

Procedures in Study B

Data were collected between March and June 2016. A questionnaire was sent by post to the antenatal clinics with instructions to the midwives at the antenatal clinic to complete it collectively. A computer software (TeleForm) was used to create the questionnaire and to scan the returned questionnaires. One reminder was sent to non-responders. During the same time an individual questionnaire was sent to midwives working in the antenatal clinics. A web-based system (Survey and Report) was used to distribute this questionnaire, as a web-link, in an e-mail to the midwives. The midwives' e-mail addresses were provided by the managers of the antenatal clinics. Two reminders were sent to non-responders.

Procedures in Study C

Parents were enrolled in the study from September 2018 to February 2019 and all data collection in the study was completed in October 2019. An overview of sources and time points for data collection is presented in Figure 4.

Data were collected from parents at two time points: baseline at approximately 18 gestational weeks and follow-up at four weeks postpartum. These questionnaires were sent by post. Two reminders were sent to non-responders.

Data collection in Study C

All parents

- Baseline questionnaire with PES at 18 weeks gestation
- Follow-up questionnaire with PES, PPSS and EPDS at 4 weeks postpartum

Midwives at antenatal clinics in the intervention group

- Evaluation form at end of training day
- Fidelity questionnaire (specific version for intervention group) after each parental group in the study
- Acceptability questionnaire after last parental group in the study
- Report of:
  - number of first-time parents who received study information
  - number of first-time parents fulfilling the inclusion criteria but not received study information
  - study participant's starting date for antenatal parental preparation

Midwives at antenatal clinics in the control group

- Fidelity questionnaire (specific version for control group) after the last parental group in the study
- Report of:
  - number of first-time parents who received study information
  - number of first-time parents fulfilling the inclusion criteria but not received study information
  - study participant's starting date for antenatal parental preparation

Statistics of Sweden

- Statistics from database on average basic salary for midwives in Sweden

Figure 4. Overview of data collection in Study C

Data were collected from midwives at the antenatal clinics on multiple occasions.

In order to assess recruitment, all midwives reported the number of parents who received study information and the number of eligible parents who did not receive study information. The starting date for antenatal parental preparation for all parents participating in the study was also reported.

To monitor fidelity to study protocol: separate questionnaires were used for the control group and the intervention group, both questionnaires were administered by post. The questionnaire to midwives at antenatal clinics in the control group was administered once, after the last parental group session during the study period, with instructions for the midwives at the antenatal clinic to complete it collectively. The midwives at antenatal clinics in the intervention group received one questionnaire for each parental group in the study with instructions for the midwife who provided the group sessions to fill in after each session.

Two questionnaires were used to assess acceptability of the intervention from a provider perspective. Midwives at antenatal clinics in the intervention group who attended the training day were asked to fill in an evaluation form at the end of the training day. After the last parental group session in the study, another questionnaire was sent as a weblink in an e-mail (using the web-based system Survey and Report) to the midwives who had provided the intervention.

One reminder was sent to non-responding antenatal clinics and midwives.

To estimate costs for provision of the intervention as compared to regular antenatal parental preparation, information on average basic salary for midwives was collected from Statistics Sweden (2018b).

Interview guide

The interviews were guided by four open questions: What is your experience of preparation for early parenthood? What does being prepared for early parenthood mean to you? What do you think is good to be prepared for? What, in your opinion, are good ways of preparing? Additional probing questions were used when needed, to further explore their responses.

Questionnaires to antenatal clinics and midwives

In Study B, two questionnaires were developed to collect data from the antenatal clinics and midwives. The questionnaires were based on questionnaires previously used by Wallby (Wallby, 2009) and Lefèvre et al. (2015) in research regarding parental support in child health services. A workshop was also held by the author of this thesis with midwives, and other interested professionals, about possibilities and challenges in the provision of antenatal parental preparation. The workshop gave additional information on relevant questions to include when adapting the questionnaires to an antenatal clinic setting. In the development of the questionnaires, a statistician was consulted regarding construction of the response alternatives in relation to the statistical analysis plan. Before data collection began, the questionnaires were tested for face validity, in terms of relevance of content and comprehensibility of the questions, by three midwives with experience of providing antenatal parental preparation. This resulted in minor adjustments.

The ANC questionnaire

The questionnaire (Appendix I) included items organised in four themes: organisation of the antenatal clinic, to whom antenatal parental preparation was offered, the form of the antenatal parental preparation offered and the extent of topic coverage. The first

three themes were answered by multiple choice alternatives. Questions regarding the extent of topic coverage in the antenatal parental preparation, were answered on 5-point Likert-type scales, ranging from 0 (not at all) to 4 (to a very large extent). Questions regarding percentage of the time in antenatal parental preparation allocated to each topic were also posed but excluded in the analyses since the construction of these items were found to be unclear; the items were misinterpreted by the respondents and rendered percentages exceeding 100%. A space for open comments was also provided in the questionnaire.

The midwife questionnaire

The questionnaire to individual midwives (Appendix II) contained items which focused on the midwife's views on topic importance and experiences of support, skills and challenges when working with antenatal parental preparation which were answered on 4-point Likert-type scales, ranging from 1 (of no importance/do not agree at all) to 4 (very important/totally agree). Items also included questions on the midwife's age, professional experience, and use of websites or mobile applications in antenatal parental preparation; these questions had fixed, multiple choice alternatives. A space for open comments was also provided.

In Study C; four questionnaires, all developed for this study, were used to collect data from midwives.

Fidelity questionnaire to control group

A short version of the ANC questionnaire used in Study B (Appendix III) was answered by midwives at antenatal clinics in the control group to measure fidelity to the regular antenatal parental preparation program. It consisted of questions regarding the number and length of sessions offered, order of topics and extent of topic coverage. An open space for comments was also provided.

Fidelity questionnaire to intervention group

A questionnaire to midwives at antenatal clinics in the intervention group (Appendix IV) consisted of questions to measure fidelity to the study manual. Questions were posed regarding number of participants and to what extent the manual was followed (totally / partly / not at all) for each session. If there were deviations from the manual, the midwife was asked to describe the deviations and reasons for making the changes in free text. An extra open space for additional comments was also included.

Acceptability questionnaires

Two acceptability questionnaires were used and were based on a course evaluation form used in further training for primary healthcare nurses and in a study with nurses in child health services (Lefèvre, Lundqvist, Drevenhorn, & Hallström, 2017).

The questionnaire used to evaluate the training day (Appendix V) consisted of questions regarding the content, how well prepared they felt to provide the intervention and to what extent the training day provided them with new knowledge. These questions were answered on Likert-type scales ranging from bad/small extent to excellent/large extent (scores 1-5). Open spaces for suggestions for additional content and improvements or other comments were also included.

The questionnaire to evaluate the acceptability of the intervention from a provider perspective (Appendix VI) included questions about to what extent the training day, written manual and access to supervision was sufficient for them to provide the intervention. These questions were responded to on Likert-type scales ranging from small to large extent (scores 1-5). The midwives were asked to describe their experiences of providing the intervention in free text. An open space for other comments was also included.

Questionnaires to parents

For parents in Study C, two questionnaires (baseline and follow-up) for the evaluation of antenatal parental preparation were developed based on questionnaires previously used in an Australian trial of antenatal parental preparation (Svensson et al., 2009). Some modifications on questions and response alternatives were made and the questionnaires were tested for face validity on two mothers and two fathers who found them to be comprehensible and no adjustments were made. These were used in combination with instruments described below.

Baseline questionnaires

A baseline questionnaire (Appendix VII) included sociodemographic information, questions about intention to breastfeed and history of treatment for mental illness and was administered together with the antenatal version of the instrument Parent Expectation Survey (PES).

Follow-up questionnaires

A follow-up questionnaire (Appendix VIII) included questions about attendance and satisfaction with the content and form of the antenatal parental preparation and questions related to the birth, breastfeeding and experienced degree of the father's involvement as a parent. To fathers a question about experienced degree of inclusion in the topics and discussions in the antenatal parental preparation was also posed. Questions related to satisfaction, birth experience, experienced degrees of inclusion and involvement were all answered on 11-point Likert-type scales with response alternatives ranging from 0 (not satisfied at all / very negative experience / not included at all / not involved at all) to 10 (totally satisfied / very positive experience / totally included / totally involved). Other questions had fixed multiple choice alternatives. Three

questions regarding satisfaction with antenatal parental preparation provided possibilities for additional open comments. The postnatal version of Parent Expectation Survey (PES) was administered at follow-up as were the instruments Parents' Postnatal Sense of Security (PPSS) and Edinburgh Postnatal Depression Scale (EPDS).

Parent Expectation Survey

The Parent Expectation Survey (PES) measures parental self-efficacy (Reece, 1992; Reece & Harkless, 1998) and exists in two versions; one for antenatal use and one for postnatal use, later referred to as antenatal-PES and postnatal-PES. As no versions of PES were available in Swedish the instruments were forward translated by a person fluent in both Swedish and English and then back translated by a bilingual person. The Swedish versions were then tested for face validity by two mothers and two fathers which showed that the instrument was comprehensible, and no further adjustments were made. Both antenatal and postnatal versions contain 25 items with statements related to perceived parental skills. The statements were answered on 11-point Likert-type scales ranging from 0 (cannot do) to 10 (certain can do). The first item, concerning feeding the baby, was not used for fathers. Total scores range from 0 to 250 for mothers and 0 to 240 for fathers: higher scores indicate higher parental self-efficacy. The instrument has been tested for content validity and concurrent validity (Reece, 1992). Test of internal consistency reliability measured with Cronbach's alpha showed high internal consistency; 0.92 for the antenatal version and 0.97 for the postnatal version (Reece & Harkless, 1998). Two of the statements were culturally adapted for a Swedish setting; items 10 and 14. Item 10, originally phrased "I can work out my concerns about working or not once the baby arrives", was re-phrased to "I can work out my concerns about working or being on parental leave once the baby arrives". In item 14, originally phrased "I can easily get the baby and myself out for a doctor's visit", the words "a doctor's visit" was changed to "a visit to the child health clinic".

Parents' Postnatal Sense of Security

Parents' postnatal sense of security was measured at follow-up with the instrument PPSS (Persson et al., 2007) which exists in two versions, one for mothers and one for fathers. The mother's version contains 18 items and the father's version contains 13 items, both with four dimensions. Dimensions in mothers' version are *a sense of the midwives'/nurses' empowering behaviour* (6 items), *a sense of general well-being* (5 items), *a sense of affinity within the family* (4 items) and *a sense that breast feeding was manageable* (3 items). Dimensions in fathers' version are *a sense of the midwives'/nurses' empowering behaviour* (5 items), *a sense of the mother's general well-being including breastfeeding* (3 items), *a sense of general well-being* (3 items) and *a sense of affinity within the family* (2 items). All items were answered on 4-point Likert-type scales ranging from strongly disagree to strongly agree (score 1 to 4). Total scores for mothers' version range from 18 to 72 and for the fathers' version from 13 to 52: higher scores indicate a higher sense

of security. Both the PPSS versions have previously been tested for different aspects of validity; content, construct and concurrent validity (Persson et al., 2007). Internal consistency reliability using Cronbach's alphas were 0.88 (mother's version) and 0.77 (father's version) (Persson et al., 2007).

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) was used to measure parents' risk for postnatal depression at follow-up (Cox et al., 1987; Lundh & Gyllang, 1993). EPDS is a 10-item self-report scale designed to screen for symptoms of postnatal depression in community samples. All items were answered on a 4-point scale (score 0 to 3), with a total score range of 0 to 30. The risk for postnatal depression increases as scores increase. EPDS has been well tested for validity and reliability (Ahlqvist-Björkroth et al., 2016; Cox et al., 1987; Wickberg & Hwang, 1996). Internal consistency reliability measured by Cronbach's alpha was 0.80 for mothers and 0.79 for fathers (Ahlqvist-Björkroth et al., 2016).

Data analysis

Phenomenography

To gain in-depth information about first-time parents' varied conceptions of preparation for the early parenthood period, the transcribed interviews in Study A were analysed using a phenomenographic approach (Marton, 1981; Sjöström & Dahlgren, 2002) with seven steps in the analysis process (Sjöström & Dahlgren, 2002). In the first step, *familiarization*, the transcribed interviews were listened to in order to ensure correct transcription and read through several times to gain an overall impression of the material. In step two, *compilation*, relevant statements of being prepared for the early parenthood period from all participants were identified. Central parts of these statements were identified in a third step, *condensation*. In step four the condensed statements were compared and sorted into different preliminary categories, so called preliminary *grouping*. The fifth step *comparison* of categories was made to ensure that these categories could be distinguished from each other, followed by *naming* the categories in a sixth step to emphasise their essence. Finally, in a seventh step, *contrastive comparison* of categories regarding similarities and differences was performed. The steps are described in separate and chronological order even though they have mutual relationships and revisiting the steps was a continuous process during the analysis. From the individual participants' statements, conceptions could be identified and formed into categories and presented in an outcome space. Conception describes the way a phenomenon is perceived and a category consists of a group of conceptions. Outcome

space can be seen as an explanation of a logical relationship between the categories (Sjöström & Dahlgren, 2002). Categories and conceptions were discussed between all authors of the papers until consensus was reached.

Preunderstanding

Preunderstanding, referring to familiarity with a context, may facilitate as well as limit interpretation and understanding of the data in qualitative research (Nyström & Dahlberg, 2001); researchers' preunderstanding is therefore important to describe. The author of this thesis has several years of experience working as a midwife in antenatal care and providing antenatal parental preparation. None of the co-authors of the papers included in this thesis had any practical experience of providing antenatal parental preparation, although they have considerable clinical experience in midwifery or paediatric nursing. During the research process all authors preunderstanding was reflected on. By openness to new experiences, being aware of and reflecting upon our preunderstanding, efforts were made to limit the bias of preunderstanding (Nyström & Dahlberg, 2001). The study results were also discussed in multi-professional research group seminars.

Statistical analyses

Descriptive statistics with frequencies and percentages or mean, standard deviation and max-min values were used to present the data.

In order to compare midwives' age and their use of websites and mobile applications in antenatal parental preparation the age variable was dichotomised to ≤40 or >40 years. To examine whether midwives' self-rated skills in pedagogic and group-leadership differed in relation to their experience in leading parental groups the variable "years of experience in leading parental groups in antenatal parental preparation" was dichotomised to ≤5 or >5 years of experience based on Benner's theory on progress from novice to expert (Benner, 1984). Comparisons between these groups were performed using Pearson's Chi-2 test (Paper III).

Comparisons were made between mean scores for midwives' rating of their overall topic knowledge about birth, breastfeeding and parenthood using the paired samples t-test (Paper III).

To compare ANCs' responses on topic coverage and midwives rated topic importance, the values 0 (not at all) and 1 (to a very small extent) on the ANCs' 5-point scale was merged to one to allow comparison with the individual midwives' responses on a 4-point scale. Means were then compared using the independent samples t-test (Paper III).

The independent samples t-test was used to compare intervention group and control group for total scores for satisfaction with content and form in antenatal parental preparation, total PPSS and EPDS scores and change in total scores on PES from baseline to follow-up. Total scores for satisfaction with content and form in antenatal parental preparation were calculated on 7 items in parents' follow-up questionnaire and total score range was 0 to 70 (Paper IV).

Responses to a question concerning the child's nutrition were dichotomised to breastfeeding exclusively or combining breastfeeding with formula. Fischer's exact test was then used to compare the intervention and control groups for the child's nutrition at follow-up. In this analysis mothers not providing breast milk were excluded. Reported lack of content in the antenatal parental preparation was compared between intervention group and control group using Fisher's exact test (Paper IV).

Cronbach's alpha was used to test for internal consistency reliability between items regarding topics in antenatal parental preparation in the ANC and Midwife questionnaires (Paper III). Internal consistency in items in parents' total scores for satisfaction with content and form in antenatal parental preparation and the instruments PES, PPSS and EPDS (Paper IV) were also tested with Cronbach's alpha.

Missing values in Study B (Paper III) were excluded from the analyses. In Study C (Paper IV), in order to allow total score calculations for the instruments PES, PPSS and EPDS a single missing value was replaced with a mean value of the item (imputation of the mean). Missing values on more than one item in an instrument were not replaced and these were excluded from the analyses as was the case for missing values in other questions. Data from mothers and fathers were analysed separately.

The significance level was set at $p \leq 0.05$, all analyses were two-sided and statistical analyses were conducted using the IBM SPSS Statistics 24 and 25 Windows (IBM Corporation, Armonk, NY, USA).

Ethical considerations

Ethical approvals to conduct the studies were given by the Regional Ethical Review Board in Lund, Sweden (2013/651 for Study A and B; 2017/746 for Study C). Permission for recruitment, intervention and data collection were obtained from managers responsible for all care units involved in the studies. The studies were carried out in accordance to The Declaration of Helsinki, (World Medical Association, 2013) with respect to ethical principles of autonomy, beneficence and non-maleficence, and justice (Beauchamp & Childress, 2019). All data were handled according to The General Data Protection Regulation (2016/679/EU).

Beneficence and Non-maleficence

The principles of beneficence and non-maleficence involve actions to benefit a person's welfare and to not inflict harm (Beauchamp & Childress, 2019); benefits should outweigh risks for participants in a study. The transition to parenthood is a sensitive period in life and asking parents about their experiences of the early parenthood period including questions related to perceived parenting skills, relational and emotional status may evoke negative feelings for individual parents. By conducting the interviews at a time and place chosen by the parent and with an open, respectful and non-judgemental approach from the researcher efforts were made to create a safe environment. All parents were also provided, in the written study information, with contact information to a midwife at the university if questions arose or support was needed. Parents were informed that the information they provided within the studies would only be accessed by the researchers and no information was transferred to health professionals. The instrument EPDS is used to screen for symptoms of postnatal depression, higher scores indicate an elevated risk for depression, but EPDS is not a diagnostic tool (Wickberg, 2019). Parents' in Study C filled in the instrument approximately four weeks postpartum and returned the questionnaire by post. In Sweden the new-born baby and its parents are during the first weeks and months postpartum offered frequent follow-up visits to a nurse in child health services where parental support is included. All mothers are to be offered an individual visit and screening with EPDS six to eight weeks postpartum (Wickberg, 2019). In the region where the study was conducted fathers/co-parents are also offered an individual visit with the opportunity to talk about their own wellbeing and parental role (Ivarsson, Olsson & Pihl, 2019). These measures increased the likelihood of provision of adequate support for parents in need of it.

The decision to not disclose randomisation allocation to parents in Study C was taken in order to minimise bias affecting their responses and may be justified with the argument that no parents were withheld regular antenatal parental preparation. Parents in the intervention group received a more extensive programme, however, since the programme for antenatal parental preparation provided in the intervention group had not previously been tested no known effects in favour of one of the tested programs existed which put parents in the intervention group at risk of receiving a more extensive programme without significant outcome. To avoid unnecessary inconvenience for the participants the questionnaires used in the studies were kept as short as possible. Code numbers were used to ensure confidentiality for the parents, and the code keys were stored in a safe place separate from the data. All collected data from individual midwives in Study B were handled anonymously within the web-based system Survey and Report. Other data collected from midwives and antenatal clinics have been handled to ensure confidentiality. When findings were presented no data were linked to any individual parents, midwives or antenatal clinics.

The possible inconvenience of participating in the studies was considered to be minor and the results may benefit other expectant and new families as well as healthcare professionals who engage with these families.

Autonomy

In research, the principle of autonomy refers to the right for an individual to make an informed and voluntary decision of whether to participate or not without interference from researchers and/or caregivers (Beauchamp & Childress, 2019). All participants in the studies received written information about the purpose of the study and procedures emphasising that participation was voluntary. When under care, patients may be in a dependent relationship with their caregiver and feel obligated to accept participation in research when approached. Therefore, parents were ensured that their decision would not affect their care in any way, and both oral and written information were given before written informed consent was collected. Midwives received written information together with the questionnaires which in Study C was combined with oral information before the study start. For midwives, voluntary participation was confirmed by responding to the questionnaire. All participants in all studies were also informed of their right to discontinue their participation at any time during the study, without explanation.

Justice

The principles of justice deal with issues of fairness and non-discrimination of participants in recruitment and treatment (Beauchamp & Childress, 2019). Mothers and fathers were given equal opportunities to participate in the studies, further the intervention was based on both mothers' and fathers' needs. However, parents without Swedish speaking skills had limited possibilities to participate in the studies as interviews were only offered in Swedish or English and the antenatal parental preparation as well as the questionnaires in Study C were only offered in Swedish. Parents without mastery of Swedish can be a vulnerable group with increased risk for illhealth (Falah-Hassani et al., 2015; Liu, Ahlberg, Hjern & Stephansson, 2019) and of not receiving adequate care (Heslehurst, Brown, Pemu, Coleman & Rankin, 2018; Liu et al., 2019). The limited possibilities for this group to participate in the studies stands in conflict with the principle of justice. Parents who did not want to take part in Study C, irrespective of reason, were offered antenatal parental preparation without receiving the questionnaires. All antenatal clinics and all midwives working in antenatal care in the region were offered participation in the survey of antenatal parental preparation. The antenatal clinics involved in Study C provided antenatal parental preparation in a similar way before the randomisation, which was performed by an external statistician to ensure randomness.

To increase transparency of the process in the intervention study (Study C), the trial was registered in a database for clinical trials before the study start (ClinicalTrials.gov ID: NCT03679520). Researchers also have an ethical obligation to make all their findings publicly available (WMA, 2013). Efforts have therefore been made to disseminate the findings from this thesis widely, also outside scientific settings. Results have been made available to midwives, other healthcare professionals and stakeholders in the healthcare sector as well as to the surrounding community for example through oral presentations, newspapers and social media.

Findings

The findings are presented in relation to the MRC framework for development and evaluation of complex interventions (Craig et al., 2008; MRC, 2008). In the section "Development phase" findings from Paper I-III are integrated and the respective paper referred to. Findings from Paper IV are presented in the section "Feasibility/piloting phase". Midwives' evaluation of the training day in Study C and costs to provide the intervention are also presented as findings in the "Feasibility/piloting phase"; these have not previously been reported in the papers and are referred to as Thesis.

Development phase

Parental preferences and provision of antenatal parental preparation

While some parents expressed a desire to know everything about early parenthood in advance others stated it was impossible to be prepared as there were so many things that could happen that were impossible to control. Others had reflected on the difficulties of being fully prepared for everything and perceived that being prepared for the early parenthood period was rather about having a picture of what lays ahead and knowing where to turn for more information and support. According to their statements access to sources of support in the preparation for parenthood assisted them to gain knowledge and form realistic expectations. The parents described how this in turn facilitated for them to strengthen their own resources and develop strategies to deal with the challenges of early parenthood (Figure 5). According to the parents, access to sources of support included both professional support and informal support from peers and relatives (Paper I-II).

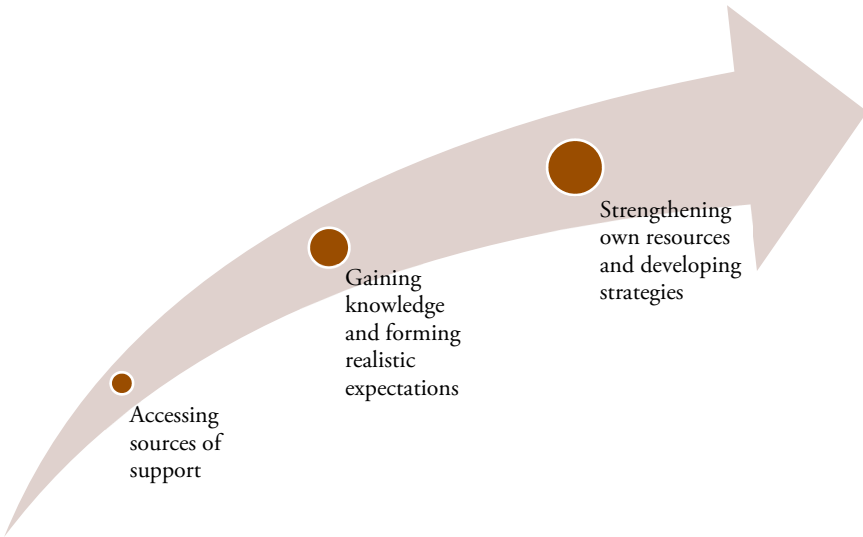


Figure 5. Preparation for early parenthood

Both mothers and fathers perceived that as an expectant first-time parent it was difficult to know what knowledge they might need in order to be prepared. Instead they suggested that the midwife more actively should address postnatal issues.

> *The midwife was very nice… and she asked: do you have any questions? But you don´t have any questions if you don´t know what is coming. I would know now (after birth) what to ask (Father code 10).*

Parents often expressed that the antenatal parental preparation provided by their antenatal clinic had not focused on the postnatal period (Paper I-II). This was in accordance with results from the survey of contemporary antenatal parental preparation offered at ANCs, where the topics normal birth, pain relief, partner role during birth, breastfeeding advantages and breastfeeding initiation were those best covered according to the midwives. When topic coverage was compared to how midwives' rated importance of the topics, the importance was significantly higher than the ANCs topic coverage, especially regarding topics related to postnatal themes (p 0.05 to <0.01). Most commonly, antenatal parental preparation was offered with a start in gestational week 30-34 (64.7%; n=33) (Paper III). Especially mothers stated that in late pregnancy they had become more focused on the imminent birth (Paper II).

> *Something happens there in the end (of the pregnancy) … and suddenly the baby's arrival is imminent, and you think about how the baby will come out…and you get a bit stuck on that. (Mother code 9).*

Varying preferences for the structure of antenatal parental preparation were expressed among the parents. While some parents, mainly fathers, stated a preferred focus on communicating facts in a time-effective way, most mothers and fathers perceived interactive discussions as more favourable. A small group size and enough sessions for parents to get to know each other enhanced the discussion climate according to the parents. They also described that groups consisting exclusively of first-time parents limited possibilities for peer learning and some suggested that experienced parents could be invited to share their experience with the expectant parents (Paper I-II).

Antenatal parental preparation in larger lectures was offered by 30.8% (n=16) of the ANCs while small parental groups with less than 15 expectant parents was the most common form and offered by 90.4% of the ANCs (n=47). The length of antenatal parental preparation offered ranged from two to ten hours (m=5.8; SD 1.8). In 61.5% of the ANCs (n=32) group discussions were included in most of the sessions while in 19.2% (n=10) of the ANCs group discussions were never included (Paper III). Group-based antenatal parental preparation was not appreciated by all parents; some fathers for example stated that the group climate sometimes became too intimate or competitive (Paper I). When midwives rated their own skills in group-leadership and pedagogics, 38.3% (n=41) of them reported not having sufficient skills in group leadership and 55.1% (n=59) reported not having sufficient pedagogical skills. No statistically significant differences between midwives with up to 5 years of experience and midwives with more than 5 years of experience were found for their self-rated skills, neither in group leadership nor pedagogics (Paper III).

Parents described how internet and smart phone applications gave easy access to information presented in different ways, but the information also caused worry and required a critical eye to assess its reliability which they sometimes found difficult. More guidance from healthcare professionals to identify reliable websites and apps was suggested by the parents (Paper I-II). When midwives reported their coverage of websites and apps in antenatal parental preparation 14.2% (n=15) of the midwives frequently introduced websites to parents and 2.8% (n=3) frequently introduced apps. There were no statistically significant differences between midwives aged ≤40 or >40 years in use of websites or apps in antenatal parental preparation (Paper III).

According to parents' statements they did not perceive information on possible challenges or difficulties in early parenthood as discouraging rather a necessity to create realistic expectations and to be prepared for early parenthood. Breastfeeding was often stated as more challenging than expected by both mothers and fathers who said that they would have preferred information with more focus on problem-solving in order to be better equipped to face these challenges. For example, they stated it was important to know how time-consuming breastfeeding was in the beginning. Information on alternatives to exclusive breastfeeding, to acknowledge that not all mothers can or want to breastfeed was also suggested. Parents described how they wanted to be able to

understand the baby's needs and to tell when the baby was unwell (Paper I-II). Mothers stated that the baby's need for physical closeness sometimes caused concerns on where the baby should sleep and they requested more knowledge about co-sleeping and sudden infant death syndrome (Paper II).

Parents described that discussing the loss of control in the planning of everyday-life and the extent of sleep deprivation in early parenthood would be helpful to normalise these aspects. Emotional oscillation for both mothers and fathers and how this could be distinguished from postnatal depression should according to parents also be discussed in antenatal parental preparation. Parents perceived that relationship changes could occur as a result of the strains of early parenthood which entailed less spare time and a high level of focus on the baby and they expressed a need to be prepared for how to balance their parental and partner roles (Paper I-II).

In order to provide mutual support in dealing with challenges of early parenthood parents suggested that an open, constructive and ongoing communication with ones' partner was essential and should be discussed in the preparation. Making a joint plan and sharing expectations was perceived to improve both parents' involvement (Paper I-II). Fathers spoke of forming a fatherhood identity by taking on a participating role where making practical preparations also made the imminent arrival of a baby more real. They described their role as facilitating for the mother and the baby to be as comfortable as possible. However, being seen solely as a helper for the mother was perceived as inconsistent with the idea of parental equality and the father's desire to bond with the baby (Paper I). Mothers described that establishing breastfeeding was demanding in time and effort; additionally, the breastfeeding baby was perceived as more easily "settled by the breast". These points were mentioned by mothers as issues leading to initial unequal parent-baby time for mothers and fathers where fathers could potentially feel left out. Information during pregnancy regarding both parents bonding with the baby, their early roles and reassurance to the father of his equal importance as a parent were therefore highlighted by the mothers (Paper II). The importance of addressing support and information directly to both mothers and fathers was emphasised in both mothers' and fathers' statements (Paper I-II).

A model of the intervention

The intervention, process and outcomes were modelled according to the methodological framework described earlier (Figure 6).

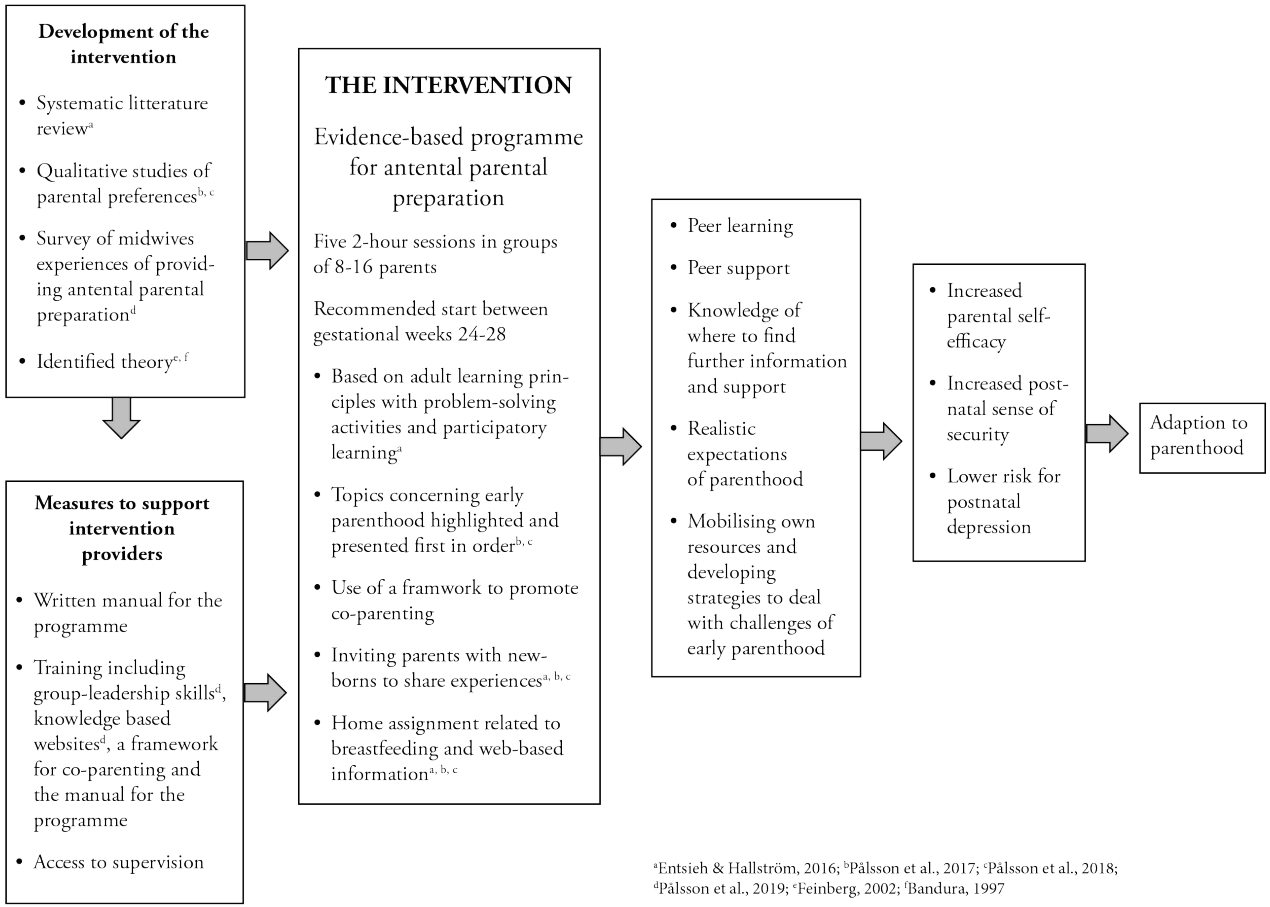


Figure 6. A model of the intervention, process and outcomes.

Feasibility/piloting phase

Feasibility of the evidence-based programme

Seven clusters (ANCs), partook in Study C, with a mean cluster size of six mothers and five fathers (range in cluster size: 3 mothers and 2 fathers to 11 mothers and 8 fathers). No ANCs dropped out after the study start. In total 19 mothers and 14 fathers were enrolled to the intervention group and 20 mothers and 18 fathers to the control group. In the intervention group 13 mothers (68%) and 11 fathers (79%) received the intervention and responded to the follow-up questionnaire. In the control group 18 mothers (90%) and 12 fathers (67%) received regular antenatal parental preparation and responded to the follow-up questionnaire (Figure 2).

Fidelity to study protocol

In the intervention group the written manual was followed for all sessions with minor adjustments of time allocated to the activities. Two times out of six no invited parents with new-borns attended the discussion session and the second option provided in the manual for the intervention was used. In the control group regular antenatal parental preparation was provided with fidelity to the regular program, although in one of the ANCs the topics breastfeeding and parenthood were discussed in the first session instead of the last session.

Parental acceptability and outcomes

Attendance in antenatal parental preparation was high among mothers and fathers in both the intervention group and the control group. Parents in the intervention group attended other preparation activities beside the antenatal parental preparation offered at the ANCs to a lesser extent than parents in the control group (Table 5).

Table 5. Attendance in antenatal parental preparation

		Mothers		Fathers	
		Intervention group N=13 n (%)	**Control group N=18 n (%)**	**Intervention group N=11 n (%)**	**Control group N=12 n (%)**
Gestational weeks when antenatal parental preparation started	m	27	32	27	32
	(SD)	(4.35)	(2.33)	(4.03)	(2.57)
	min – max	21-36	28-35	21-33	28-35
	Missing		3		2
Number of sessions offered	m	5	2.50	5	2.42
	(SD)		(0.51)		(0.52)
	min – max	5	2-3	5	2-3
Number of sessions attended	m	4.46	2.33	4.82	2.33
	(SD)	(0.88)	(0.69)	(0.41)	(0.65)
	min – max	2-5	1-3	4-5	1-3
Attendance in other preparation activities	Psychoprophylaxis	4 (30.8)	4 (22.2)	3 (27.3)	1 (8.3)
	Yoga	1 (7.7)	7 (38.9)		1 (8.3)
	Water exercise*	2 (15.4)	2 (11.1)		
	Hospital lecture		2 (11.1)		1 (8.3)
	Breastfeeding lecture	1 (7.7)	3 (16.7)		
	Fatherhood group				2 (16.7)
	None	6 (46.2)	7 (38.9)	8 (72.7)	7 (58.3)

*For pregnant women

Mothers' total scores for satisfaction with content and form in antenatal parental preparation were higher in the intervention group (mean 53.31; SD 11.69) than in the control group (mean 44.65; SD 18.17) (between-group difference mean 9.23; 95% CI -2.99 to 21.53; p=0.13), although there was no statistically significant difference between the groups. Fathers had similar total satisfaction scores in the intervention group (mean 42.36; SD 16.11) and the control group (mean 44.83; SD 11.13) (between-group difference mean -2.47; 95% CI -14.39 to 9.49; p=0.67). Significantly less mothers in the intervention group reported content lacking in the antenatal parental preparation than in the control group (38.5% vs 82.4%; p=0.02) whereas the difference for fathers was not statistically significant (45.5% vs 50%; p=1.0). In the intervention group mothers stated lack of information on alternatives to breastfeeding whereas fathers would have liked more information on where to turn for support. Both

parents also reported lack of information about the new-born baby, for example health-related conditions. In the control group parents often reported lack of topics related to early parenthood, such as breastfeeding challenges, postnatal health, parental role, the new-born baby and where to turn for support. In both the intervention group and the control group mothers and fathers stated they would have liked more information on birth related topics, caesarean section in particular.

In the intervention group 75% (9/12) of the mothers who at baseline intended to breastfeed exclusively in fact breastfed exclusively at follow up compared to 46% (6/13) in the control group (p=0.19). Parental self-efficacy measured by the change in PES total scores from baseline (antenatal-PES) to follow-up (postnatal-PES) increased more for fathers in the intervention group than for fathers in the control group (Table 6). However, there were no statistically significant differences in outcome measurements (parental self-efficacy, parents' postnatal sense of security and risk for postnatal depression) between the intervention group and the control group (Table 6)

Table 6. Parental outcome measurements for intervention group and control group

		Mothers				Fathers			
		Intervention group N=13	Control group N=18	Between-group difference, mean (95% CI)	p-value	Intervention group N=11	Control group N=12	Between-group difference, mean (95% CI)	p-value
PES total score at baseline[a]	m	215.63	214.47			197.58	190.88		
	(SD)	(24.52)	(19.95)			(27.79)	(25.37)		
	Min – Max	172-245	172-250			115-218	160-228		
	Mean imputation used	1							
	Missing/excluded						1		
PES total score at follow up[b]	m	212.31	216.12			207.45	198.58		
	(SD)	(25.23)	(17.50)			(16.45)	(25.90)		
	Min – Max	150-248	184-239			168-226	152-235		
	Mean imputation used	1				1	1		
	Missing/excluded		1						
PES difference antenatal and postnatal total scores	m	-0.77	1.53	-2.30	p 0.78	11.18	3.72	7.45	p 0.55
	(SD)	(28.67)	(15.06)	(-18.87 to		(27.08)	(30.15)	(-18.04 to	
	Min – Max	-65-39	-25-32	14.27)		-23-84	-61-60	32.94)	
	Missing/excluded		1				1		
PPSS total score[c]	m	56.31	58.06	-1.75	p 0.55	40.00	40.58	-0.58	p 0.79
	(SD)	(8.41)	(7.63)	(-7.68 to 4.18)		(6.47)	(3.50)	(-5.04 to 3.87)	
	Min – Max	37-69	43-69			27-50	35-47		
	Mean imputation used		1						
EPDS total score[d]	m	8.69	6.50	2.19	p 0.17	4.90	4.42	0.49	p 0.77
	(SD)	(5.38)	(3.43)	(-1.04 to 5.43)		(4.64)	(3.32)	(-2.98 to 3.96)	
	Min – Max	1-18	0-12			0-15	0-11		
	Mean imputation used		1						

[a] Cronbach's alpha for mothers 0.93; fathers 0.94; [b] Cronbach's alpha for mothers 0.89; fathers 0.90; [c] Cronbach's alpha for mothers 0.82; fathers 0.67; [d] Cronbach's alpha for mothers 0.85; fathers 0.83

Provider acceptability

According to the midwives' evaluation of the training day (n=6) they were generally satisfied with the content related to the background for the development of the programme (mean 4.7, range 4-5), group leadership (mean 3.8, range 3-5) and the intervention programme (mean 4.5, range 4-5). The midwives rated that the training day to a moderate extent prepared them to provide antenatal parental preparation according to the programme (mean 3.5, range 3-4) and provided them with new knowledge (mean 3.5, range 2-4). The group leadership part could, according to one of the midwives, be expanded to further improve the training day (Thesis).

According to the midwives who provided the intervention during the study (n=4) the training day (mean 3.5, range 2-5) and the written manual (mean 4.0, range 2-5) sufficiently supported them in provision of the intervention. The midwives also perceived their access to supervision during the study as sufficient (mean 4.0, range 2-5). Midwives had access to further supervision upon request which none of the midwives requested. Providing the intervention was described as fruitful in several ways by the midwives.

> *Exciting conversations and discussions and nice to avoid having to talk to yourself all the time but instead see the parents work and look for what they felt they needed. Positive that both parents became equally involved and the attendance among partners was great, which gave extra spice to the education. Sometimes it felt a little stressful and short of time when the couples got started and had a hard time to stop talking. The more they learned, the more knowledge they wanted in some way.*

Midwives stated there were sometimes parents who did not want or were not able to attend all five sessions in the programme. With only a few expectant parents attending it was challenging to have a good discussion.

> *Five sessions are a bit too many both for us and for the parents who also attend other courses maybe… If it is possible to shorten down on something, it would be positive. Then more would probably come even though I felt that the attendance was great especially once they started and then it was sad to end.*

Estimated costs to provide the intervention

An estimation of cost to the antenatal clinics was carried out, based on the hours midwives allocated to the training day, their own preparation, supervision and provision of the intervention.

All midwives providing the intervention attended a full day's training (8 hours) and it was estimated that they used another four hours for their own preparation and supervision. The salary for the midwife was estimated to 385 SEK/hour based on the

average basic salary and including general payroll tax for midwives at antenatal clinics in Sweden (Statistics Sweden, 2018b). The total cost was estimated to 4620 SEK/midwife.

For every two-hour session in the antenatal parental preparation, it was estimated that three hours in total were used which included preparation of the room before the session and tidying up after the session. As antenatal parental preparation is most commonly provided to groups of 8 to 16 parents (Paper III) an average of 12 parents was used as an estimate for number of parents attending each session. When five sessions are to be offered to a group of 12 parents, the additional cost would be 193 SEK/parent when compared to a regular three sessions programme (Thesis).

Internal consistency of measurements

Cronbach's alpha for items regarding antenatal parental preparation topics in the ANC questionnaire was 0.92 and for the Midwife questionnaire 0.89 (Paper III). For items regarding satisfaction with content and form in antenatal parental preparation Cronbach's alpha was 0.91 for mothers and for fathers 0.89. Cronbach's alphas for the instruments PES, PPSS and EPDS are presented in Table 6 (Paper IV).

Discussion

Methodological considerations

The use of MRCs framework for development and evaluation of complex interventions is a major methodological strength in this thesis. The fact that development of the intervention was based on evidence from previous studies, theory, studies on parents' preferences and providers perspectives on delivering antenatal parental preparation is likely to enhance the fit into clinical practice (Bleijenberg et al., 2018). Testing the feasibility of the intervention and procedures will facilitate an evaluation in a full-scale trial (Craig et al., 2008; MRC, 2008). Registration of the study protocol for Study C in ClinicalTrials.gov prior to study start increases the transparency of the study and provided a peer review of the study plan, which is also a strength.

Both qualitative and quantitative methods have been used in this thesis. All methods have their strengths and limitations (Kazdin, 2017; Polit & Beck, 2016). These strengths and limitations are discussed in relation to trustworthiness for the qualitative study and in relation to reliability and validity for the quantitative studies in the sections below.

Trustworthiness

Trustworthiness reflects the quality in qualitative studies and involves the aspects of credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985; Polit & Beck, 2016). Although described as separate aspects these are to some extent intertwined.

Credibility

Credibility refers to confidence in the truth of data (Lincoln & Guba, 1985; Polit & Beck, 2016). How well the data can be trusted depends on choices of participants and methods for collection and analyses of data. Strategic sampling of participants was used to maximise variation in age, education, ethnicity, place of antenatal care and mode of birth to get insights of various experiences of first-time parents' preparation for parenthood. It was also a conscious decision not to exclude parents who had not

participated in group-based antenatal parental preparation at the antenatal clinics as it is known that one third of all first-time parents do not attend (The Swedish Pregnancy Register, 2019). The timing of the data collection, one month after the baby was born, was chosen for parents to reflect on their needs for preparation in relation to their recent experiences of early parenthood.

It is important to establish trust with participants in order to obtain, rich data in interviews. The author of this thesis, who conducted the interviews in Study A, was involved in the process of recruitment by personally providing information to eligible participants at the postnatal units after the initial contact was made by midwives. This gave parents the possibility to ask questions about the study directly. When the participants have a possibility to assess the interviewer before the interview starts it may increase the likelihood for participants to open up and share their experiences (Morse, 2015). The participants chose place and time for interviews to help create a safe environment which may also have an impact on trust and the richness of data. Probing questions were also used to further explore the participants' experiences which enhanced the richness of data. In order to avoid misinterpretation of the respondent's statements these were, when necessary, summarised during the interviews by the interviewer who then asked the respondent if the statement was comprehended correctly. Mothers and fathers were interviewed separately, the interviews were also analysed separately, to shed light on their individual experiences.

The choice of a phenomenographical approach for the analysis was based on interest in describing variations in parents' experiences. Preparation for parenthood involves aspects of learning which makes phenomenography, originally developed to study phenomena in learning, especially suitable. However, qualitative content analysis could also have provided a description of parents' varied experiences. The term data saturation is not commonly used in phenomenography, although Larsson & Holmström (2012) state that new conceptions rarely emerge after 10 to 12 interviews and therefore the number of interviewed mothers (n=18) and fathers (n=15) could be considered more than sufficient.

Dependability

Dependability refers to the stability of data over time and conditions (Lincoln & Guba, 1985; Polit & Beck, 2016). Carrying out interviews is an evolving process often leading to new insights for the researcher, which may influence questions posed to study participants as data collection progresses. By using an interview guide the same main questions guiding the interviews were posed to all participants. Note-taking was used during the data collection and analysis as a tool to continually reflect and enhance data exploration. The author of this thesis conducted the primary analysis, which was confirmed by the last authors of the papers (I-II), and thereafter discussed between all co-authors until consensus was reached. The findings were also discussed in multi-professional research group seminars.

Conformability

Confirmability refers to objectivity of the data and interpretation (Lincoln & Guba, 1985; Polit & Beck, 2016). All categories and conceptions were supported by quotations from the individual interviews in order to enrich the descriptions and increase transparency and trustworthiness of the analytic process. Preunderstanding differed among the authors and was openly stated which also strengthens confirmability.

Transferability

Transferability refers to the possibility to transfer findings to other settings than the one studied. Although the researcher may give suggestions for transferability, it is the reader who is responsible for judgement of transferability of the findings (Lincoln & Guba, 1985; Polit & Beck, 2016). To facilitate this judgment effort has been made to provide a rich description of participants, phenomenon and setting along with the findings.

Reliability

Reliability refers to consistency and stability of the measures obtained (Kazdin, 2017). Internal consistency is a common concept used to test reliability of an instrument and refers to the degree by which the items in an instrument measure the same attribute (Kazdin, 2017). Cronbach's alpha was used to test internal consistency in items regarding topics in antenatal parental preparation in the questionnaires used in Study B (ANC questionnaire and Midwife questionnaire, Paper III). In Study C: items regarding satisfaction with content and form in antenatal parental preparation and the instruments PES, PPSS and EPDS showed acceptable values for Cronbach's alpha. Acceptable values are reported to be between 0.70 and 0.95; although a value of >0.90 indicates that items may be overlapping and that the number of items may be reduced (Tavakol & Dennick, 2011). Cronbach's alphas in the samples in this thesis were, except for father's version of PPSS, all within the acceptable range. For father's version of PPSS Cronbach's alpha was 0,67 which is lower than in a previous study (0.77) (Persson et al., 2007) and may be due to the small sample size.

Validity

External validity refers to the ability to generalise the results to other populations and settings. Internal validity refers to the extent conclusions can be trusted to be valid. Occasionally a decision to increase one aspect of validity can be made at the expense of another aspect of validity; for example, when a researcher applies tight control of a study to maximise internal validity it may result in a study setting that differs from a "real life" setting affecting the external validity (Kazdin, 2017; Polit & Beck, 2016).

External validity

Selection bias is a common threat to external validity (Kazdin, 2017; Polit & Beck, 2016) and it is important to consider how representative the sample is to the population. Providing a rich description of study participants and setting is important to enhance the possibilities for generalisability of the findings.

Study B was a cross-sectional study where all antenatal clinics in the region and all midwives working in these antenatal clinics were offered participation to get a broad sample. Managers of 80.5% of the antenatal clinics in the region gave consent for questionnaires to be sent to the antenatal clinics and the midwives. There is no register or data regarding the number of midwives working in antenatal clinics in the region so the number of questionnaires sent to midwives cannot be set in relation to the total number of ANC midwives in the region. The response rate for the Midwife questionnaire was lower (57.1%) than for the ANC questionnaire (78.8%); a plausible explanation is that the Midwife questionnaire was administered shortly after the ANC questionnaire, and as the content in the questionnaire was similar to the ANC questionnaire some midwives might also have misinterpreted this as the same questionnaire. Administering the questionnaires at separate time points and more clearly stating the difference between the questionnaires might have rendered a higher response rate for the Midwife questionnaire. The sample included antenatal clinics of differing size, organisation, and ownership. The midwives responding to the Midwife questionnaire also varied in age and years of professional experience. The inclusion of only one region should be considered as a limitation; yet, some of the findings from this study were supported by other Swedish studies as well as international studies indicating generalisability to settings where antenatal parental preparation is organised in a similar manner.

In Study C, the rationale for inclusion of antenatal clinics was that they provided the most common programme for antenatal parental preparation in the area under study, which also meant they were all providing antenatal parental preparation in a similar way before the study start. Further, the antenatal clinics were located in both urban and rural areas. The intervention was provided by the midwives in the participating antenatal clinics creating a more naturalistic setting. These can be considered as strengths to the external validity. The sample is however small due to the pilot-study design. Parents were highly educated which corresponds to those who are more prone to attend group-based antenatal parental preparation (Fabian, Rådestad, & Waldenström, 2004; Lefèvre, Pålsson, & Köhler, 2018; Lu et al., 2003). Although some parents were born outside Sweden the inclusion only of parents who mastered Swedish is a limitation. There was only one single mother recruited to the intervention group, otherwise the sample consisted of co-habiting parents and all co-parents were fathers. Lack of diversity in a study sample for a full-scale RCT to evaluate the effectiveness of the intervention may pose a threat to the external validity.

Internal validity

Using validated questionnaires increases the internal validity (Kazdin, 2017). In both Study B and C study specific questionnaires had to be developed as no existing suitable questionnaires were identified. These were all based on questionnaires previously used in similar studies. Findings from previous research and a workshop on antenatal parental preparation held with professionals also influenced the composition of the questionnaires. For questionnaires in Study B (ANC questionnaire and Midwife questionnaire) the construction of response alternatives was discussed with a statistician. Further, all questionnaires were tested for face validity before data collection. These actions may contribute to the relevance of the questions in the developed questionnaires.

The selected instruments used to measure parental outcomes in Study C: PES, PPSS and EPDS had all been validated and tested for reliability in previous studies. However, PES used to measure parental self-efficacy was translated for this study and has not been validated in a Swedish setting. Total scores on PES measured at baseline were higher for mothers in this sample than in in a previous study (Svensson et al., 2009). In other Scandinavian studies ceiling effects were found when measuring self-efficacy in relation to parenting (Pontoppidan, Andrade, Kristensen, & Mortensen, 2019) and breastfeeding (Nilsson, Strandberg-Larsen, Knight, Hansen, & Kronborg, 2017); these instruments however used more narrow scales than the PES. It may be the case that the PES has less sensitivity for the measurement of parental self-efficacy in a Swedish setting. Another possible explanation for the high scores could be social desirability bias (Kazdin, 2017). High baseline scores may limit the possibility for scores to increase from baseline to follow up. Follow up at four weeks postpartum may also have been too early as it may take time to adjust to life as a new parent, in several other intervention studies later follow-ups were chosen (Feinberg et al., 2010; Koushede et al., 2017; Svensson et al., 2009). For fathers the first item in PES regarding feeding the baby was excluded. This decision was based on a high intention among Swedish parents to breastfeed and therefore difficulties in the interpretation of fathers' responses could be expected; if the baby was breastfed would their response then be hypothetical or would their response reflect that they are not able to breastfeed?

The use of cluster randomisation may increase the risk for selection bias (Campbell, Piaggio, Elbourne, & Altman, 2012; Kazdin, 2017; Lamb & Altman, 2015); therefore stratification of antenatal clinics based on CNI was applied prior to randomisation. Cluster-randomisation was used to deal with the risk of treatment contamination between the intervention group and control group (Kazdin, 2017; Lamb & Altman, 2015). Diffusion of treatment and concomitant treatment may threaten internal validity and are important to monitor (Kazdin, 2017; Polit & Beck, 2016). Fidelity to study protocol in Study C was high but attending other preparation activities than the antenatal parental preparation at the antenatal clinic was more common among parents in the control group than in the intervention group. This is an issue that might have

led to smaller differences in parental outcome measurements between parents in the intervention group and the control group.

Recruitment and retention rates in studies may also affect the risk for selection bias and the internal validity (Kazdin, 2017; Polit & Beck, 2016). The recruitment rate was higher in the intervention group than in the control group. One possible explanation might be that midwives at antenatal clinics in the intervention group approached parents more actively, this could be explained by the fact that these midwives were more likely to be reminded of the ongoing study. Closer contacts with midwives in the control group might have resolved this.

Statistical conclusion validity

Means, standard deviations and parametric tests were used in Study B and C with data from Likert-type scales The report of means and standard deviations and use of parametric tests on measurements of Likert-type scales is a subject of debate (Jamieson, 2004), but according to Norman (2010) parametric tests can, due to their robustness, be used with this type of data.

Cluster randomization, as used in Study C, demands larger sample sizes than if individual randomisation is used. This is explained by the risk of clustering effect where observations of participants in the same cluster, in this case antenatal clinics, tend to correlate (Campbell et al., 2012). Due to the small sample, adjustments for cluster effects were not made in the analyses. Study C was designed as a pilot study with the main purpose to test feasibility of the intervention and procedures, although findings on parental outcomes are presented these should be interpreted with caution. CONSORT guideline on randomised pilot and feasibility trials (Eldrige et al., 2016) does not recommend formal hypothesis testing for effectiveness; a pilot study usually lack adequate power to evaluate effectiveness. These analyses were carried out to asses potential effectiveness but should be viewed as secondary due to the design as a pilot study. Adjusting for cluster effect in the outcomes analyses will be made in a full scale trial evaluating the effectiveness of the intervention.

General discussion of the findings

The overall aim of this thesis was to develop an evidence-based programme for antenatal preparation for the early parenthood period, and to test the feasibility of the programme. The findings from this thesis provide an overview of parental preferences for antenatal parental preparation in relation to what is offered, supporting the need for development of an evidence-based programme. When modelling the intervention, findings from the exploration of midwives' experiences of providing antenatal parental preparation gave insights to possible hindrances and facilitating factors to consider

regarding the delivery of the intervention. Results from the feasibility test of the intervention indicated that the intervention may have benefits for both mothers and fathers. Before proceeding to a larger evaluation some modifications to the study protocol are suggested.

Development phase

Findings from studies in the development phase showed that mothers and fathers perceived it was difficult as expectant first-time parents to know what knowledge was needed in order to be prepared for early parenthood; they clearly expressed a need for more guidance in their preparation. These findings are consistent with results from previous studies (Deave et al., 2008; Persson et al., 2011, 2012). Parents expressed that midwives should more actively address postnatal issues and help them think beyond birth. This is an important finding because parental support within antenatal care and parental support within child health services are often approached in both practice and research as being the same issue. This indicates that parental support during pregnancy when the focus is to prepare for situations ahead and parental support in child health services when the baby is present may to some extent require different strategies, although there are several similarities. Asking expectant parents' what they would like to know more about is a valuable pedagogical tool to increase their involvement (Knowles et al., 2015) and should not be ignored, yet it is important that midwives are aware of the body of research showing expectant first-time parents' need for guidance to postnatal issues. The call for more guidance should not be interpreted as a need for a didactive approach by the midwife, as parents also reported a preference for more interactive learning in line with previous research (Barimani et al., 2017; Entsieh & Hallström, 2016; Schrader McMillan, Barlow, & Redshaw, 2009). For example, as parental groups in antenatal parental preparation often consist of mainly expectant first-time parents, they suggested involvement of parents with new-borns who could come and share their recent experiences of early parenthood. The value of peer learning and peer support are supported in the literature (Berlin, Törnkvist, & Barimani, 2016; Entsieh & Hallström, 2016; Forslund Frykedal & Rosander, 2015; Schrader McMillan et al., 2009; Widarsson et al., 2012) and offers opportunities for parents to increase their self-efficacy through vicarious experience (Bandura, 1997). However, competitive group climate reported by some fathers in this thesis may undermine parents' self-efficacy (Bandura, 1997). These situations call for midwives to assume responsibility to moderate the discussions in parental groups in antenatal parental preparation, which demands skills in group leadership. However, 38.3% of the midwives reported insufficient skills in group leadership and furthermore, insufficient skills in pedagogics. Lack of skills in group leadership and pedagogics are likely to affect parents' learning outcomes from antenatal parental preparation. Supporting midwives

to increase their skills in group leadership and pedagogics should therefore be of high priority for management.

Findings also showed that parents' need for guidance to reliable web-based information was not met by midwives in antenatal parental preparation. Parents' need for professional guidance among available information on the internet has also been reported by other researchers (Danbjorg, Wagner, & Clemensen, 2014; Widarsson et al., 2012). Parental access to knowledge-based websites with information that is understandable regardless of their educational level and language is essential and especially important in these times of fake information on the internet. Time is limited in antenatal parental preparation and even if the time were extended it is reasonable to conclude that even then, it would not be possible to cover all there is to know about early parenthood. Not all parents participate in antenatal parental preparation; in particular those who are socioeconomically disadvantaged are underrepresented among the attending parents (Fabian et al., 2004; Lefèvre et al., 2018; Lu et al., 2003). It has earlier been suggested that antenatal care should give increased focus to the support of parents' health literacy (Renkert & Nutbeam, 2001); this includes knowing where to turn for information and how to critically analyse and use the information to maintain or improve one's health. Being able to master the need for information and apply this in new situations may also increase self-efficacy (Bandura, 1997).

It was shown that antenatal parental preparation is most commonly provided in the third trimester, a time mothers stated their thoughts were occupied by how to manage the birth which also is supported in literature (Stern & Bruschweiler-Stern, 1999). Svensson et al. (2006) have earlier implied that the second trimester may be a better timing for the start of antenatal parental preparation. This influenced the decision to provide the intervention with a recommended start in 24 to 28 gestational weeks.

Another important finding was the need for knowledge about possible challenges in the early parenthood period, expressed by the parents. This supports findings in other studies (Barimani et al., 2017; Buultjens et al., 2017; Deave et al., 2008; Erlandsson & Häggström-Nordin, 2010). The importance of providing a realistic picture of breastfeeding, perceived by both mothers and fathers, has also previously been pinpointed (Barimani et al., 2017; Blixt, Johansson, Hildingsson, Papoutsi, & Rubertsson, 2019; Razurel, Bruchon-Schweitzer, Dupanloup, Irion, & Epiney, 2011; Schmied, Beake, Sheehan, McCourt, & Dykes, 2011). Experiences of difficulties in the initial phase of breastfeeding are common (Colin & Scott, 2002; Feenstra et al., 2018; Wagner et al., 2013) and are a risk factor for early cessation (Almqvist-Tangen, Bergman, Dahlgren, Roswall, & Alm, 2012; Wagner et al., 2013). The beneficence of breastfeeding for the baby is well known (Victora et al., 2016). Early breastfeeding cessation may also affect the mother's self-image as a mother (Ayton, Tesch, & Hansen, 2019; Zwedberg, 2010) and increase the risk of anxiety and postnatal depression (Ystrom, 2012). Feelings of failure also pose threats to the mother's parental self-

efficacy (Bandura, 1997; Hankel, Kunseler, & Oosterman, 2019). In the light of this and the fact that breastfeeding rates are declining in Sweden today (The Swedish National Board of Health and Welfare, 2019a; Caballero & Derwig, 2019), it is essential to improve breastfeeding support for parents both during pregnancy and in the early parenthood period. Parents in this thesis also stated that they would have liked information acknowledging the fact that breastfeeding sometimes does not work and also to have discussed alternatives to exclusive breastfeeding. The well-informed decision on breastfeeding is for the individual mother to make and in this process professional sensitivity is required (Blixt et al., 2019). Support for those who, for different reasons do not breastfeed, is important. Fathers in this thesis perceived their role as facilitator for the mother and the baby to make life as comfortable as possible. However, they also perceived that being seen solely as a helper for the mother is inconsistent with the idea of parental equality and the father's desire to bond with the baby. Although fathers do not breastfeed there is evidence for the importance of the father's support to the breastfeeding mother and preparation for breastfeeding should include the father's role (Sherriff, Hall, & Panton, 2014; Al Namir, Brady & Gallagher, 2017; Abbass-Dick, Brown, Jackson, Rempel & Dennis, 2019) and address ways for fathers to bond with the baby. Parents' perception of the importance and benefits of open and constructive communication with one's partner is in line with the concept of co-parenting; how parents can provide mutual support and work together in their parenting roles (Feinberg, 2002). This should be emphasised in the antenatal parental preparation.

Feasibility/piloting phase

Findings from the feasibility/piloting phase showed that the intervention provided in this thesis may possibly entail greater satisfaction for mothers when tested in a full-scale trial. It has been suggested that maternal satisfaction studies should be interpreted with caution; they may have limitations as parents tend to value the care they have received over care they have not experienced (van Teijlingen, Hundley, Rennie, Graham, & Fitzmaurice, 2003). However, fewer mothers in the intervention group also reported lack of content in the antenatal parental preparation than mothers in the control group. Although the intervention was based on both mothers' and fathers' preferences, fathers in both groups had similar total scores for satisfaction with the antenatal parental preparation and reported to a similar extent that content was lacking. Some suggestions for improvement of the programme in the intervention were given by parents such as: to strengthen topics about the new-born baby and provide more information on where to turn for support. The intervention could therefore be further developed according to these suggestions. It should however be noted that several of the topics mentioned as lacking by parents in the control group, for example breastfeeding challenges and the parental role, were topics incorporated in the intervention which strengthens the

content in the programme. Previous studies have also shown that parents value information about these topics (Barimani et al., 2017; Buultjens et al., 2017). Although not in the main scope of this thesis, parents in both groups reported lack of content regarding birth complications. This has also previously been reported (Deave & Johnson, 2008; Erlandsson & Häggström-Nordin, 2010; Johansson, Fenwick, & Premberg, 2015) and is in line with the need for realistic information if expectant parents are to be prepared to meet these challenges.

Fathers' satisfaction scores regarding the intervention were observed to be lower than for mothers. Gender may be an issue in this matter. Studies have shown that fathers may have less access to peer support in their own social network and more often experience lack of parental role models (Deave & Johnson, 2008; Johnsen, Stenback, Halldén, Crang Svalenius, & Persson, 2017; Widarsson et al., 2014). It has been reported that specific groups targeted at fathers are a valued element (Friedewald, Fletcher, & Fairbairn, 2005; Premberg & Lundgren, 2006; Vikström & Barimani, 2016; Widarsson et al., 2015). We have no information on the number of fathers with new-borns who attended the second session in the programme to share their experiences with the expectant parents; one way to approach this is to take specific measures to invite experienced fathers to participate in this session in the future. Several studies have shown that fathers feel excluded by midwives in antenatal care, this may have an impact on responsiveness to the services provided. Nurses in child health services who provide parental support to new parents have expressed a lack of knowledge on how to support fathers, resulting in higher provision of support for mothers than for fathers (Wells, Massoudi, & Bergström, 2017). If this is also the case for midwives, there is reason to believe that it is not only a matter of content in the antenatal parental preparation but also how fathers are approached. It is crucial that healthcare professionals in services directed at expectant and new parents have the skills to support all parents regardless of gender. Sihota et al. (2019) have suggested that the term "parent" is sometimes misinterpreted by fathers who believe the information is directed to mothers and that the term "father" may therefore more directly point out that the father is included. On the other hand, it is important to recognise that not all co-parents are fathers and use appropriate terms in order to not exclude anyone; the term parents certainly has its advantages. The term "partner" is convenient as it includes all genders but does not relate to the co-parent's relationship with the child, rather it tells us about the relationship to the expectant or new mother. Although the importance of partner support is evident (May & Fletcher, 2013; Widarsson et al., 2012), by using the term partner healthcare professionals may unintentionally provide co-parents with the idea that the co-parent is seen as someone providing support to the mother and not as an equal parent also in need of support.

Findings showed that the intervention may possibly increase parental self-efficacy for fathers when tested in a full-scale trial. It is an interesting finding that despite that fathers' scores for satisfaction with the intervention were observed to be lower than for

mothers there was an indication that fathers' parental self-efficacy may benefit more from the intervention than mothers' parental self-efficacy. When parents work together in their parenting roles fathers' self-efficacy has been shown to be more influenced than mothers' self-efficacy (Dumka, Prost, & Barrera, 2002). This could be an explanation for the fathers increased self-efficacy in this thesis, however, as no data on co-parenting behaviour has been collected this assumption cannot be confirmed. Fathers' increased self-efficacy may benefit the whole family. According to Bandura (1997) people with self-efficacy are more likely to take actions. In line with this theory and previous research (de Montigny, Lacharité, & Devault, 2012), it may be feasible that an increase in fathers' self-efficacy could increase fathers' engagement in parental duties and responsibilities leading to other positive short- and long-term outcomes with benefits for the child and the mother. Previous studies have shown that parental stress and strain are associated with increased risk for marital separation (Hansson & Ahlborg, 2016; Widarsson et al., 2014). This stress includes lack of equality and insufficient communication (Hansson & Ahlborg, 2016) which to some extent may be preventable with improved antenatal parental preparation.

An important finding was the intervention may possibly increase mothers' possibilities to fulfil their breastfeeding intention when tested in a full-scale trial; more mothers in the intervention group followed their intention to exclusively breastfeed than in the control group. A likely explanation would be the realistic expectations on breastfeeding in combination with increased problem-solving skills as a result of the intervention; this however needs to be confirmed in a large-scale evaluation. If this positive outcome persists, it would provide short- and long-term health benefits for both the child and the mother (Victora et al., 2016).

It was shown in this thesis that it was feasible for midwives to provide the evidence-based programme developed for the study, when they were provided with support from a full-day training, one telephone contact for supervision and a written manual. Although extra supervision was available, this option was not requested by any of the midwives. These findings support the possibility of implementing the evidence-based programme in routine care if cost-effectiveness can be determined. The suggestion that content related to group leadership could be expanded in the training day is not a surprising finding as lack of skills in group leadership was reported by the midwives in Study B (Paper III) and has also been shown in previous studies (Fabian, Sarkadi, & Åhman, 2015; Forslund Frykedal, Rosander, Berlin, & Barimani, 2016). It is unrealistic that the one-day training provided in this thesis could also encompass midwives' desire for improved skills in group leadership and pedagogics. Regardless of which programme midwives provide their need for improved skills should not be ignored but should be addressed to support midwives who aim to provide high quality antenatal parental preparation.

Although costs for antenatal clinics to provide the intervention have been estimated, not all costs have been included in this estimation; costs for provision of training and supervision for the midwives and costs for parents who may have to take time off from work to attend the sessions have not been estimated. Neither has an analysis of the cost-effectiveness of the intervention been carried out. The additional costs to provide the intervention compared to regular antenatal parental preparation, 193 SEK/parent, should be viewed in relation to the number of parents who are to be offered antenatal parental preparation. If midwives are to allocate time to provision of the intervention other areas of care may be impacted. Costs should also be put in relation to short- and long-term outcomes for parents, and children in particular; additional costs may very well be justified. Therefor and in accordance with the ethical principle of justice (Beauchamp & Childress, 2019) an analysis of cost-effectiveness is necessary and should include both healthcare cost and costs for parents.

Final remarks

Gaps in the Swedish chain of care during childbearing, in particular the first weeks postpartum, have been in focus for some time for both researchers and national authorities (Barimani, 2012; Rubin & Fredriksson, 2018; The Swedish National Board of Health and Welfare, 2017, 2019b). There is an ongoing debate on how to address these gaps and organise care to improve the quality of care during childbearing. The author of this thesis makes no claim that findings in this thesis support how care during childbearing should best be organised. However, strengthening antenatal parental preparation could contribute to bridging the effects of these gaps. Knowledge of what to expect, skills to find reliable information and knowledge of where to turn for support is likely to empower parents during this vulnerable time.

Conclusions and clinical implications

When parents have access to antenatal parental preparation where they gain knowledge and form realistic expectations, their own resources are strengthened and they are supported in development of strategies to adjust to parenthood. In line with parents' preferences midwives should be more proactive in addressing postnatal issues earlier than in the third trimester, should provide guidance to reliable web-based information and offer the possibility for peer learning in antenatal parental preparation.

Contemporary antenatal parental preparation does not fully meet parents' needs and preferences. Further, the diversity in provision found in this thesis is problematic since it negates access to equal and evidence-based care. This highlights the importance of

developing evidence-based guidelines for antenatal parental preparation. The reported lack of skills in group leadership and pedagogics for midwives who provide antenatal parental preparation needs to be addressed; supporting midwives to achieve these skills is likely to increase the quality of antenatal parental preparation.

The evidence-based programme developed in this thesis was shown to be feasible with possible positive effects for both mothers and fathers. However, a full-scale RCT is needed in order to draw conclusions on the effectiveness of the intervention. Before proceeding to a full scale RCT further improvements to the intervention, as suggested by the parents in the pilot study, could be taken under consideration as well as postponing the time for follow-up, since four weeks postpartum may be too early.

Supporting parents in their transition to parenthood has benefits for the individual parent, for the couple and ultimately for the new-born child. In line with the UN convention on the Rights of the Child (UN, 1989) and Swedish law (SFS 2018:1197) the effects of the evidence-based programme developed for this thesis should be viewed from a child perspective; the child benefits when the mother is able to breastfeed and is highly likely to benefit from the father's/co-parent's increased self-efficacy as this may promote parental engagement. Evidence-based antenatal parental preparation could be considered as an investment with potential short- and long-term effects.

Further research

A full-scale evaluation of the evidence-based program for antenatal parental preparation to determine the cost effectiveness of the programme would be valuable. Including qualitative methods to provide more information for process evaluation could also be of interest. In a full-scale evaluation attempts should be made to include a more diverse sample relating to parents with different education levels, languages/cultures and family constellations.

There are parents who do not want to participate in group based antenatal parental preparation and it has been shown that socioeconomically disadvantaged parents are less likely to attend group-based antenatal parental preparation (Fabian et al., 2004; Lefèvre et al., 2018; Lu et al., 2003). It is therefore important to develop evidence-based methods to use in antenatal parental preparation for parents who do not attend group-based antenatal parental preparation; for example, development and evaluation of web-based solutions and strategies for midwives to use at individual visits.

Populärvetenskaplig sammanfattning

Att bli förälder är en stor livsomställning och föräldrars upplevelse av första tiden efter att barnet fötts påverkas bland annat av den information och förberedelse de får under graviditeten. Depression efter förlossningen drabbar cirka 10 % av alla föräldrar, något som även kan påverka anknytningen till barnet och därigenom barnets hälsa och utveckling. Tidigare forskning har visat att nyblivna föräldrar önskar att de varit bättre förberedda för tiden efter förlossningen och att det finns ett samband mellan en hög känsla av trygghet och lägre risk för depression efter förlossningen för både mammor och pappor/medföräldrar. Samtidigt saknas evidensbaserade riktlinjer för föräldraförberedelse inom mödrahälsovården. Att föräldrar ges tillgång till stöd i sitt föräldraskap är också inkluderat i FN:s barnkonvention, som numera är svensk lag, för att främja barns hälsa och utveckling.

Det övergripande syftet med denna avhandling var att utveckla ett evidensbaserat program för föräldraförberedelse och att testa genomförbarheten av programmet. Avhandlingsarbetet utgår från ett metodologiskt ramverk i att utveckla komplexa interventioner i hälso- och sjukvården och bygger på tre delstudier som resulterat i fyra artiklar.

I den första studien intervjuades nyblivna förstagångsföräldrar, cirka en månad efter förlossningen, om sina erfarenheter av föräldraförberedelse i relation till de utmaningar de mött efter förlossningen. Trettiotre föräldrar, 18 mammor och 15 pappor, intervjuades individuellt och intervjuerna analyserades med en fenomenografisk ansats. Resultaten visade att förstagångsföräldrarna upplevde att det, utan erfarenhet av föräldraskap, kunde vara svårt att veta vilken information de skulle efterfråga under graviditeten. De önskade få information som möjliggör realistiska förväntningar för att kunna skapa strategier till att hantera utmaningar i det tidiga föräldraskapet och att det är viktigt att förberedelsen på ett relevant sätt inkluderar både mammor och pappor/medföräldrar. Amning var något som föräldrarna upplevde som betydligt mer utmanande än de väntat sig. De ville få ta del av småbarnsföräldrars erfarenheter av den första tiden och uttryckte också behov av mer vägledning från vårdpersonal för att hitta tillförlitlig information på internet. Föräldrarna ansåg också att en öppen och konstruktiv kommunikation med sin partner är ett viktigt redskap både i förberedelsen och i det ömsesidiga stödet som nyblivna föräldrar.

I den andra studien kartlades den föräldraförberedelse som erbjuds i mödrahälsovården i Skåne och barnmorskors erfarenheter av att arbeta med föräldraförberedelse. En postenkät skickades ut och besvarades av barnmorskor på femtiotvå barnmorskemottagningar. Hundraåtta barnmorskor besvarade också en individuell webbaserad enkät. Studien visade att det finns skillnader i både innehåll och form i föräldraförberedelsen mellan olika barnmorskemottagningar. Det mest vanligt förekommande sättet att erbjuda föräldraförberedelse var mindre grupper med upp till 16 personer och omfattade i genomsnitt 5,8 timmar. Ett strukturerat program för föräldraförberedelsen i grupp användes på 37 % av barnmorskemottagningarna. De ämnen som i störst utsträckning täcktes var relaterade till normal förlossning, fördelar med amning och amningsstarten. Färre än var femte barnmorska använde websidor frekvent i föräldraförberedelsen. Barnmorskorna angav i hög grad att det var roligt att arbeta med föräldraförberedelse i grupp men uttryckte samtidigt att de saknade organisatoriskt stöd samt kunskaper inom pedagogik och gruppledarskap.

I den tredje studien utvecklades ett evidensbaserat program för föräldraförberedelse som baserades på resultaten från de två första studierna, en systematisk litteraturstudie och med teoretiska utgångspunkter i Banduras social kognitiva teori kring att utveckla tillit till sin egen förmåga samt Feinbergs ramverk om att främja gemensamt föräldraskap vilket handlar om hur föräldrar samverkar och stöttar varandra i sina föräldraroller. Sju barnmorskemottagningar, som erbjöd föräldraförberedelse på det mest vanligt förekommande sättet, deltog i en klusterrandomiserad kontrollerad pilotstudie. Fyra barnmorskemottagningar lottades till att tillhöra en kontrollgrupp, och att fortsätta ge föräldraförberedelse på samma sätt som tidigare. Tre barnmorskemottagningar lottades till interventionsgruppen, och erbjöd föräldraförberedelse med det evidensbaserade programmet vilket innehöll fem tvåtimmarsträffar i mindre grupp med upp till 16 blivande föräldrar. Innan barnmorskorna skulle börja ge föräldraförberedelse enligt det evidensbaserade programmet deltog de i en utbildningsdag och fick en skriftlig manual för programmet, därefter hade barnmorskorna ett handledningstillfälle via telefon med psykologen som höll i utbildningsdagen. I det evidensbaserade programmet startade föräldraförberedelsen kring graviditetsvecka 25 med förberedelse inför föräldraskap och tiden efter förlossning, och avslutades med förlossningsförberedelse. Viktiga pedagogiska utgångspunkter i programmet var fokus på problemlösning och att stimulera föräldrarnas egen aktivitet i lärandet. Nyblivna föräldrar bjöds in till en av träffarna för att delge sina erfarenheter av den första tiden efter förlossningen. Internetsidor med kunskapsbaserad information introducerades till en hemuppgift, där föräldrarna själva sökte information om olika amningsproblem. Totalt inkluderades 71 förstagångsföräldrar i studien, 19 mammor och 14 pappor i interventionsgruppen samt 20 mammor och 18 pappor i kontrollgruppen. Föräldrarna besvarade enkäter vid två tillfällen och deras tilltro till sin förmåga i föräldraskapet, känsla av trygghet samt risk för depression efter förlossningen mättes med självskattningsinstrument. Första enkäten besvarades i mitten av graviditeten innan de

deltog i föräldraförberedelsen på barnmorskemottagningen och andra enkäten besvarades en månad efter barnets födelse. Barnmorskor på barnmorskemottagningar i både kontrollgruppen och interventionsgruppen besvarade enkäter om hur föräldraförberedelse getts under tiden som studien pågick. Barnmorskorna som gav föräldraförberedelse i interventionsgruppen besvarade dessutom frågor om hur de upplevt utbildningsdagen och att arbeta med det evidensbaserade programmet. Resultaten från studien visade att det evidensbaserade programmet är genomförbart och godtagbart både utifrån föräldrars och barnmorskors perspektiv. Signifikant färre mammor i interventionsgruppen angav att de saknade något i sin föräldraförberedelse jämfört med mammor i kontrollgruppen. Det noterades att pappor som fick det evidensbaserade programmet ökade sin tilltro sin förmåga i föräldraskapet i störst utsträckning även om inga statistiskt signifikanta skillnader kunde ses för utfallsmåtten mellan grupperna i pilotstudien. I en utforskande analys noterades en möjlig positiv effekt på amning av interventionen, det var att fler mammor i interventionsgruppen som följde sin intention om helamning. Slutsatsen är att det evidensbaserade programmet för föräldraförberedelse bör vidareutvecklas samt testas och utvärderas i en större randomiserad studie.

Sammantaget ger avhandlingens resultat stöd till att anpassa föräldraförberedelsen efter föräldrars önskemål och behov samt till att stärka barnmorskor i deras arbete med att erbjuda föräldraförberedelse. När blivande föräldrar har tillgång till förberedelse som ger kunskap och realistiska förväntningar stärks deras egna resurser och underlättar för att skapa strategier att hantera utmaningarna i det tidiga föräldraskapet. Att vara förberedd handlar inte bara om att ha en bild av vad som väntar utan också att veta var man kan vända sig för mer information och stöd. Mer vägledning i föräldra-förberedelsen efterfrågades av föräldrar. Att ge barnmorskor stöd till att stärka sin kompetens i gruppledarskap och pedagogik kan bidra till ökad kvalitet på föräldraförberedelsen. Resultaten från avhandlingen kan användas i utvecklingen av riktlinjer för föräldraförberedelse vilket på sikt ger en mer jämlik vård för blivande föräldrar. Att föräldrar känner sig mer förbereda inför sitt föräldraskap kan ge en bättre start för hela familjen och öka barnets möjligheter till god hälsa och utveckling, vilket i sin tur även kan ge positiva hälsoekonomiska effekter för samhället. För att kunna dra säkra slutsatser om effekter av det evidensbaserade programmet för föräldraförberedelse behöver en större studie genomföras. En sådan studie bör även inkludera ett hälsoekonomiskt perspektiv.

Acknowledgements

This thesis was carried out at the department of Health Sciences, Faculty of Medicine, Lund University. I would like to express my sincere gratitude to everyone who have supported me in this work. In particular I would like to thank:

First and foremost, all mothers, fathers and midwives who have participated in the studies – your contribution to this thesis is substantial.

My supervisors for providing scientific guidance throughout my journey as a PhD student.

Inger Hallström, for your structured supervision and always rapid, constructive critical appraisal of manuscripts. Thank you for letting me know that what first may seem impossible very well can turn out to be possible in the end.

Linda Kvist, for your patience, commitment and inspiring supervision Thank you for sharing your scientific skills and for challenging me in statistical matters. I am also grateful for your language revision of our papers and this thesis.

Eva K Persson, for sharing your knowledge in research on early parenthood and for your ability to be completely honest with such genuine kindness. I value our discussions and your support.

Maria Ekelin, for thoughtful, skilled and supportive supervision. You always made me feel that your office door was open for me to pop in and discuss whatever was on my mind.

My present and past colleagues in the research group Child and family health for interesting discussions, shared knowledge and for valuable comments on my manuscripts in our research seminars. And of course, for nice coffee breaks, which became even more important at the end of this PhD journey. A special thank you to *Charlotte Castor, Jet Derwig, Kajsa Lamm, Åsa Lefèvre, Malin Skoog* and *Angela Afua Quaye* for sharing the ups and downs in our everyday-life as PhD students - you are a splendid example of peer support at its best!

My colleagues in the research group Midwifery research - reproductive, perinatal and sexual health, for all inspiring and empowering encounters.

Anna-Karin Dykes, you have inspired my interest in research since the first time we met, 25 years ago.

Anna Blomgren, what would my tables and figures or the layout of this thesis be without you?!

Alexander von Schuppler for providing training and supervision for the midwives in the intervention study, for valuable inputs and our interesting discussions on co-parenting.

My colleagues in clinical midwifery and at the Centre of knowledge women's health for inspiring discussions, your interest in my research and support.

All my friends and relatives, thanks for still being here despite my absence during the most intensive times.

Eva-Lena, you have a special place in my heart.

Ann-Sophie, my mother, who also share a professional interest in the transition to parenthood. You always trust in my capacity and encourage me. What an amazing source you are to my self-efficacy! I am also very grateful to you and my mother-in-law, *Christina*, for being present grandmothers.

Last, but not least, my dear family for love, patience and support during these years. *Thomas*, my husband, thank you for encouraging me to do this. *Selma* and *Karin*, my children, thank you for reminding me of what really matters in life. You are simply the best and I love you to the moon and back!

The studies were supported by grants from FORTE (Swedish Research Council for Health, Working Life and Welfare), Föreningen Södra Sveriges Sjuksköterskehem, Lions Forskningsfond Skåne, Föreningen Mjölkdroppen Helsingborg and Vivian Wahlbergs forskningsfond.

References

Abbas-Dick, J., Brown, H. K., Jackson, K. T., Rempel, L., & Dennis, C. L. (2019). Perinatal breastfeeding interventions including fathers/partners: A systematic review of the literature. *Midwifery, 75*, 41–51. doi:10.1016/j.midw.2019.04.001

Ahldén, I., Ahlehagen, S., Dahlgren, L. O., & Josefsson, A. (2012). Parents' expectations about participating in antenatal parenthood education classes. *J Perinat Educ, 21*(1), 11-17. doi:10.1891/1058-1243.21.1.11

Ahlqvist-Björkroth, S., Vaarno, J., Junttila, N., Pajulo, M., Räihä, H., Niinikoski, H., & Lagström, H. (2016). Initiation and exclusivity of breastfeeding: association with mothers' and fathers' prenatal and postnatal depression and marital distress. *Acta Obstet Gynecol Scand, 95*(4), 396-404. doi:10.1111/aogs.12857

Almqvist-Tangen, G., Bergman, S., Dahlgren, J., Roswall, J., & Alm, B. (2012). Factors associated with discontinuation of breastfeeding before 1 month of age. *Acta Paediatr, 101*(1), 55-60. doi:10.1111/j.1651-2227.2011.02405.x

Al Namir, H. M. A., Brady, A., & Gallagher, L. (2017). Fathers and breastfeeding: Attitudes, involvement and support. *British Journal of Midwifery, 25*(7), 426-440. doi:10.12968/bjom.2017.25.7.426

Andersson, E., & Hildingsson, I. (2016). Mother's postnatal stress: an investigation of links to various factors during pregnancy and post-partum. *Scand J Caring Sci, 30*(4), 782-789. doi:10.1111/scs.12305

Anding, J. E., Röhrle, B., Grieshop, M., Schücking, B., & Christiansen, H. (2016). Couple comorbidity and correlates of postnatal depressive symptoms in mothers and fathers in the first two weeks following delivery. *Journal of affective disorders, 190*, 300-309. doi:10.1016/j.jad.2015.10.033

Australian Department of Health. (2019, May 29, 2019). *Clinical Practice Guidelines: Pregnancy Care*. https://www.health.gov.au/resources/pregnancy-care-guidelines (Accessed February 2, 2020).

Ayton, J. E., Tesch, L., & Hansen, E. (2019). Women's experiences of ceasing to breastfeed: Australian qualitative study. *BMJ Open, 9*(5), e026234. doi:10.1136/bmjopen-2018-026234

Baldwin, S., Malone, M., Sandall, J., & Bick, D. (2019). A qualitative exploratory study of UK first-time fathers' experiences, mental health and wellbeing needs during their transition to fatherhood. *BMJ Open, 9*(9), e030792-e030792. doi:10.1136/bmjopen-2019-030792

Bandura, A. (1997). *Self-efficacy : the exercise of control.* New York: W. H. Freeman.

Barimani, M. (2012). *Bridging the gap in the chain of care for expectant and new mothers*. Doctoral thesis, Stockholm, Karolinska Institutet.

Barimani, M., Forslund Frykedal, K., Rosander, M., & Berlin, A. (2018). Childbirth and parenting preparation in antenatal classes. *Midwifery, 57*, 1-7. doi:10.1016/j.midw.2017.10.021

Barimani, M., Vikstrom, A., Rosander, M., Forslund Frykedal, K., & Berlin, A. (2017). Facilitating and inhibiting factors in transition to parenthood - ways in which health professionals can support parents. *Scand J Caring Sci*. doi:10.1111/scs.12367

Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics*. Oxford: Oxford university press.

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

Bergström, M., Kieler, H., & Waldenström, U. (2011). A randomised controlled multicentre trial of women's and men's satisfaction with two models of antenatal education. *Midwifery, 27*(6), e195-200. doi:10.1016/j.midw.2010.07.005

Berlin, A., Törnkvist, L., & Barimani, M. (2016). Content and Presentation of Content in Parental Education Groups in Sweden. *J Perinat Educ, 25*(2), 87-96. doi:10.1891/1058-1243.25.2.87

Bleijenberg, N., de Man-van Ginkel, J. M., Trappenburg, J. C. A., Ettema, R. G. A., Sino, C. G., Heim, N., . . . Schuurmans, M. J. (2018). Increasing value and reducing waste by optimizing the development of complex interventions: Enriching the development phase of the Medical Research Council (MRC) Framework. *Int J Nurs Stud, 79*, 86-93. doi:10.1016/j.ijnurstu.2017.12.001

Blixt, I., Johansson, M., Hildingsson, I., Papoutsi, Z., & Rubertsson, C. (2019). Women's advice to healthcare professionals regarding breastfeeding: "offer sensitive individualized breastfeeding support"- an interview study. *International breastfeeding journal, 14*, 51-51. doi:10.1186/s13006-019-0247-4

Buultjens, M., Murphy, G., Robinson, P., Milgrom, J., & Monfries, M. (2017). Women's experiences of, and attitudes to, maternity education across the perinatal period in Victoria, Australia: A mixed-methods approach. *Women Birth*. doi:10.1016/j.wombi.2017.03.005

Bäckström, C. (2018). *Professional and social support for first-time mothers and partners during childbearing*: Doctoral thesis, Jönköping University, School of Health and Welfare.

Caballero, R., & Derwig, M. (2019) Levnadsvanor. In Centre of knowledge women's health & Centre of knowledge child health services, *För jämlik mödra- och barnhälsovård i Skåne: En nulägesrapport och underlag för handling* (Life habits. For equal maternal and child healthcare in Skåne: A current report and basis for action) [In Swedish] (pp. 18-37). Malmö: Region Skåne. https://vardgivare.skane.se/siteassets/3.-kompetens-och-utveckling/sakkunniggrupper/kvinnohalsa/rapporter/for-jamlik-modra--och-barnhalsovard-i-skane-2019.pdf (Accessed February 2, 2020).

Cameron, E. E., Sedov, I. D., & Tomfohr-Madsen, L. M. (2016). Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis. *J Affect Disord, 206*, 189-203. doi:10.1016/j.jad.2016.07.044

Campbell, M. K., Piaggio, G., Elbourne, D. R., & Altman, D. G. (2012). Consort 2010 statement: extension to cluster randomised trials. *BMJ, 345,* e5661. doi:10.1136/bmj.e5661

Carlberg, M., Edhborg, M., & Lindberg, L. (2018). Paternal Perinatal Depression Assessed by the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale: Prevalence and Possible Risk Factors. *Am J Mens Health, 12*(4), 720-729. doi:10.1177/1557988317749071

Centre of knowledge women's health & Centre of knowledge child health services (Kunskapscentrum kvinnohälsa & Kunskapscentrum barnhälsovård). (2019). *För jämlik mödra- och barnhälsovård i Skåne: En nulägesrapport och underlag för handling* (For equal maternal and child healthcare in Skåne: A current report and basis for action) [In Swedish]. Malmö: Region Skåne. https://vardgivare.skane.se/siteassets/3.-kompetens-och-utveckling/sakkunniggrupper/kvinnohalsa/rapporter/for-jamlik-modra--och-barnhalsovard-i-skane-2019.pdf (Accessed February 2, 2020).

Center on the Developing Child at Harvard University. (2016). *From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families.* http://www.developingchild.harvard.edu/resources/from-best-practices-to-breakthrough-impacts/ (Accessed February 2, 2020).

Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology, 23*(2), 167-180. doi:10.1080/02646830500129487

Claesson, I. M., Myrgård, M., Wallberg, M., & Blomberg, M. (2019). Pregnant women's intention to breastfeed; their estimated extent and duration of the forthcoming breastfeeding in relation to the actual breastfeeding in the first year postpartum-A Swedish cohort study. *Midwifery, 76*, 102-109. doi:10.1016/j.midw.2019.05.014

Colin, W. B., & Scott, J. A. (2002). Breastfeeding: reasons for starting, reasons for stopping and problems along the way. *Breastfeed Rev, 10*(2), 13-19.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry, 150*(6), 782-786. doi:10.1192/bjp.150.6.782

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *Bmj, 337*, a1655. doi:10.1136/bmj.a1655

Daly, M., Bruckauf, Z., Byrne, J., Pecnik, N., Samms-Vaughan, M., Bray, R., & Margaria, A. (2015). *Family and Parenting Support: Policy and Provision in a Global Context. Innocenti Insight.* Florence: UNICEF Office of Research. https://www.unicef-irc.org/publications/770-family-and-parenting-support-policy-and-provision-in-a-global-context.html (Accessed February 2, 2020).

Daley-McCoy, C., Rogers, M., & Slade, P. (2015). Enhancing relationship functioning during the transition to parenthood: a cluster-randomised controlled trial. *Archives of women's mental health, 18*(5), 681-692. doi:10.1007/s00737-015-0510-7

Danbjorg, D. B., Wagner, L., & Clemensen, J. (2014). Do families after early postnatal discharge need new ways to communicate with the hospital? A feasibilility study. *Midwifery, 30*(6), 725-732. doi:10.1016/j.midw.2013.06.006

de Montigny, F., Lacharité, C., & Devault, A. (2012). Transition to fatherhood: modeling the experience of fathers of breastfed infants. *Adv Nurs Sci, 35*(3), E11-E22. doi:10.1097/ANS.0b013e3182626167

Deave, T., & Johnson, D. (2008). The transition to parenthood: what does it mean for fathers? *J Adv Nurs, 63*(6), 626-633. doi:10.1111/j.1365-2648.2008.04748.x

Deave, T., Johnson, D., & Ingram, J. (2008). Transition to parenthood: the needs of parents in pregnancy and early parenthood. *BMC Pregnancy Childbirth, 8*, 30. doi:10.1186/1471-2393-8-30

Doyle, O., Harmon, C. P., Heckman, J. J., & Tremblay, R. E. (2009). Investing in early human development: timing and economic efficiency. *Economics and human biology, 7*(1), 1-6. doi:10.1016/j.ehb.2009.01.002

Draper, J. (2003). Men's passage to fatherhood: an analysis of the contemporary relevance of transition theory. *Nursing inquiry, 10*(1), 66-77. doi:10.1046/j.1440-1800.2003.00157.x

Dumka, L. E., Prost, J., & Barrera, M. (2002). The Parental Relationship and Adolescent Conduct Problems in Mexican American and European American Families. *Journal of Couple & Relationship Therapy, 1*(4), 37-57. doi:10.1300/J398v01n04_02

Durtschi, J. A., Soloski, K. L., & Kimmes, J. (2017). The Dyadic Effects of Supportive Coparenting and Parental Stress on Relationship Quality Across the Transition to Parenthood. *J Marital Fam Ther, 43*(2), 308-321. doi:10.1111/jmft.12194

Ekelin, M., Crang-Svalenius, E., & Dykes, A.-K. (2004). A qualitative study of mothers' and fathers' experiences of routine ultrasound examination in Sweden. *Midwifery, 20*(4), 335-344. doi:10.1016/j.midw.2004.02.001

Eldridge, S. M., Chan, C. L., Campbell, M. J., O'Cathain, A., Bond, C. M., Hopewell, S., … Tugwell, P. (2016). CONSORT 2010 statement: Extension to randomised pilot and feasibility trials. *Pilot and Feasibility Studies, 2*(1). doi:10.1186/s40814-016-0105-8

Entsieh, A. A., & Hallström, I. K. (2016). First-time parents' prenatal needs for early parenthood preparation-A systematic review and meta-synthesis of qualitative literature. *Midwifery, 39*, 1-11. doi:10.1016/j.midw.2016.04.006

Erlandsson, K., & Häggström-Nordin, E. (2010). Prenatal parental education from the perspective of fathers with experience as primary caregiver immediately following birth: a phenomenographic study. *The Journal of Perinatal Education, 19*(1), 19-28. doi:10.1624/105812410X481537

Fabian, H., Sarkadi, A., & Åhman, A. (2015). Challenges and benefits of conducting parental classes in Sweden: Midwives' perspectives. *Sex Reprod Healthc, 6*(4), 236-242. doi:10.1016/j.srhc.2015.05.007

Fabian, H. M., Rådestad, I. J., & Waldenström, U. (2004). Characteristics of Swedish women who do not attend childbirth and parenthood education classes during pregnancy. *Midwifery, 20*(3), 226-235. doi:10.1016/j.midw.2004.01.003

Fabian, H. M., Rådestad, I. J., & Waldenström, U. (2005). Childbirth and parenthood education classes in Sweden. Women's opinion and possible outcomes. *Acta Obstet Gynecol Scand, 84*(5), 436-443. doi:10.1111/j.0001-6349.2005.00732.x

Falah-Hassani, K., Shiri, R., Vigod, S., & Dennis, C. L. (2015). Prevalence of postpartum depression among immigrant women: A systematic review and meta-analysis. *J Psychiatr Res, 70*, 67-82. doi:10.1016/j.jpsychires.2015.08.010

Feenstra, M. M., Jorgine Kirkeby, M., Thygesen, M., Danbjorg, D. B., & Kronborg, H. (2018). Early breastfeeding problems: A mixed method study of mothers' experiences. *Sex Reprod Healthc, 16*, 167-174. doi:10.1016/j.srhc.2018.04.003

Feinberg, M. E. (2002). Coparenting and the transition to parenthood: a framework for prevention. *Clin Child Fam Psychol Rev, 5*(3), 173-195. doi:10.1023/a:1019695015110

Feinberg, M. E., Jones, D. E., Hostetler, M. L., Roettger, M. E., Paul, I. M., & Ehrenthal, D. B. (2016). Couple-Focused Prevention at the Transition to Parenthood, a Randomized Trial: Effects on Coparenting, Parenting, Family Violence, and Parent and Child Adjustment. *Prev Sci, 17*(6), 751-764. doi:10.1007/s11121-016-0674-z

Feinberg, M. E., Jones, D. E., Kan, M. L., & Goslin, M. C. (2010). Effects of family foundations on parents and children: 3.5 years after baseline. *J Fam Psychol, 24*(5), 532-542. doi:10.1037/a0020837

Fenwick, J., Bayes, S., & Johansson, M. (2012). A qualitative investigation into the pregnancy experiences and childbirth expectations of Australian fathers-to-be. *Sex Reprod Healthc, 3*(1), 3-9. doi:10.1016/j.srhc.2011.11.001

Forslund Frykedal, K., & Rosander, M. (2015). The role as moderator and mediator in parent education groups--a leadership and teaching approach model from a parent perspective. *J Clin Nurs, 24*(13-14), 1966-1974. doi:10.1111/jocn.12856

Forslund Frykedal, K., Rosander, M., Berlin, A., & Barimani, M. (2016). With or without the group: Swedish midwives' and child healthcare nurses' experiences in leading parent education groups. *Health Promot Int, 31*(4), 899-907. doi:10.1093/heapro/dav082

Fredriksson, G. E. M., Högberg, U., & Lundman, B. M. (2003). Postpartum care should provide alternatives to meet parents' need for safety, active participation, and 'bonding'. *Midwifery, 19*(4), 267-276. doi:10.1016/s0266-6138(03)00030-5

Friedewald, M., Fletcher, R., & Fairbairn, H. (2005). All-male discussion forums for expectant fathers: evaluation of a model. *The Journal of Perinatal Education, 14*(2), 8-18. doi:10.1624/105812405X44673

Gagnon, A. J., & Sandall, J. (2007). Individual or group antenatal education for childbirth or parenthood, or both. *Cochrane Database Syst Rev*(3), Cd002869. doi:10.1002/14651858.CD002869.pub2

2016/679/EU. *General Data Protection Regulation.* Council of the European Union and European Parliament.

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

Hankel, M. A., Kunseler, F. C., & Oosterman, M. (2019). Early Breastfeeding Experiences Predict Maternal Self-Efficacy During the Transition to Parenthood. *Breastfeeding Medicine, 14*(8), 568-574. doi:10.1089/bfm.2019.0023

Hansson, M., & Ahlborg, T. (2016). Factors contributing to separation/divorce in parents of small children in Sweden. *Nordic Psychology, 68*(1), 40-57. doi:10.1080/19012276.2015.1071201

Harwood, K., McLean, N., & Durkin, K. (2007). First-time mothers' expectations of parenthood: What happens when optimistic expectations are not matched by later experiences? *Dev Psychol, 43*(1), 1-12. doi:10.1037/0012-1649.43.1.1

Heslehurst, N., Brown, H., Pemu, A., Coleman, H., & Rankin, J. (2018). Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Medicine, 16,*89. doi:10.1186/s12916-018-1064-0

Institute for Patient- and Family-Centered Care. *Patient and Family Engagement Strategies.* https://www.ipfcc.org/bestpractices/engagement-strategies-and-definitions.pdf (Accessed February 6, 2020).

International Confederation of Midwives. (2017). *Core Document: International Definition of the Midwife.* https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf (Accessed February 2, 2020).

Irwin, L. G., Siddiqi, A., & Hertzman, G. (2007). *Early child development: a powerful equalizer*. World Health Organization's Commission on the Social Determinants of Health. https://apps.who.int/iris/bitstream/handle/10665/69729/a91213.pdf?sequence=1 (Acessed February 5, 2020).

Ivarsson, I., Olsson, L., & Pihl, E. (2019). Psykisk hälsa. In Centre of knowledge women's health & Centre of knowledge child health services, *För jämlik mödra- och barnhälsovård i Skåne: En nulägesrapport och underlag för handling* (Mental health. For equal maternal and child healthcare in Skåne: A current report and basis for action) [In Swedish] (pp. 38-55). Malmö: Region Skåne. https://vardgivare.skane.se/siteassets/3.-kompetens-och-utveckling/sakkunniggrupper/kvinnohalsa/rapporter/for-jamlik-modra--och-barnhalsovard-i-skane-2019.pdf (Accessed February 2, 2020).

Jamieson, S. (2004). Likert scales: how to (ab)use them. *Med Educ, 38*(12), 1217-1218. doi:10.1111/j.1365-2929.2004.02012.x

Johansson, M., Fenwick, J., & Premberg, Å. (2015). A meta-synthesis of fathers' experiences of their partner's labour and the birth of their baby. *Midwifery, 31*(1), 9-18. doi:10.1016/j.midw.2014.05.005

Johnsen, H., Stenback, P., Halldén, B.-M., Crang Svalenius, E., & Persson, E. K. (2017). Nordic fathers' willingness to participate during pregnancy. *Journal of Reproductive and Infant Psychology, 35*(3), 223-235. doi:10.1080/02646838.2017.1297890

Kazdin, A. E. (2017). *Research design in clinical psychology*. Boston: Pearson.

Kerstis, B., Aarts, C., Tillman, C., Persson, H., Engström, G., Edlund, B., . . . Skalkidou, A. (2016). Association between parental depressive symptoms and impaired bonding with the infant. *Arch Womens Ment Health, 19*(1), 87-94. doi:10.1007/s00737-015-0522-3

Klittmark, S., Garzón, M., Andersson, E., & Wells, M. B. (2019). LGBTQ competence wanted: LGBTQ parents' experiences of reproductive health care in Sweden. *Scand J Caring Sci, 33*(2), 417-426. doi:10.1111/scs.12639

Knowles, M. S., Swanson, R. A., & Holton, E. F. (2015). *The adult learner : the definitive classic in adult education and human resource development* (8th. ed.). Oxon: Routledge.

Koushede, V., Brixval, C. S., Thygesen, L. C., Axelsen, S. F., Winkel, P., Lindschou, J., . . . Due, P. (2017). Antenatal small-class education versus auditorium-based lectures to promote positive transitioning to parenthood - A randomised trial. *PLoS One, 12*(5), e0176819. doi:10.1371/journal.pone.0176819

Lamb, S., & Altman, D. G. (2015). Individually and cluster-randomized trials. In D. A. Richards. & I. Rahm Hallberg (Eds.), *Complex interventions in health: An overview of research methods* (pp. 191-199). Oxon: Routledge.

Larsson, J., & Holmström, K. I. (2012). Fenomenografi. In M. Henricsson (Ed.), *Vetenskaplig teori och metod. Från idé till examination inom omvårdnad* (Phenomenography. Scientific theory and methodology. From concept to examination in nursing) [In Swedish] (pp. 389–405). Lund: Studentlitteratur AB.

Lefèvre, Å., Lundqvist, P., Drevenhorn, E., & Hallström, I. (2015). Managing parental groups during early childhood: New challenges faced by Swedish child health-care nurses. *J Child Health Care, 19*(3), 381-391. doi:10.1177/1367493513509421

Lefèvre, Å., Lundqvist, P., Drevenhorn, E., & Hallström, I. (2017). Managing parental groups: personal impact of a group leadership course for child healthcare nurses. *J Clin Nurs, 26*(3-4), 466-476. doi:10.1111/jocn.13446

Lefèvre, Å., Pålsson, P., & Köhler, M. (2018). *Föräldrastöd i grupp inom mödra- och barnhälsovården i Skåne 2017*. (Parental support in group in antenatal care and child health care in Skåne 2017*)*. [In Swedish]. Malmö: Region Skåne. https://vardgivare.skane.se/siteassets/3.-kompetens-och-utveckling/sakkunniggrupper/bhv/arsrapport/foraldrastod-i-grupp-inom-modra--och-barnhalsovarden-i-skane-2017.pdf (Accessed February 5, 2020).

Levtov, R., van der Gaag, N., Greene, M., Kaufman, M., & Barker, G. (2015). *State of the World's Fathers: A MenCare Advocacy Publication.* Washington DC: Promundo, Rutgers, Save the Children, Sonke Gender Justice, and the MenEngage Alliance. https://www.savethechildren.net/sites/default/files/libraries/state-of-the-worlds-fathers_12-june-2015.pdf (Accessed February 4, 2020).

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*: Los Angeles: Sage.

Liu, C., Ahlberg, M., Hjern, A., & Stephansson A. (2019). Perinatal Health of Refugee and Asylum-Seeking Women in Sweden 2014-17: A Register-Based Cohort Study. *Eur J Public Health, 29*(6), 1048-1055. doi: 10.1093/eurpub/ckz120

Lu, M. C., Prentice, J., Yu, S. M., Inkelas, M., Lange, L. O., & Halfon, N. (2003). Childbirth education classes: sociodemographic disparities in attendance and the association of attendance with breastfeeding initiation. *Matern Child Health J, 7*(2), 87-93. doi:10.1023/a:1023812826136

Lundh, W., & Gyllang, C. (1993). Use of the Edinburgh Postnatal Depression Scale in some Swedish child health care centres. *Scand J Caring Sci, 7*(3), 149-154. doi:10.1111/j.1471-6712.1993.tb00190.x

Marton, F. (1981). Phenomenography - Describing the conceptions of the world around us *Instructional Science, 10*(2), 177-200.

Massoudi, P., Hwang, C. P., & Wickberg, B. (2016). Fathers' depressive symptoms in the postnatal period: Prevalence and correlates in a population-based Swedish study. *Scand J Public Health, 44*(7), 688-694. doi:10.1177/1403494816661652

May, C., & Fletcher, R. (2013). Preparing fathers for the transition to parenthood: recommendations for the content of antenatal education. *Midwifery, 29*(5), 474-478. doi:10.1016/j.midw.2012.03.005

McKellar, L., Pincombe, J., & Henderson, A. (2008). Enhancing fathers' educational experiences during the early postnatal period. *The Journal of Perinatal Education, 17*(4), 12-20. doi:10.1624/105812408X364134

Meleis, A. I., Sawyer, L. M., Im, E. O., Hilfinger Messias, D. K., & Schumacher, K. (2000). Experiencing transitions: an emerging middle-range theory. *Adv Nurs Sci, 23*(1), 12-28. doi:10.1097/00012272-200009000-00006

Morse, J. M. (2015). Critical Analysis of Strategies for Determining Rigor in Qualitative Inquiry. *Qual Health Res, 25*(9), 1212-1222. doi:10.1177/1049732315588501

Nilsson, I., Danbjorg, D. B., Aagaard, H., Strandberg-Larsen, K., Clemensen, J., & Kronborg, H. (2015). Parental experiences of early postnatal discharge: A meta-synthesis. *Midwifery, 31*(10), 926-934. doi:10.1016/j.midw.2015.07.004

Nilsson, I. M. S., Strandberg-Larsen, K., Knight, C. H., Hansen, A. V., & Kronborg, H. (2017). Focused breastfeeding counselling improves short- and long-term success in an early-discharge setting: A cluster-randomized study. *Matern Child Nutr, 13*(4). doi:10.1111/mcn.12432

Norman, G. (2010). Likert scales, levels of measurement and the "laws" of statistics. *Adv Health Sci Educ Theory Pract, 15*(5), 625-632. doi:10.1007/s10459-010-9222-y

Nyström, M., & Dahlberg, K. (2001). Pre-understanding and openness - a relationship without hope? *Scand J Caring Sci, 15*(4), 339-346. doi:10.1046/j.1471-6712.2001.00043.x

Persson, E. (2010). *Parents' postnatal sense of security (PPSS) : developing an instrument and description of important factors based on mothers' and fathers' experiences*: Doctoral thesis, Lund University.

Persson, E., & Kvist, L. (2014). Postnatal sense of security, anxiety and risk for postnatal depression. *J Womens Health, 3*(3), 4. doi:10.4172/2325-9795.1000141

Persson, E. K., & Dykes, A.-K. (2009). Important variables for parents' postnatal sense of security: evaluating a new Swedish instrument (the PPSS instrument). *Midwifery, 25*(4), 449-460. doi:10.1016/j.midw.2007.08.001

Persson, E. K., Fridlund, B., & Dykes, A. K. (2007). Parents' postnatal sense of security (PPSS): development of the PPSS instrument. *Scand J Caring Sci, 21*(1), 118-125. doi:10.1111/j.1471-6712.2007.00442.x

Persson, E. K., Fridlund, B., Kvist, L. J., & Dykes, A. K. (2011). Mothers' sense of security in the first postnatal week: interview study. *J Adv Nurs, 67*(1), 105-116. doi:10.1111/j.1365-2648.2010.05485.x

Persson, E. K., Fridlund, B., Kvist, L. J., & Dykes, A. K. (2012). Fathers' sense of security during the first postnatal week--a qualitative interview study in Sweden. *Midwifery, 28*(5), e697-704. doi:10.1016/j.midw.2011.08.010

Polit, D. F., & Beck, C. T. (2016). *Nursing research : generating and assessing evidence for nursing practice* (10th ed.). Philadelphia: Wolters Kluwer.

Pontoppidan, M., Andrade, S. B., Kristensen, I. H., & Mortensen, E. L. (2019). Maternal confidence after birth in at-risk and not-at-risk mothers: internal and external validity of the Danish version of the Karitane Parenting Confidence Scale (KPCS). *J Patient Rep Outcomes, 3*(1), 33. doi:10.1186/s41687-019-0126-1

Premberg, Å., & Lundgren, I. (2006). Fathers' Experiences of Childbirth Education. *The Journal of Perinatal Education, 15*(2), 21-28. doi:10.1624/105812406X107780

Ramchandani, P. G., Stein, A., O'Connor, T. G., Heron, J., Murray, L., & Evans, J. (2008). Depression in men in the postnatal period and later child psychopathology: a population cohort study. *J Am Acad Child Adolesc Psychiatry, 47*(4), 390-398. doi:10.1097/CHI.0b013e31816429c2

Razurel, C., Bruchon-Schweitzer, M., Dupanloup, A., Irion, O., & Epiney, M. (2011). Stressful events, social support and coping strategies of primiparous women during the postpartum period: a qualitative study. *Midwifery, 27*(2), 237-242. doi:10.1016/j.midw.2009.06.005

Reece, S. M. (1992). The parent expectations survey: a measure of perceived self-efficacy. *Clin Nurs Res, 1*(4), 336-346. doi:10.1177/105477389200100404

Reece, S. M., & Harkless, G. (1998). Self-efficacy, stress, and parental adaptation: Applications to the care of childbearing families. *Journal of Family Nursing, 4*(2), 198-215. doi:10.1177/107484079800400206

Region Skåne. (2019). *Förfrågningsunderlag och avtal för barnmorskemottagning i Hälsoval Skåne gällande år 2020*. (Specifications and agreements for antenatal clinic in Healthcare choice Skåne 2020) [In Swedish]. https://vardgivare.skane.se/siteassets/4.-uppdrag-och-avtal/lov-lol-lof/ackreditering---fillistning/forfragningsunderlag-bmm-2020.pdf (Accessed February 2, 2020).

Region Skåne. (2019). *Basprogram för graviditetsövervakning/hälsovård – fördjupning*. (Regional guidelines for antenatal care in Skåne) [In Swedish]. https://vardgivare.skane.se/siteassets/1.-vardriktlinjer/regionala-riktlinjer---fillistning/basprogram-for-graviditetsovervakning---fordjupning-2019-10-08.pdf (Accessed February 2, 2020).

Renkert, S., & Nutbeam, D. (2001). Opportunities to improve maternal health literacy through antenatal education: an exploratory study. *Health Promot Int, 16*(4), 381-388.

Rubin, G., & Fredriksson, J. (2018). *Blivande föräldrars upplevelse av vården i Region Skåne före under och efter graviditet.* (Expectant parents' experience of care in Region Skåne before, during and after pregnancy) [In Swedish]. Malmö: Region Skåne & InUse. https://www.skane.se/siteassets/organisation_politik/publikationer_dokument/insiktsrapport.pdf (Accessed February 2, 2020).

Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn´t. *BMJ, 312*(7023), 71-72. doi:10.1136/bmj.312.7023.71

Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement and children's developmental outcomes: a systematic review of longitudinal studies. *Acta Paediatr, 97*(2), 153-158. doi:10.1111/j.1651-2227.2007.00572.x

Schmied, V., Beake, S., Sheehan, A., McCourt, C., & Dykes, F. (2011). Women's perceptions and experiences of breastfeeding support: a metasynthesis. *Birth, 38*(1), 49-60. doi:10.1111/j.1523-536X.2010.00446.x

Schrader McMillan, A., Barlow, J., & Redshaw, M. (2009). *Birth and beyond:A review of the evidence about antenatal education*. London: Department of Health.

SFOG Svensk Förening för Obstetrik och Gynekologi (Swedish Society of Obstetrics and Gynecology). (2016). *Mödrahälsovård, sexuell och reproduktiv hälsa Rapport nr 76.* (Maternity healthcare, sexual and reproductive health Report no 76). [In Swedish]. https://www.sfog.se/natupplaga/ARG76web4a328b70-0d76-474e-840e-31f70a89eae9.pdf (Accessed February 5, 2020).

SFS 2018:1197 *Lag om Förenta nationernas konvention om barnets rättigheter* (Swedish law on UN Convention on the Rights of the Child). https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-20181197-om-forenta-nationernas-konvention_sfs-2018-1197 (Accessed February 2, 2020).

Sherriff, N., Hall, V., & Panton, C. (2014). Engaging and supporting fathers to promote breast feeding: a concept analysis. *Midwifery, 30*(6), 667-677. doi:10.1016/j.midw.2013.07.014

Shorey, S., Chee, C. Y. I., Ng, E. D., Chan, Y. H., Tam, W. W. S., & Chong, Y. S. (2018). Prevalence and incidence of postpartum depression among healthy mothers: A systematic review and meta-analysis. *J Psychiatr Res, 104*, 235-248. doi:10.1016/j.jpsychires.2018.08.001

Sihota, H., Oliffe, J., Kelly, M. T., & McCuaig, F. (2019). Fathers' Experiences and Perspectives of Breastfeeding: A Scoping Review. *Am J Mens Health, 13*(3), 1557988319851616-1557988319851616. doi:10.1177/1557988319851616

Sjöström, B., & Dahlgren, L. O. (2002). Applying phenomenography in nursing research. *J Adv Nurs, 40*(3), 339-345. doi:10.1046/j.1365-2648.2002.02375.x

Statistics Sweden (Statistiska centralbyrån). (2018a). Population statistics. http://www.statistikdatabasen.scb.se/pxweb/sv/ssd/START__BE__BE0101__BE0101H/FoddaK/ (Accessed February 2, 2020).

Statistics Sweden (Statistiska centralbyrån). (2018b). Labour market statistics. http://www.statistikdatabasen.scb.se/sq/80679 (Accessed February 2, 2020).

Steen, M., Downe, S., Bamford, N., & Edozien, L. (2012). Not-patient and not-visitor: a metasynthesis fathers' encounters with pregnancy, birth and maternity care. *Midwifery, 28*(4), 362-371. doi:10.1016/j.midw.2011.06.009

Stern, D. N., & Bruschweiler-Stern, N. (1999). *En mor blir till : hur moderskap förändrar dig för all framtid*. Stockholm: Natur och kultur.

Sundquist, K., Malmstrom, M., Johansson, S. E., & Sundquist, J. (2003). Care Need Index, a useful tool for the distribution of primary health care resources. *J Epidemiol Community Health, 57*(5), 347-352. doi:10.1136/jech.57.5.347

Svensson, J., Barclay, L., & Cooke, M. (2006). The concerns and interests of expectant and new parents: assessing learning needs. *J Perinat Educ, 15*(4), 18-27. doi:10.1624/105812406x151385

Svensson, J., Barclay, L., & Cooke, M. (2009). Randomised-controlled trial of two antenatal education programmes. *Midwifery, 25*(2), 114-125. doi:10.1016/j.midw.2006.12.012

Swedish Ministry of Health and Welfare (Socialdepartementet). (2018). *En nationell strategi för ett stärkt föräldraskapsstöd* (A national strategy for strengthening parental support) [In Swedish]. https://www.regeringen.se/4a6017/globalassets/regeringen/dokument/socialdepartementet/barnets-rattigheter/en-nationell-strategi-for-ett-starkt-foraldraskapsstod-webb.pdf (Accessed February 2, 2020).

The Swedish National Board of Health and Welfare (Socialstyrelsen). (2012) *Om evidensbaserad praktik* (On evidence-based practice) [In Swedish]. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2012-12-20.pdf (Accessed February 2, 2020).

The Swedish National Board of Health and Welfare (Socialstyrelsen). (2017). *Vård efter förlossning: En nationell kartläggning av vården till kvinnor efter förlossning* (Care after birth: A national survey of maternal care after birth) [In Swedish]. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2017-4-13.pdf (Accessed February 2, 2020).

The Swedish National Board of Health and Welfare (Socialstyrelsen). (2019a). *Statistik om amning 2017*. (Statistics on breastfeeding 2017) [In Swedish]. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/statistik/2019-9-6378.pdf (Accessed February 2, 2020).

The Swedish National Board of Health and Welfare (Socialstyrelsen). (2019b). *Gravida och nyförlösta kvinnors situation och behov. En enkätundersökning och fokusgruppssamtal om hälsofrågor, oro, information, uppföljning och stöd* (Women's situation and needs during pregnancy and postnatal period. A survey and focus group discussion on health issues, concerns, information, follow-up and support) [In Swedish]. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2019-11-6436.pdf (Accessed February 6, 2020).The Swedish Pregnancy Register (Graviditetsregistret). (2019). *Årsrapport 2018* (Annual report 2018) [In Swedish]. https://www.medscinet.com/GR/uploads/hemsida/dokumentarkiv/2018%20GR%20%C3%A5rsrapport_2.0.pdf (Accessed February 2, 2020).

Tammentie, T., Paavilainen, E., Åstedt-Kurki, P., & Tarkka, M.-T. (2004). Family dynamics of postnatally depressed mothers - discrepancy between expectations and reality. *J Clin Nurs, 13*(1), 65-74. doi:10.1046/j.1365-2702.2003.00824.x

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *Int J Med Educ, 2*, 53-55. doi:10.5116/ijme.4dfb.8dfd

United Nations. (1989). *Convention on the Rights of the Child*.

United Nations. (2015). *Transforming our world: The 2030 agenda for sustainable development.* New York. https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf (Accessed February 2, 2020).

van Teijlingen, E. R., Hundley, V., Rennie, A. M., Graham, W., & Fitzmaurice, A. (2003). Maternity satisfaction studies and their limitations: "What is, must still be best". *Birth, 30*(2), 75-82.

Vänskä, M., Punamäki, R., Lindblom, J., Flykt, M., Tolvanen, A., Unkila-Kallio, L., . . . Tiitinen, A. (2017). Parental pre- and postpartum mental health predicts child mental health and development. *Fam Relat, 66*(3), 497-511. doi:10.1111/fare.12260

Victora, C. G., Bahl, R., Barros, A. J., Franca, G. V., Horton, S., Krasevec, J., . . . Rollins, N. C. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet, 387*(10017), 475-490. doi:10.1016/s0140-6736(15)01024-7

Vikström, A., & Barimani, M. (2016). Partners' perspective on care-system support before, during and after childbirth in relation to parenting roles. *Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives, 8*, 1-5. doi:10.1016/j.srhc.2015.11.008

Wagner, E. A., Chantry, C. J., Dewey, K. G., & Nommsen-Rivers, L. A. (2013). Breastfeeding concerns at 3 and 7 days postpartum and feeding status at 2 months. *Pediatrics, 132*(4), e865-875. doi:10.1542/peds.2013-0724

Wallby, T. (2009). Föräldrastöd på BVC - en nationell kartläggning. In A. Sarkadi (Ed.), *Föräldrastöd i Sverige idag - Vad, när och hur? (Parental support in Sweden today - What, when and how?)* (pp. 145-168) [In Swedish]. Östersund: Folkhälsoinstitutet (Swedish National Institute of Public Health).

Wells, M. B. (2016). Literature review shows that fathers are still not receiving the support they want and need from Swedish child health professionals. *Acta Paediatr, 105*(9), 1014-1023. doi:10.1111/apa.13501

Wells, M. B., & Lang, S. N. (2016). Supporting same-sex mothers in the Nordic child health field: a systematic literature review and meta-synthesis of the most gender equal countries. *J Clin Nurs, 25*(23-24), 3469-3483. doi:10.1111/jocn.13340

Wells, M. B., Massoudi, P., & Bergström, M. (2017). Swedish child health nurses treat fathers more equally in 2014 than 2004, but mothers remain their primary focus. *Acta Paediatr*. doi:10.1111/apa.13898

Werner-Bierwisch, T., Pinkert, C., Niessen, K., Metzing, S., & Hellmers, C. (2018). Mothers' and fathers' sense of security in the context of pregnancy, childbirth and the postnatal period: an integrative literature review. *BMC Pregnancy Childbirth, 18*(1), 473. doi:10.1186/s12884-018-2096-3

Wickberg, B. (2019). Screening med EPDS för depression hos nyblivna mammor. *Rikshandboken Barnhälsovård* (Screening with EPDS for depression in new mothers. The Swedish National Handbook for Child Health Services) [In Swedish]. https://www.rikshandboken-bhv.se/metoder--riktlinjer/screening-med-epds/ (Accessed February 2, 2020).

Wickberg, B., & Hwang, C. P. (1996). The Edinburgh Postnatal Depression Scale: validation on a Swedish community sample. *Acta Psychiatr Scand, 94*(3), 181-184. doi:10.1111/j.1600-0447.1996.tb09845.x

Widarsson, M., Engström, G., Berglund, A., Tydén, T., & Lundberg, P. (2014). Parental stress and dyadic consensus in early parenthood among mothers and fathers in Sweden. *Scand J Caring Sci, 28*(4), 689-699. doi:10.1111/scs.12096

Widarsson, M., Engström, G., Tydén, T., Lundberg, P., & Hammar, L. M. (2015). 'Paddling upstream': Fathers' involvement during pregnancy as described by expectant fathers and mothers. *J Clin Nurs, 24*(7-8), 1059-1068. doi:10.1111/jocn.12784

Widarsson, M., Kerstis, B., Sundquist, K., Engström, G., & Sarkadi, A. (2012). Support needs of expectant mothers and fathers: a qualitative study. *J Perinat Educ, 21*(1), 36-44. doi:10.1891/1058-1243.21.1.36

Widarsson, M., Nohlert, E., Öhrvik, J., & Kerstis, B. (2019). Parental stress and depressive symptoms increase the risk of separation among parents with children less than 11 years of age in Sweden. *Scand J Public Health, 47*(2), 207-214. doi:10.1177/1403494817724312

Wiklund, I., Wiklund, J., Pettersson, V., & Boström, A. M. (2018). New parents' experience of information and sense of security related to postnatal care: A systematic review. *Sex Reprod Healthc, 17*, 35-42. doi:10.1016/j.srhc.2018.06.001

Wojnar, D. M., & Katzenmeyer, A. (2014). Experiences of preconception, pregnancy, and new motherhood for lesbian nonbiological mothers. *J Obstet Gynecol Neonatal Nurs, 43*(1), 50-60. doi:10.1111/1552-6909.12270

World Health Organization & UNICEF. (2003). *Global strategy for infant and young child feeding.* Geneva. https://apps.who.int/iris/bitstream/handle/10665/42590/9241562218.pdf?sequence=1 (Accessed February 2, 2020).

World Health Organization. (2004). *Reproductive health strategy.* Geneva. https://apps.who.int/iris/bitstream/handle/10665/68754/WHO_RHR_04.8.pdf (Accessed February 2, 2020).

World Health Organization. (2007). Fatherhood and health outcomes in Europe. Copenhagen. http://www.euro.who.int/__data/assets/pdf_file/0017/69011/E91129.pdf (Accessed February 2, 2020).

World Health Organization. (2016a) *Standards for improving quality of maternal and newborn care in health facilities.* Geneva. https://apps.who.int/iris/bitstream/handle/10665/249155/9789241511216-eng.pdf?sequence=1 (Accessed February 2, 2020).

World Health Organization. (2016b). *WHO recommendations on antenatal care for a positive pregnancy experience.* Geneva. https://apps.who.int/iris/bitstream/handle/10665/250796/9789241549912-eng.pdf;jsessionid=4F747CE9C7CBE3C36B6C177BA11894E8?sequence=1 (Accessed February 2, 2020).

World Health Organization. (2017). *Guideline: Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services.* Geneva. https://apps.who.int/iris/bitstream/handle/10665/259386/9789241550086-eng.pdf?sequence=1 (Accessed February 2, 2020).

World Health Organization. (2018). *Infant and young child feeding.* https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding (Accessed February 2, 2020).

World Medical Association. (2013). *WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects*. https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/ (Accessed February 2, 2020).

Ystrom, E. (2012). Breastfeeding cessation and symptoms of anxiety and depression: a longitudinal cohort study. *BMC Pregnancy Childbirth, 12*, 36. doi:10.1186/1471-2393-12-36

Zwedberg, S. (2010). *Ville amma! En hermeneutisk studie av mödrar med amningsbesvär; deras upplevelser, problemhantering samt amningskonsultativa möten.* (I wanted to breastfeed! A hermeneutical study of mothers with breastfeeding problems; their experiences, coping strategies, and consultative meetings with midwives) [In Swedish]. Doctoral Thesis, Stockholm University.

Åsenhed, L., Kilstam, J., Alehagen, S., & Baggens, C. (2014). Becoming a father is an emotional roller coaster - an analysis of first-time fathers' blogs. *J Clin Nurs, 23*(9-10), 1309-1317. doi:10.1111/jocn.12355

Appendix I

I1

Föräldraförberedelse i Mödrahälsovården i Skåne

Kryssa ett alternativ där inget annat anges

Genom att kryssa i rutan för informerat samtycke ger du/ni ditt/ert medgivande till att delta i denna studie.

☐ Jag/vi samtycker

1. Barnmorskemottagningens namn?

2. I vilken kommun ligger barnmorskemottagningen?

3. Mottagningen är:

☐ Privat
☐ Offentlig

4.Hur många barnmorskor arbetar på mottagningen?

Definitioner för nedanstående fråga:

Familjecentral: *Samverkan mellan och samlokalisering av de fyra basverksamheterna mödrahälsovård, barnhälsovård, öppen förskola och socialtjänst.*

Familjecentralsliknande verksamhet:
Barnhälsovård samlokaliserad med en annan kommunal verksamhet (öppen förskola eller socialtjänst).

5. Är barnmorskemottagningen samlokaliserad i en så kallad familjecentral/familjecentralsliknande verksamhet?

☐ Ja, med barnmorskemottagning och BVC
☐ Ja, med barnmorskemottagning, BVC och öppen förskola
☐ Ja, med barnmorskemottagning, BVC och socialtjänst
☐ Ja, med barnmorskemottagning, BVC, öppen förskola och socialtjänst
☐ Ja, med barnmorskemottagning och öppen förskola
☐ Ja, med barnmorskemottagning och socialtjänst
☐ Nej, inte alls

Definitioner för nedanstående frågor:

Föräldragrupp: *Avser föräldraförberedelse till mer än ett föräldrapar i taget och gruppen har ingen övre storleksgräns.*

Pappa: *avser i denna enkät både manlig och kvinnlig partner till den gravida*

6. Arbetar alla barnmorskor på mottagningen med föräldragrupper?

☐ Ja OM "Ja", GÅ VIDARE TILL FRÅGA 9

☐ Nej

7. Om nej på ovanstående fråga: Hur många barnmorskor arbetar med föräldragrupp?

☐☐

8. Om inte alla barnmorskor arbetar med föräldragrupper:
Vad är anledningen till det? *Flera alternativ möjliga i denna fråga*

☐ Barnmorskorna i verksamheten får själva välja om de vill arbeta med föräldragrupper

☐ Verksamheten behöver inte att alla barnmorskorna arbetar med föräldragrupper

☐ Annat:

9. Vilka blivande föräldrar erbjuds föräldragrupp?

☐ Alla blivande föräldrar OM "Alla blivande föräldrar", GÅ VIDARE TILL FRÅGA 11

☐ Enbart om det är någon av föräldrarnas första barn

☐ Enbart om det är mammans första barn

☐ Förstagångsföräldrar, men även flergångsföräldrar i mån av plats eller behov

10. Om inte alla blivande föräldrar erbjuds plats:
Vad är anledningen till det? *Flera alternativ möjliga i denna fråga*

☐ Brist på lämplig lokal

☐ Brist på tid

☐ Flergångsföräldrar efterfrågar inte föräldraförberedelse i grupp

☐ Otillräckligt antal barnmorskor som arbetar med föräldragrupper

☐ Annat:

11. Händer det att föräldrar som vill delta i föräldragrupp ej kan erbjudas plats?

☐ Ja
☐ Nej

12. Vidtar ni några särskilda åtgärder för att öka deltagandet av pappor/partners i föräldragrupperna?

☐ Ja
☐ Nej GÅ VIDARE TILL FRÅGA 14

13. Om ja på ovanstående fråga: Vilka åtgärder?

14. Erbjuds särskilda träffar för mammor respektive pappor/partners?

☐ Ja, både för mammor och pappor
☐ Ja, för enbart mammor
☐ Ja, för enbart pappor
☐ Nej OM "Nej", GÅ VIDARE TILL FRÅGA 17

15. Om ja för mammor: erbjuds träff

☐ I mindre grupp
☐ I storgrupp/föreläsning

16. Om ja för pappor: erbjuds träff

☐ I mindre grupp
☐ I storgrupp/föreläsning

17. Erbjuder ni riktade föräldragrupper? *Flera alternativ möjliga i denna fråga*

☐ Ja, till flergångsföräldrar
☐ Ja, till unga föräldrar
☐ Ja, till samkönade föräldrar
☐ Ja, till tvillingföräldrar
☐ Ja, till icke-svensktalande föräldrar
☐ Ja, till ensamstående föräldrar
☐ Ja, till annan grupp. Ange vilken:
☐ Nej OM "Nej", GÅ VIDARE TILL FRÅGA 19

18. Om ja på ovanstående fråga.
Samarbetar ni med andra barnmorskemottagningarvad gäller riktade föräldragrupper?

☐ Ja

☐ Nej

19. I vilken graviditetsvecka börjar/rekommenderar ni föräldragrupp?

☐ före graviditetsvecka 20

☐ v20 - v24

☐ v25 - 29

☐ v30 - 34

☐ v35 eller senare

20. Hur erbjuder ni föräldragrupp? *Flera alternativ möjliga i denna fråga*

☐ I mindre grupp

☐ I storgrupp/föreläsningar

OM ENBART "storgrupp/föreläsningar", GÅ VIDARE TILL FRÅGA 36

ANNARS, FORTSÄTT MED FRÅGA 21

Frågor gällande mindre grupp

21. Hur många deltagare består gruppen vanligvis av?

☐☐

22. Hur många tillfällen erbjuds?

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ >6

23. Hur lång tid varar varje föräldragruppstillfälle?

- ☐ 1h
- ☐ 1,5h
- ☐ 2h
- ☐ 2,5h
- ☐ 3h
- ☐ 3,5h
- ☐ 4h eller mer

24. Vid vilka tider erbjuds föräldragrupper?

- ☐ Förmiddag (start före kl.12)
- ☐ Eftermiddag (start kl. 13-16)
- ☐ Kväll (start senare än kl 16.)
- ☐ Helg

25. Är träffarna tydligt indelade i teman/ämnen?

- ☐ Ja
- ☐ Nej

26. Är det samma grupp som ses om föräldragrupp erbjuds vid mer än ett tillfälle?

- ☐ Ja, tanken är att det ska vara en sammanhållen grupp
- ☐ Ja ofta, men det finns ingen strävan efter att det ska vara så
- ☐ Nej

27. Delas gruppen vid något tillfälle upp i mammor respektive pappor/partner?

- ☐ Ja, vid någon av träffarna
- ☐ Ja, vid flera tillfällen
- ☐ Nej

28. Ingår gruppdiskussioner i föräldragrupperna?

- ☐ Ja, vid någon av träffarna
- ☐ Ja, vid de flesta av träffarna
- ☐ Nej inte alls

29. Vem leder föräldragrupperna?

☐ Samma barnmorska leder gruppen på egen hand vid samtliga av grupptillfällena

☐ En barnmorska leder gruppen på egen hand men det är inte samma barnmorska som leder alla grupptillfällena

☐ Delat ledarskap, barnmorska tillsammans med annan barnmorska

☐ Delat ledarskap, barnmorska tillsammans med annan yrkeskategori. Barnmorskan är närvarande vid alla grupptillfällena

☐ Delat ledarskap, barnmorska tillsammans med annan yrkeskategori. Barnmorskan är inte närvarande vid alla grupptillfällena

30. Vilka andra yrkeskategorier/resurser är involverade i föräldragruppen?

☐ BVC-sjuksköterska

☐ Socionom/familjerådgivare

☐ Psykolog

☐ Förskollärare/öppna förskolan

☐ Försäkringskassan

☐ Särskild pappagruppsledare

☐ Annan yrkeskategori. Ange vilken: _____

☐ Inga andra yrkeskategorier/resurser används

31. Har ni på er barnmorskemottagning ett gemensamt program/innehåll för träffarna?

☐ Ja, och detta följs

☐ Ja, men vi ändrar det om föräldrarna har andra önskemål

☐ Ja, vi har en del fasta punktermen för övrigt avgör föräldrarnas önskemål

☐ Nej, föräldrarnas önskemål styr helt innehållet

☐ Nej, det är upp till den enskilde gruppledaren att styra innehållet

☐ Nej, gruppledaren och föräldrarnas önskemål styr tillsammans innehållet

32. Om det finns ett gemensamt program, bifoga mycket gärna detta. Tack!

☐ Program bifogas

☐ Program bifogas inte

33. I vilken utsträckning tas följande ämnen upp i föräldragruppen?

Förlossning	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Normal förlossning	☐	☐	☐	☐	☐
Metoder för andning och avslappning	☐	☐	☐	☐	☐
Partnerns roll under förlossningen	☐	☐	☐	☐	☐
Förlossningsställningar	☐	☐	☐	☐	☐
Smärtlindring	☐	☐	☐	☐	☐
Bristningar	☐	☐	☐	☐	☐
Induktion	☐	☐	☐	☐	☐
Instrumentella förlossningar	☐	☐	☐	☐	☐
Kejsarsnitt	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (förlossning)?

☐☐ %

Amning	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Amningens fördelar	☐	☐	☐	☐	☐
Amningsstart	☐	☐	☐	☐	☐
Vanliga amningsproblem	☐	☐	☐	☐	☐
Mjökersättning	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (amning)?

☐☐ %

Barnet	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Att ta hand om det nyfödda barnet	☐	☐	☐	☐	☐
Barnets hälsa de första veckorna, teckan på ohälsa	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (barnet)?

☐☐ %

Mamman	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Kroppens återhämtning, läkning efter förlossningen	☐	☐	☐	☐	☐
Bäckenbottenträning	☐	☐	☐	☐	☐
Fysisk träning efter förlossningen	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (mamman)?

☐☐ %

Familjen	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Anknytning, samspel förälder - barn	☐	☐	☐	☐	☐
Känslor och nedstämdhet efter förlossningen	☐	☐	☐	☐	☐
Sömn	☐	☐	☐	☐	☐
Syskon	☐	☐	☐	☐	☐
Relationer, sex och samlevnad	☐	☐	☐	☐	☐
Preventivmedel	☐	☐	☐	☐	☐
Jämställt föräldraskap, könsroller	☐	☐	☐	☐	☐
Ekonomi, föräldraförsäkring	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (familjen)?

☐☐ %

Praktisk information	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Förlossningsavdelningen	☐	☐	☐	☐	☐
BB-tiden/eftervård	☐	☐	☐	☐	☐
BVC	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (praktisk information)?

☐☐ %

	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Annat ämne. Ange vilket:	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (annat)?

☐☐ %

34. Lämnas föräldragruppen över till BVC, dvs fortsätter samma föräldragrupp på BVC?

☐ Ja, alltid

☐ Ja, oftast

☐ Ja, någon gång

☐ Nej, aldrig

35. Egna kommentarer:

OM NI ERBJUDER FÖRÄLDRAGRUPPER ÄVEN I STORGRUPP, FORTSÄTTER NI MED FRÅGA 36

Om inte, så är era frågor besvarade. Tack för att du/ni tog er tid att svara på frågorna!

Frågor gällande storgrupp/föreläsning

36. Hur många deltagare består gruppen vanligvis av?

37. Hur många tillfällen erbjuds?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ >6

38. Hur lång tid varar varje föräldragruppstillfälle?

- ☐ 1h
- ☐ 1,5h
- ☐ 2h
- ☐ 2,5h
- ☐ 3h
- ☐ 3,5h
- ☐ 4h eller mer

39. Vid vilka tider erbjuds föräldragrupper?

- ☐ Förmiddag (start före kl.12)
- ☐ Eftermiddag (start kl. 13-16)
- ☐ Kväll (start senare än kl 16.)
- ☐ Helg

40. Är träffarna tydligt indelade i teman/ämnen?

- ☐ Ja
- ☐ Nej

41. Är det samma grupp som ses om föräldragrupp erbjuds vid mer än ett tillfälle?

- ☐ Ja, tanken är att det ska vara en sammanhållen grupp
- ☐ Ja ofta, men det finns ingen strävan efter att det ska vara så
- ☐ Nej

42. Delas gruppen vid något tillfälle upp i mammor respektive pappor/partner?

- ☐ Ja, vid någon av träffarna
- ☐ Ja, vid flera tillfällen
- ☐ Nej

43. Ingår gruppdiskussioner i föräldragrupperna?

- ☐ Ja, vid någon av träffarna
- ☐ Ja, vid de flesta av träffarna
- ☐ Nej inte alls

44. Vem leder föräldragrupperna?

- ☐ Samma barnmorska leder gruppen på egen hand vid samtliga av grupptillfällena
- ☐ En barnmorska leder gruppen på egen hand men det är inte samma barnmorska som leder alla grupptillfällena
- ☐ Delat ledarskap, barnmorska tillsammans med annan barnmorska
- ☐ Delat ledarskap, barnmorska tillsammans med annan yrkeskategori. Barnmorskan är närvarande vid alla grupptillfällena
- ☐ Delat ledarskap, barnmorska tillsammans med annan yrkeskategori. Barnmorskan är inte närvarande vid alla grupptillfällena

45. Vilka andra yrkeskategorier/resurser är involverade i föräldragruppen?

- ☐ BVC-sjuksköterska
- ☐ Socionom/familjerådgivare
- ☐ Psykolog
- ☐ Förskollärare/öppna förskolan
- ☐ Försäkringskassan
- ☐ Särskild pappagruppsledare
- ☐ Annan yrkeskategori. Ange vilken: ____
- ☐ Inga andra yrkeskategorier/resurser används

46. Har ni på er barnmorskemottagning ett gemensamt program/innehåll för träffarna?

- ☐ Ja, och detta följs
- ☐ Ja, men vi ändrar det om föräldrarna har andra önskemål
- ☐ Ja, vi har en del fasta punktermen för övrigt avgör föräldrarnas önskemål
- ☐ Nej, föräldrarnas önskemål styr helt innehållet
- ☐ Nej, det är upp till den enskilde gruppledaren att styra innehållet
- ☐ Nej, gruppledaren och föräldrarnas önskemål styr tillsammans innehållet

47. Om det finns ett gemensamt program, bifoga mycket gärna detta. Tack!

- ☐ Program bifogas
- ☐ Program bifogas inte

48. I vilken utsträckning tas följande ämnen upp i föräldragruppen?

Förlossning	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Normal förlossning	☐	☐	☐	☐	☐
Metoder för andning och avslappning	☐	☐	☐	☐	☐
Partnerns roll under förlossningen	☐	☐	☐	☐	☐
Förlossningsställningar	☐	☐	☐	☐	☐
Smärtlindring	☐	☐	☐	☐	☐
Bristningar	☐	☐	☐	☐	☐
Induktion	☐	☐	☐	☐	☐
Instrumentella förlossningar	☐	☐	☐	☐	☐
Kejsarsnitt	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (förlossning)?

☐☐ %

Amning	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Amningens fördelar	☐	☐	☐	☐	☐
Amningsstart	☐	☐	☐	☐	☐
Vanliga amningsproblem	☐	☐	☐	☐	☐
Mjökersättning	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (amning)?

☐☐ %

Barnet	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Att ta hand om det nyfödda barnet	☐	☐	☐	☐	☐
Barnets hälsa de första veckorna, teckan på ohälsa	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (barnet)?

☐☐ %

Mamman	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Kroppens återhämtning, läkning efter förlossningen	☐	☐	☐	☐	☐
Bäckenbottenträning	☐	☐	☐	☐	☐
Fysisk träning efter förlossningen	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (mamman)?

☐☐ %

Familjen	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Anknytning, samspel förälder - barn	☐	☐	☐	☐	☐
Känslor och nedstämdhet efter förlossningen	☐	☐	☐	☐	☐
Sömn	☐	☐	☐	☐	☐
Syskon	☐	☐	☐	☐	☐
Relationer, sex och samlevnad	☐	☐	☐	☐	☐
Preventivmedel	☐	☐	☐	☐	☐
Jämställt föräldraskap, könsroller	☐	☐	☐	☐	☐
Ekonomi, föräldraförsäkring	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (familjen)?

☐☐ %

Praktisk information	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Förlossningsavdelningen	☐	☐	☐	☐	☐
BB-tiden/eftervård	☐	☐	☐	☐	☐
BVC	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (praktisk information)?

☐☐ %

	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad	Inte alls
Annat ämne. Ange vilket:	☐	☐	☐	☐	☐

Hur stor del av tiden läggs på förberedelse inom ovanstående område (annat)?

☐☐ %

49. Lämnas föräldragruppen över till BVC, dvs fortsätter samma föräldragrupp på BVC?

☐ Ja, alltid

☐ Ja, oftast

☐ Ja, någon gång

☐ Nej, aldrig

50. Egna kommentarer:

Tack för att du/ni tog er tid att svara på frågorna!

Grundenkäten är framtagen av Thomas Wallby mfl. Landstinget i Uppsala län.

Appendix II

1. Din ålder

2. Hur lång är din yrkeserfarenhet som barnmorska? (i antal år)

3. Hur lång är din erfarenhet av att leda föräldragrupp? (i antal år)

4. Vilka typer av föräldragrupper har du erfarenhet av att leda?

- [ ] Mindre grupp
- [ ] Storgrupp/föreläsning
- [ ] Jag har ingen erfarenhet av att leda föräldragrupp

5. Vilken grupp leder du oftast?

- ○ Mindre grupp
- ○ Storgrupp/föreläsning
- ○ Jag leder inte föräldragrupp

6. Använder du websidor i ditt arbete med förlossnings- och föräldraförberedelse?

- ○ Ja, ofta
- ○ Ja, ibland
- ○ Nej

7. Använder du appar i ditt arbete med förlossnings- och föräldraförberedelse?

- ○ Ja, ofta
- ○ Ja, ibland
- ○ Nej

8. Hur viktigt anser du det är att förlossnings- och föräldraförberedelsen innehåller följande ämnen?

	Inte alls viktigt	Mindre viktigt	Viktigt	Mycket viktigt
Normal förlossning	☐	☐	☐	☐
Metoder för andning och avslappning	☐	☐	☐	☐
Partnerns roll under förlossningen	☐	☐	☐	☐
Förlossningsställningar	☐	☐	☐	☐
Smärtlindring	☐	☐	☐	☐
Bristningar	☐	☐	☐	☐
Induktion	☐	☐	☐	☐
Instrumentella förlossningar	☐	☐	☐	☐
Kejsarsnitt	☐	☐	☐	☐
Förlossningskomplikationer	☐	☐	☐	☐
Amningens fördelar	☐	☐	☐	☐
Amningsstart	☐	☐	☐	☐
Vanliga amningsproblem	☐	☐	☐	☐
Mjölkersättning	☐	☐	☐	☐
Att ta hand om det nyfödda barnet	☐	☐	☐	☐
Barnets hälsa de första veckorna, tecken på ohälsa	☐	☐	☐	☐
Kroppens återhämtning/läkning efter förlossningen	☐	☐	☐	☐
Bäckenbottenträning	☐	☐	☐	☐
Fysisk träning efter förlossningen	☐	☐	☐	☐
Anknytning, samspel förälder - barn	☐	☐	☐	☐
Känslor och nedstämdhet efter förlossningen	☐	☐	☐	☐
Sömn	☐	☐	☐	☐
Syskon	☐	☐	☐	☐
Relationer, sex och samlevnad	☐	☐	☐	☐
Preventivmedel	☐	☐	☐	☐
Jämställt föräldraskap, könsroller	☐	☐	☐	☐
Ekonomi, föräldraförsäkring	☐	☐	☐	☐
Praktisk information, förlossningsavdelning	☐	☐	☐	☐
Praktisk information, BB-	☐	☐	☐	☐

tiden/eftervård				
Praktisk information, BVC	☐	☐	☐	☐
Annat ämne. Ange vilket:	☐	☐	☐	☐

9. Hur tycker du det är att leda föräldragrupper?

	Stämmer inte alls	Stämmer i låg grad	Stämmer i hög grad	Stämmer helt
Jag tycker att det är roligt att leda föräldragrupper	☐	☐	☐	☐
Jag tycker att det är svårt att leda föräldragrupper	☐	☐	☐	☐
Jag tycker att det är stimulerande att leda föräldragrupper	☐	☐	☐	☐
Jag skulle gärna avstå från att leda föräldragrupper	☐	☐	☐	☐
Jag känner mig bekväm i rollen som gruppledare	☐	☐	☐	☐
Jag har tillräcklig kunskap om gruppledarskap, dvs hur ledaren och gruppen interagerar	☐	☐	☐	☐
Jag har tillräcklig kunskap i pedagogik, dvs hur jag lär ut något	☐	☐	☐	☐
Jag har tillräckligt stöd från mina kollegor i arbetet med föräldragrupper	☐	☐	☐	☐
Jag har tillräckligt stöd från min chef i arbetet med föräldragrupper	☐	☐	☐	☐
Jag har tillgång till all teknisk utrustning som jag behöver i arbetet med föräldragrupper	☐	☐	☐	☐
Jag upplever att den eller de lokaler jag har tillgång till fungerar bra att hålla föräldragrupper i	☐	☐	☐	☐
Jag har möjlighet att avsätta tillräcklig tid för förberedelse inför föräldragrupper	☐	☐	☐	☐
Jag tycker att tiden under föräldragruppstillfället/tillfällena räcker till för att förbereda de blivande föräldrarna inför förlossning och föräldraskap	☐	☐	☐	☐
Jag har tillräcklig ämneskunskap för att förbereda blivande föräldrar om förlossning	☐	☐	☐	☐
Jag har tillräcklig ämneskunskap för att förbereda blivande föräldrar om amning	☐	☐	☐	☐
Jag har tillräcklig ämneskunskap för att förbereda blivande föräldrar om föräldraskap och den första tiden efter förlossningen	☐	☐	☐	☐

10. Vad anser du bäst beskriver begreppet föräldrastöd? Ange de fyra alternativ som bäst beskriver din uppfattning

- [ ] Tillgänglighet per telefon
- [ ] Personkännedom/kontinuitet
- [ ] Kunna erbjuda kontakt med psykolog
- [ ] Föräldragrupper
- [ ] Tillgänglighet för individuella besök
- [ ] Tillgänglighet till pålitliga websidor och appfunktioner kring graviditet, förlossning och första tiden med barnet
- [ ] Råd om litteratur
- [ ] Samarbete med BVC, socialförvaltning och/eller öppna förskolan
- [ ] Annat: Ange vad

11. Egna kommentarer:

Appendix III

LUNDS UNIVERSITET

Enkät om hur föräldraförberedelse getts under tiden som studien om föräldraförberedelse pågått

Enkäten besvaras gemensamt av de barnmorskor som haft föräldragrupperna

1. Mellan vilka graviditetsveckor var deltagarna vanligtvis i när föräldragrupperna startade?

_____ - _____

2. Hur många deltagare bestod gruppen vanligtvis av? _____

3. Hur många tillfällen erbjöds?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ >6

4. Hur lång tid varade varje föräldragruppstillfälle?

☐ 1h ☐ 1,5h ☐ 2h ☐ 2,5h ☐ 3h ☐ 3,5h ☐ ≥4h

5. I vilken utsträckning togs följande ämnen upp i föräldragruppen?

	Inte alls	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad
Förlossning					
Normal förlossning	☐	☐	☐	☐	☐
Metoder för andning och avslappning	☐	☐	☐	☐	☐
Partnerns roll under förlossningen	☐	☐	☐	☐	☐
Förlossningsställningar	☐	☐	☐	☐	☐
Smärtlindring	☐	☐	☐	☐	☐
Bristningar	☐	☐	☐	☐	☐
Induktion	☐	☐	☐	☐	☐
Instrumentella förlossningar	☐	☐	☐	☐	☐
Kejsarsnitt	☐	☐	☐	☐	☐

	Inte alls	I mycket låg grad	I låg grad	I hög grad	I mycket hög grad
Amning					
Amningens fördelar	☐	☐	☐	☐	☐
Amningsstart	☐	☐	☐	☐	☐
Vanliga amningsproblem	☐	☐	☐	☐	☐
Mjölkersättning	☐	☐	☐	☐	☐
Barnet					
Att ta hand om det nyfödda barnet	☐	☐	☐	☐	☐
Barnets hälsa de första veckorna, tecken på ohälsa	☐	☐	☐	☐	☐
Mamman					
Kroppens återhämtning, läkning efter förlossningen	☐	☐	☐	☐	☐
Bäckenbottenträning	☐	☐	☐	☐	☐
Fysisk träning efter förlossningen	☐	☐	☐	☐	☐
Familjen					
Anknytning, samspel förälder - barn	☐	☐	☐	☐	☐
Känslor och nedstämdhet efter förlossningen	☐	☐	☐	☐	☐
Sömn	☐	☐	☐	☐	☐
Syskon	☐	☐	☐	☐	☐
Relationer, sex och samlevnad	☐	☐	☐	☐	☐
Preventivmedel	☐	☐	☐	☐	☐
Jämställt föräldraskap, könsroller	☐	☐	☐	☐	☐
Ekonomi, föräldraförsäkring	☐	☐	☐	☐	☐
Praktisk information					
Förlossningsavdelningen	☐	☐	☐	☐	☐
BB-tiden/eftervård	☐	☐	☐	☐	☐
BVC	☐	☐	☐	☐	☐

6. Ange vid vilket tillfälle följande teman (i huvudsak) togs upp:

Förlossning

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ >6

Amning

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ >6

Föräldraskap

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ >6

7. Egna kommentarer:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Tack för hjälpen!

Appendix IV

LUNDS UNIVERSITET

Studie om föräldraförberedelse

Enkät till barnmorskan om hur föräldraförberedelsen getts

Fylls i efter varje tillfälle/träff

Fyll i enkäten efter varje tillfälle/träff.

Syftet med enkäten är att utvärdera hur det i praktiken fungerar att arbeta med den nya föräldraförberedelsen.

Nedanstående översikt av innehållet i träffarna kan vara till hjälp när du fyller i enkäten. För mer detaljer om innehållet kan du se manualen som du fick vid utbildningsdagen och via mail.

Tillfälle 1 – tema introduktion och gemensamt föräldraskap	• Introduktion • Gemensamt föräldraskap – presentation och diskussion • ”Hem-uppgift” – förväntningar på sig själv och sin partner inför föräldraskapet
Tillfälle 2 – tema tidigt föräldraskap	• Hur är första tiden som nybliven förälder – diskussion med nyblivna föräldrar • Amningsutmaningar – lista och hemuppgift att följa upp vid tillfälle 3, info om 1177.se och amningshjalpen.se
Tillfälle 3 – tema amning, det nyfödda barnet och tidigt föräldraskap	• Amningsfilm – Hud mot hud • Amningsutmaningar – uppföljning och diskussion av ”hemuppgift från tillfälle 2” • Det nyfödda barnets hälsa och behov – diskussioner utifrån både barnets och föräldrarnas perspektiv. Tex skrik, närhet, sömn. • Tidigt föräldraskap – diskussion/samtal om känslomässiga reaktioner, depression, relationen. • Var kan föräldrar få stöd i sitt föräldraskap
Tillfälle 4 – tema förlossning	• Normal förlossning • Förlossningskomplikationer • Partnerns roll • Smärtlindring (Detta tema fortsätter på träff 5)
Tillfälle 5 – tema förlossning och eftervård	• Fortsättning förlossning (från tillfälle 4) • Eftervård: BB, tidig hemgång, • Fysisk återhämtning efter förlossningen: bristningar, avslag, bäckenbottenträning • Praktisk information: - Kvinnokliniken – förlossning och eftervård - BVC - Efterkontroll • Avslutning – ”knyta ihop säcken”

Tillfälle 1

1. Hur många blivande föräldrar deltog på träffen? _____

2. Mellan vilka graviditetsveckor var deltagarna när föräldragruppen startade i idag?

_____ - _____

3. I vilken utsträckning följdes manualen för innehållet i föräldraförberedelsen?

Helt ☐ Delvis ☐ Inte alls ☐

Om delvis eller inte alls, ange vilka avsteg/förändringar som gjorts och anledningen till dessa:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Övriga kommentarer:

_____

_____

_____

_____

_____

Tillfälle 2

1. Hur många blivande föräldrar deltog på träffen? _____

2. Hur många nyblivna föräldrar deltog på träffen? _____

3. I vilken utsträckning följdes manualen för innehållet i föräldraförberedelsen?

Helt ☐ Delvis ☐ Inte alls ☐

Om delvis eller inte alls, ange vilka avsteg/förändringar som gjorts och anledningen till dessa:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Övriga kommentarer:

_____

_____

_____

_____

_____

Tillfälle 3

1. Hur många blivande föräldrar deltog på träffen? _____

2. I vilken utsträckning följdes manualen för innehållet i föräldraförberedelsen?

Helt ☐ Delvis ☐ Inte alls ☐

Om delvis eller inte alls, ange vilka avsteg/förändringar som gjorts och anledningen till dessa:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Övriga kommentarer:

_____

_____

_____

_____

_____

Tillfälle 4

1. Hur många blivande föräldrar deltog på träffen? _____

2. I vilken utsträckning följdes manualen för innehållet i föräldraförberedelsen?

Helt ☐ Delvis ☐ Inte alls ☐

Om delvis eller inte alls, ange vilka avsteg/förändringar som gjorts och anledningen till dessa:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Övriga kommentarer:

_____

_____

_____

_____

_____

Tillfälle 5

1. Hur många blivande föräldrar deltog på träffen? _____

2. I vilken utsträckning följdes manualen för innehållet i föräldraförberedelsen?

Helt ☐ Delvis ☐ Inte alls ☐

Om delvis eller inte alls, ange vilka avsteg/förändringar som gjorts och anledningen till dessa:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Övriga kommentarer:

_____

_____

_____

_____

_____

Appendix V

Utvärdering av utbildningsdag i studien om föräldraförberedelse

1. Vad tyckte du om utbildningens innehåll: Sätt kryss i lämplig ruta!

	Dåligt 1	2	3	4	5 Utmärkt
- Bakgrund till det nya programmet för föräldraförberedelse	☐	☐	☐	☐	☐
- Information om gruppledarskap	☐	☐	☐	☐	☐
- Genomgång av det nya programmet för föräldraförberedelse	☐	☐	☐	☐	☐

2. Hur väl förberedd känner du dig för att ge föräldraförberedelse enligt det nya programmet?

Dåligt 1	2	3	4	5 Utmärkt
☐	☐	☐	☐	☐

3. I vilken mån/utsträckning gav dig utbildningsdagen någon ny kunskap som du har nytta av i ditt arbete med föräldraförberedelse?

Liten 1	2	3	4	5 Stor
☐	☐	☐	☐	☐

4. Följande avsnitt/ämne borde ha utökats/tillkommit för att göra utbildningsdagen bättre?

……

……

……

……

……

5. Övriga synpunkter:

……

……

……

……

……

Appendix VI

LUNDS UNIVERSITET

Enkät till dig som är barnmorska - att arbeta med det nya programmet för föräldraförberedelse

1. I vilken mån/utsträckning gav utbildningsdagen dig en tillräcklig förberedelse för att ge det nya programmet för föräldraförberedelse?

Liten ○ ○ ○ ○ ○ Stor

2. I vilken mån/utsträckning var manualen ett tillräckligt stöd för att ge det nya programmet för föräldraförberedelse?

Liten ○ ○ ○ ○ ○ Stor

3. I vilken mån/utsträckning var tillgången till handledning under studiens gång tillräcklig?

Liten ○ ○ ○ ○ ○ Stor

4. Hur upplevde du att arbeta med det nya programmet för föräldraförberedelse?

5. Övriga kommentarer/synpunkter:

Appendix VII

LUNDS UNIVERSITET

Studie om föräldraförberedelse

Enkät graviditet

KODNUMMER

KODNUMMER

När är ditt barn beräknat att födas? Datum:_____

Hur gammal är du? _____ år

I vilket land är du född? _____

Vilken är din högsta utbildning?

☐ Mindre än 9 års grundskola eller motsvarande

☐ Grundskola

☐ Gymnasium

☐ Högskola/universitet

Vilket är ditt civilstånd?

☐ Ensamstående

☐ Sammanboende

☐ Annat, ange vad:_____

Vilken är din huvudsakliga sysselsättning?

☐ Förvärvsarbetar

☐ Studerande

☐ Arbetssökande

☐ Sjukskriven/sjukersättning

☐ Annat, ange vad:_____

Behandlas du eller har du tidigare behandlats för psykisk ohälsa? Med behandling avses både läkemedel och samtalsterapi.

☐ Ja, tidigare behandling

☐ Ja, pågående behandling

☐ Nej

Planerar du/din partner att amma barnet?

☐ Ja, helt

☐ Ja, delvis

☐ Nej

☐ Vet ej

Appendix VIII

LUNDS UNIVERSITET

Studie om föräldraförberedelse

Enkät uppföljning efter förlossningen till dig som är mamma

KODNUMMER:

DEL A

1. Hur många föräldragruppsträffar erbjöds du på barnmorskemottagningen?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ ≥ 6

2. Hur många föräldragruppsträffar deltog du i på barnmorskemottagningen under graviditeten?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ ≥ 6

3. Hur upplevde du antalet träffar som erbjöds?

☐ För få

☐ Tillräckligt antal

☐ För många

4. Hur nöjd är du med ämnesinnehållet i föräldraförberedelsen?
Ringa in den siffra som bäst motsvarar din upplevelse

a. gällande ämnen om förlossning

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

b. gällande ämnen om amning

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

c. gällande ämnen om det nyfödda barnet

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

d. gällande ämnen om föräldraskap/att bli förälder

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

e. gällande vart jag kan vända mig för att få mer information och stöd som rör mitt barn

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

f. gällande vart jag kan vända mig för mer information och stöd som rör mig som förälder

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

Utrymme för egna kommentarer:

_____

_____

_____

_____

_____

_____

_____

5. Hur nöjd är du med formerna/upplägget för föräldraförberedelsen?
Ringa in den siffra som bäst motsvarar din upplevelse

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

Utrymme för egna kommentarer:

_____

_____

_____

_____

_____

_____

_____

6. Saknade du något i föräldraförberedelsen?

☐ Ja, ange vad_____

☐ Nej

7. Deltog du i annan föräldraförberedelse än de föräldragruppsträffar som erbjöds via barnmorskemottagningen?

☐ Ja, psykoprofylax

☐ Ja, yoga för gravida

☐ Föräldraförberedelse i vatten/vattengympa för gravida

☐ Annan, ange vad_____

☐ Nej

8. I vilken graviditetsvecka föddes ditt/dina barn? _____

9. Hur många veckor är ditt/dina barn idag? _____

10. Hur många barn fick du?

☐ Ett barn

☐ Tvillingar

☐ Trillingar eller fler

11. Hur föddes ditt/dina barn?

☐ Vaginal förlossning

☐ Vaginal förlossning med sugklocka eller tång

☐ Akut kejsarsnitt

☐ Planerat kejsarsnitt

12. Hur upplevde du förlossningen?

Ringa in den siffra som bäst motsvarar din upplevelse

Mycket negativ upplevelse — Mycket positiv upplevelse

0 1 2 3 4 5 6 7 8 9 10

13. Hur fick ditt/dina barn mat under tiden på eftervårdsavdelningen?

☐ Enbart amning/bröstmjölk

☐ Både amning/bröstmjölk och ersättning

☐ Enbart ersättning

14. Hur får ditt/dina barn mat nu?

☐ Enbart amning/bröstmjölk

☐ Mestadels amning/bröstmjölk och enstaka tillfällen med ersättning

☐ Hälften amning/bröstmjölk och hälften ersättning

☐ Mestadels ersättning och enstaka tillfällen med amning/bröstmjölk

☐ Enbart ersättning

15. Har ditt/dina barn haft några problem med hälsan efter förlossningen som krävt sjukhusvård?

☐ Ja

☐ Nej

16. I vilken utsträckning upplever du att <u>din partner</u> är delaktig i föräldraskapet?
Ringa in den siffra som bäst motsvarar din upplevelse

Inte alls delaktig										Helt delaktig
0	1	2	3	4	5	6	7	8	9	10

LUNDS UNIVERSITET

Studie om föräldraförberedelse

Enkät uppföljning efter förlossningen till dig som är pappa/medförälder

KODNUMMER:

DEL A

1. Hur många föräldragruppsträffar erbjöds du på barnmorskemottagningen?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ ≥ 6

2. Hur många föräldragruppsträffar deltog du i på barnmorskemottagningen under graviditeten?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ ≥ 6

3. Hur upplevde du antalet träffar som erbjöds?

☐ För få

☐ Tillräckligt antal

☐ För många

4. Hur nöjd är du med ämnesinnehållet i föräldraförberedelsen?
Ringa in den siffra som bäst motsvarar din upplevelse

a. gällande ämnen om förlossning

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

b. gällande ämnen om amning

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

c. gällande ämnen om det nyfödda barnet

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

d. gällande ämnen om föräldraskap/att bli förälder

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

e. gällande vart jag kan vända mig för att få mer information och stöd som rör mitt barn

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

f. gällande vart jag kan vända mig för mer information och stöd som rör mig som förälder

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

Utrymme för egna kommentarer:

_____

_____

_____

_____

_____

_____

_____

5. Hur nöjd är du med formerna/upplägget för föräldraförberedelsen?
Ringa in den siffra som bäst motsvarar din upplevelse

Inte alls nöjd Helt nöjd

0 1 2 3 4 5 6 7 8 9 10

Utrymme för egna kommentarer:

_____

_____

_____

_____

_____

_____

_____

6. Saknade du något i föräldraförberedelsen?

☐ Ja, ange vad_____

☐ Nej

7. Hur inkluderad kände du dig som pappa/medförälder i de ämnen och diskussioner som togs upp i föräldraförberedelsen?

Ringa in den siffra som bäst motsvarar din upplevelse

Inte alls inkluderad — Helt inkluderad

0 1 2 3 4 5 6 7 8 9 10

8. Deltog du i annan föräldraförberedelse än de träffar som erbjöds via barnmorskemottagningen?

☐ Ja, psykoprofylax

☐ Ja, pappaträff

☐ Ja, annan, ange vad_____

☐ Nej

9. I vilken graviditetsvecka föddes ditt/dina barn? _____

10. Hur många veckor är ditt/dina barn idag? _____

11. Hur många barn fick du?

☐ Ett barn

☐ Tvillingar

☐ Trillingar eller fler

12. Hur föddes ditt/dina barn?

☐ Vaginal förlossning

☐ Vaginalförlossning med sugklocka eller tång

☐ Akut kejsarsnitt

☐ Planerat kejsarsnitt

13. Hur upplevde du förlossningen?

Ringa in den siffra som bäst motsvarar din upplevelse

Mycket negativ upplevelse — Mycket positiv upplevelse

0 1 2 3 4 5 6 7 8 9 10

14. Hur fick ditt/dina barn mat under tiden på eftervårdsavdelningen?

☐ Enbart amning/bröstmjölk

☐ Både amning/bröstmjölk och ersättning

☐ Enbart ersättning

15. Hur får ditt/dina barn mat nu?

☐ Enbart amning/bröstmjölk

☐ Mestadels amning/bröstmjölk och enstaka tillfällen med ersättning

☐ Hälften amning/bröstmjölk och hälften ersättning

☐ Mestadels ersättning och enstaka tillfällen med amning/bröstmjölk

☐ Enbart ersättning

16. Har ditt/dina barn haft några problem med hälsan efter förlossningen som krävt sjukhusvård?

☐ Ja

☐ Nej

17. Hur delaktig känner du dig som pappa/medförälder i föräldraskapet?

Ringa in den siffra som bäst motsvarar din upplevelse

Inte alls delaktig Helt delaktig

0 1 2 3 4 5 6 7 8 9 10

Avhandlingar i ämnet vårdvetenskap vid forskargruppen "Barns och familjers hälsa", vid Institutionen för Hälsovetenskaper, Medicinska fakulteten, Lunds universitet.

Wennick, Anne. Living with childhood diabetes. Family experiences and long-term effects. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2007.

Kjaergaard, Hanne. Dystocia in nulliparous women. Incidence, outcomes, risk indicators and women's experiences. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2007

Björk, Maria. Living with childhood cancer. Family members' experiences and needs. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2008

Ekelin, Maria. Parents' expectations, experiences and reactions to routine ultrasound examination during pregnancy. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2008

Lundqvist, Pia. Children born prematurely. Their fathers' experiences and trends in mortality and morbidity during a ten-year period. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2008.

Larsson, Anna-Karin. Parents' experiences and reactions when an unexpected finding in their foetus is revealed at a routine ultrasound examination – a multi method study. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2009.

Hegaard, Hanne. Pregnancy and leisure time physical activity. 2009.

Persson, Eva. Parents' postnatal sense of security (PPSS) – developing an instrument and description of important factors based on mothers' and fathers' experiences. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2010.

Danerek, Margareta. Decision-making in critical situations during pregnancy and birth. 2010.

Törnqvist, Erna. Going through magnetic resonance imaging. Patients' experiences and the value of information and preparation for adults and children. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2010.

Jönsson, Lisbeth. Experiences of the education process when a child is diagnosed with typ 1 diabetes mellitus. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2011. Licentiatavhandling.

Landgren, Kajsa. Infants with colic – Parents' experiences in short and long perspectives and the effect of acupuncture treatment on crying, feeding, stooling and sleep. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2011.

Tiberg, Irén. The initial care when a child is diagnosed with type 1 diabetes. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2012.

Björquist, Elisabet. Living in transition to adulthood. Adolescents with cerebral palsy and their parents' experiences of health, wellbeing and needs. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2013. Licentiatavhandling.

Lefèvre, Åsa. Early Parental Support in Child Healthcare. Parental groups – a challenge in a changing society. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2014. Licentiatavhandling.

Jönsson, Lisbeth. Children with type 1 diabetes – the initial education process and the impact on children and their parents over the first two years. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2014.

Måstrup, Ragnhild. Breastfeeding of preterm infants – Associated factors in infants, mothers and clinical practice. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2014.

Tornoe, Birte. The child with tension-type headache. Physical factors and interactive interventions. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2014.

Lauruschkus, Katarina. Participation in physical activities and sedentary behavior among children with physical disabilities. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2015.

Björquist, Elisabet. Mind the gap. Transition to adulthood – youths' with disabilities and their caregivers' perspectives. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2016.

Lefèvre, Åsa. Group-based Parental Support in Child Health Service. Development and evaluation of a group leadership course for nurses. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2016.

Gårdling, Jenny. When children undergo radiotherapy. Exploring care, developing and testing preparation procedures. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2017.

Biru, Mulatu. Children diagnosed with HIV on antiretroviral therapy in Ethiopia. The family caregivers' lived experience and treatment outcomes. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2017.

Skoog, Malin. Experiences of Screening for Postpartum Depression in Non-Native-Speaking Immigrant Mothers in the Swedish Child Health Services. Nurses' and Mothers' Perspectives. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2018. Licentiatavhandling.

Castor, Charlotte. Home Care Services for Sick Children. Family, Healthcare and health economic perspectives Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2019.

Pålsson, Petra. Antenatal preparation for the early parenthood period. Development and feasibility of an evidence-based programme for antenatal parental preparation. Department of Health Sciences, Faculty of Medicine, Lund University, Sweden 2020.

Ovanstående kan rekvireras från:

Lunds universitet
Institutionen för Hälsovetenskaper
Box 157
221 00 Lund