Putting families and local professionals at the heart of implementation research
A qualitative implementation study on Greenland's universal parenting programme MANU 0-1 Year
Ingemann, Christine

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Christine Ingemann

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Title: Putting families and local professionals at the heart of implementation research – A qualitative implementation study on Greenland’s universal parenting programme MANU 0-1 Year

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Keywords

Abbreviations
CBPR Community-Based Participatory Research
CFIR Consolidated Framework for Implementation Research
CMCH Circumpolar Maternal and Child Health (working group)
KTB Klar til Barn (Prepared for Child) – previous universal parenting programme
LPC Local Prevention Committee
MANU Meeraq Angajoqqaat Nuannaarneq (Child’ and parents’ happiness), the Greenlandic parenting programme
I would like to give my warmest thanks to all professionals, parents and elders taking the time to be part of my study and sharing their experiences, thoughts and reflections with me. I am grateful for the insights and perspectives the reference group members of the project have shared during the different research phases. These have been fundamental to the research. Furthermore, I would like to thank the Board for Health and Prevention and the Agency of Social Affairs for their support and their willingness to look at the hard work they do on a daily basis from a critical perspective to improve the well-being of the population.

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01 Summaries

01.01 Summary (English)

**Introduction and background:** Context matters. The influence of context in implementation has received increasing attention in implementation research. This includes a discussion of the right fidelity-adaptation balance when interventions are to be implemented in a new context, a relevant discussion when looking at national public health interventions. In Greenland, public health interventions are typically adopted evidence-based programmes or developed based on general understandings of the country’s context. They rarely build on local resources and strengths of the different towns and villages. Evaluations of interventions show how interventions are not sustained after initiation, they are not adaptable to local context and intervention recipients’ needs are barely explored prior to the development of interventions.

The Greenlandic parenting programme MANU 0-1 Year, which stands for Meeraq Angajoqqaat Nuannaarneq meaning ‘child’s and parent’s happiness’, henceforth MANU, was developed to provide expectant and new parents with information and reflections on parenthood through pedagogical exercises. MANU is a universal programme that intends to be accessible to all expectant and new parents. Ultimately, MANU is expected to secure a healthy foundation for children’s development and to contribute to the prevention of adverse childhood experiences. The programme is based on developmental theories, international evidence on the First Thousand Days and the intent to reduce the high prevalence of vulnerable families in Greenland. Parents’ perspectives were only explored to a limited extent during the development process of MANU. Furthermore, from the outset of MANU’s implementation a tension existed between the MANU team’s ambition for implementation fidelity and the local professionals’ need to adapt the programme to fit their local context.

Arctic and Greenlandic public health scholars are increasingly drawing attention to the importance of integrating or building on cultural belief and relevance, values and local practices when developing and implementing interventions.

**Objective:** The aim of this PhD project was to study the local implementation of the parenting programme MANU 0-1 Year and parents’ experiences with the programme in regard to expectations, needs, culture and values.

**Conceptual framework:** The Consolidated Framework for Implementation Research (CFIR) by Damschroder et al. (2009) was applied due to its breadth of in-
cluded aspects that influence implementation. It provides an overarching systematic classification of implementation determinants in different contexts. Furthermore, the PhD project applied a community-based participatory research (CBPR) approach following the five stages introduced by Reimer and Rink (2020) and based on the key principles by Wallerstein et al. (2018). CBPR focuses on creating partnerships and building trust between the researchers and the community people, who ultimately are meant to gain from the research. Finally, the framework outlining the potential adverse effects of public health interventions by Lorenc and Oliver (2014) provided a retrospective perspective on MANU’s unintended effects.

**Study design and methods:** The PhD project has been performed in accordance with the Declaration of Helsinki, and the Greenlandic Science Ethics Committee (Danish: Videnskabsetisk Udvalg) granted ethical approval of the project. As a key CBPR element a reference group consisting of nine different stakeholders was established and was involved throughout the PhD project. Different qualitative methods were applied, including open-ended and semi-structured interviews, observations, document analysis and a sharing circle. Data were collected in three of Greenland’s five health regions.

**Results:** The results are presented in three sections in this PhD dissertation. First, parents’ perspectives on parenthood and child-rearing are described. Parents described the life changing experience it was to become a parent, and they point out toqqissismaneq (English: security and care) and ataatsimoorneq (English: community or feeling of togetherness) to be important aspects in child-rearing. Secondly, both parents’ and professionals’ experiences with MANU are presented. Both strengths and challenges with MANU’s format, content and accessibility were identified. For example, MANU group sessions have the potential to create a space for parents to reflect, however, group sessions are not necessarily accessible to everyone. Finally, professionals’ perspectives on local implementation include aspects related to: the organisational structure and context they are working in; the circumstance of having to prioritise limited resources which leads to MANU not being a priority; the professionals need for support and skills to maintain motivation for implementation and sustainment of the programme.

**Discussion:** The PhD dissertation discusses how national programmes like MANU often are disconnected from local contexts, since they are based on the assumption that dissemination of materials and sending professionals to trainings will enable sustainable implementation of new interventions. Then the applicability of implementation frameworks, specifically the CFIR and the updates to the CFIR framework, are discussed in relation to the Arctic context, interventions recipients’ perspectives on
implementation outcomes and sustaining interventions in a context with persistent high turnover. This then leads to introducing CBPR as an integral part of implementation research in order to meet equity in implementation. Intervention studies conducted in the Arctic describe how CBPR contributes to a culturally sensitivity intervention and to the community taking ownership of the intervention. Finally, methodological and ethical considerations are presented.

**Conclusion:** It is concluded that by putting families and local professionals at the heart of implementation research, interventions will more likely be culturally sensitive and increasingly relevant to local contexts. Furthermore, potential barriers in implementation and adverse effects of an intervention could be addressed early on and likely prevented.

**Implications:** The dissertation includes suggestions for future research and recommendations for public health practice. The latter includes input form the reference group, who shared their thoughts on how they would like to adjust MANU and other health promotional interventions based on this project’s results.

**01.02 Eqikkaaneq (Kalaallisut)**

Angajoqqaanngornissamut kalaallit piareersaataat MANU 0-imiit 1-inik ukiulinnut, uunga naalisaataasoq Meeraq Angajoqqaat Nuannaarneq, isumaqartoq ‘meeqqap aamma angajoqqaat nuannaamerat’, (kingorna MANU-mik taagorneqartussaq) iner-simasunut atuaritisinertut periuseqarluni angajoqqaanngortussanut aamma anga-
joqqaanngorlaanut angajoqqaajuneq pillugu paasissutissanik aamma angajoqqaajun-
nissamik eqqarsaatiginninnissamik siunertaqarpoq. MANU tamanut siunner-
feqarpoq, angajoqqaanngortussanit aamma angajoqqaanngorlaanit tamanit pis-
sarsiarineqarsinjaasussasut siunertaqarluni. Naggaterpiaatigut meeeqqat tammamik
peqqissumik ineriartomissaasa aamma meeqqat tamarmik toqqissisimanartumik,
artukkerneqamatik, peroriartomissaasa tunngavilemeqarnissassa qulakkeerneqarnissaat MANUmit peqataaffigineqassasooq naatsorsuutigineqarpoq. Angajoqqaanngortussanat aamma angajoqqaanngorlaanut piaareersaat ineriartomeq
pillugu allaaserisanit, nunat tamalaat akornanni ilisimatusarnikut tunngavilimmik De
Første Tusinde Dagemik (ullut siulliit 1000-mik) aamma Kalaallit Nunaanni ilaqutarit
aarlerinaatilimmik inissisimasut amerlanerujussuiva ikillisinnegarnissanik siunert-
tamik tunngaveqarpoq. MANUp ineriartortinneqarnerani angajoqqaat isiginnertar
killilimmik misissuuffigineqarsimavoq. MANUp atuutilersinneqarnerata aallaqqaaan-
illli MANUmik suliaqartut piaareersaatit atuutilersinneqarnerni nalaani ilusaata
eqqortinnissaanik takorluugaat akerlilersomeqarpoq, sumiiffinni suliassaqaarfinni
sulaliit sumiiffimminni suliamininnk ingerlatsinnarsinjaasisamminnut piaareersaatit
MANUp nalimmassarnissaanik pisariaqariaqartissimmata.

Issittumi aamma Kalaallit Nunaanni inuiaqatigiit peqqissusiannik ilisimatusartartut
akuluuffiginnilluni suliniuit sumiiffimmik kulturi, sumiiffimmiki naleqartit, nukissat aam-
ma sulieriantarnerit aallaavigalugit ineriartortinneqarlutillu atuutilersinneqartarnissaa-
sa pingaarteqassusiat eqqumaffigineruleriartiunnarpaat.

Siunertaq: Ph.d.-ingorniutigalu suliniummi matumani siunertarineqartoq
tassaasimavoq, angajoqqaanngornissamut piaareersaatit MANU 0-imiit 1-inik
ukiulinnut sumiiffinni atuutilersinneqarnerna aamma piaeraasaammut tunntagillugu
angajoqqaat naatsorsuutigisaminnut, pisariaqartitaminnut, kulurikkut aamma
naeqrtitamminut atatillugu misillitagaasa misissuuffigineqarnissaat.

Suliamut tunngavik: The Consolidated Framework for Implementation Research
(CFIR) af Dacmshroder et al. (2009) atorneqarpoq, taassuma atuutilersitsinermut
sunniuteqartumik peqataatitsinermik anneruumik ilaqarnera pissaqalugo. Taanna
ataatsenam isoqinnilluni aqqusselsamik pisuni assiiginnngtsuni atuutilersitsinermi
tunngavileeqataasunik imnikkoortiteriffiuvoq. Tamatuma saniatigut Ph.d.-
ingorniutigalu suliniummi Community-based participatory research (CBPR)
torneqarpoq, allorierarter tallimat ukunangna Reimer and Rink (2020) saqqummi-


Inerniliiineq: Atuutilersitsinernik ilisimatusarnerni ilaqtariit aamma sumiiiffinni suliaassaqarfimmik suliallit qitiutinnerisigut akuliuuffiginnittamerit sumiiiffinnut ataqatigiissinneqarsinnaannerisa naleqgunnerusunngortinneqarsinnaanerat inernili-unnearpoq, aamma immaqa kulturikut naleqgunnerulersinnaallutik. Tamatuma sanitigut tamanna akuliuuffiginnilluni atuutilersitsinermi unammilligassaaasinnaasunik kisalu siunertaangtsutut pitsaanngitsumik kinguneqatsaasinnaasunik siuississukkut paasiaqarfiullunilu tamakku pitsaalioorneqarsinnaannissaanennut peqataasinaavoq.


01.03 Sammenfatning (Dansk)

Indledning og baggrund: Kontekst er vigtigt. Kontekstens indflydelse i implementeringen har fået stigende opmærksomhed i implementeringsforskningen. Dette inkluderer en diskussion af den rigtige balance mellem tilpasning og overholdelse af interventionens design, når interventioner skal implementeres i en ny kontekst. Det
er også en relevant diskussion, når man ser på nationale interventioner på folkesundhedsområdet. I Grønland er folkesundhedsinterventioner typisk evidensbaserede programmer fra et andet land eller udviklet baseret på generelle forståelser af forholdene i landet. Interventionerne bygger sjældent på de lokale ressourcer og styrker der eksisterer i de forskellige byer og bygder. Evalueringer af interventioner viser, at interventioner hurtigt falder til jorden efter implementering, det er svært at tilpasse dem til de lokale kontekster, og slutbrugernes behov er sjældent undersøgt inden udviklingen af interventionerne.

Det grønlandske forældreprogram MANU 0-1 år, som står for Meeraq Angajoqqaat Nuannaarneq, der betyder ‘barnets og forældrenes glæde’, (fremover kaldet MANU) har til formål at give vordende og nybagte forældre information og refleksioner om forældreskab ved hjælp af en voksengymnastisk tilgang. MANU er et universelt program, der har til hensigt at være tilgængeligt for alle vordende og nybagte forældre. I sidste ende forventes MANU at sikre et sundt grundlag for børns udvikling og bidrage til at alle børn vokser op i trygge rammer uden belastninger. Programmet er baseret på udviklingsledder, international evidens om de Første Tusinde Dage og en intention om at reducere det høje antal af familier i en udsat position i Grønland.

Forældreperspektivet blev kun i begrænset omfang udforsket under udviklingen af MANU. Fra starten af MANUs implementering mødt MANU-teamet modstand for deres ambition om overholdelse af programmets design under implementering, i det de lokale fagpersoners behov var at tilpasse programmet for at MANU kunne fungere i deres lokale kontekst.

Arktiske og grønlandske forskere i folkesundhed gør i stigende grad opmærksom på vigtigheden af, at interventioner udvikles og implementeres med udgangspunkt i den lokale kultur, lokale værdier, kapacitet og praksis.

**Formål:** Formålet med dette ph.d.-projekt var at undersøge både den lokale implementering af forældreprogrammet MANU 0-1 år og forældres erfaringer med programmet i forhold til deres forventninger, behov, kultur og værdier.

folkesundhedsinterventioner beskrevet af Lorenc og Oliver (2014) et retrospektivt perspektiv på MANUs utilsigtede konsekvenser.


**Resultater:** Resultaterne præsenteres i tre afsnit. Først beskrives forældres perspektiver på forældreskab og børneopdragelse. Forældre beskrev den livsforandring der skete når de blev forældre, og de beskrev toqissisimaneq (dansk: tryghed) og ataatsimoorneq (dansk: fællesskab) som vigtige aspekter i deres barns opvækst. For det andet præsenteres både forældres og fagpersoners erfaringer med MANU. Her beskrives både styrker og udfordringer ved MANUs format, indhold og tilgængelighed. For eksempel har MANUs gruppessessioner potentialet til at skabe et rum for forældre til at reflektere, men gruppesessioner er ikke nødvendigvis en mulighed for alle forældre. Endelig beskrives fagpersoners oplevelser med at implementere MANU som omhandler: den organisatoriske struktur og kontekst, de arbejder i; udfordringer med at skulle prioritere i forvejen begrænsede ressourcer, hvilket fører til, at MANU ikke er en prioritet; de professionelle har brug for støtte og færdigheder, hvilket vil understøtte deres motivationen for implementering og vedligeholdelse af programmet.

**Diskussion:** Ph.d.-afhandlingen diskuterer, hvordan nationale programmer som MANU ofte er løsrevet fra lokale kontekster, da de er baseret på antagelsen om, at adgang af materialer og træning af fagpersoner medfører bæredygtig implementering af nye interventioner. Derefter diskuteres anvendeligheden af implementerings teorier, her specifikt CFIR og justeringer af CFIR, i forhold til den arktiske kontekst, slutbrugernes perspektiver på implementering, og vedligeholdelse af interventioner i en kontekst med høj personaleudskiftning. Efterfølgende introduceres CBPR som en brugbar tilgang til at sikre en ligeværdighed i implementeringsforskning. Interventionsstudier fra andre arktiske lande beskriver, hvordan CBPR bidrager til en kulturel sensitiv intervention og til, at samfundet tager ejerskab over interventionen. Til sidst redegøres der for metodiske og etiske overvejelser.

**Konklusion:** Det konkluderes, at ved at sætte familier og lokale fagpersoner i centrum af implementeringsforskning, vil interventioner i stigende grad være relevante for lokale kontekster og formentlig i højere grad kulturelt relevante. Desuden kan
dette medvirke at potentielle udfordringer i implementeringen samt utilsigtede negative konsekvenser af en intervention bliver adresserede tidligt og sandsynligvis forebygges.

**Implikationer:** Afhandlingen indeholder forslag til fremtidige undersøgelser og anbefalinger til praksis indenfor folkesundhed. Sidstnævnte omfatter input fra referencegruppen, som delte deres tanker om, hvordan de kunne tænke sig at justere MANU og andre sundhedsfremmende indsatser baseret på dette projekts resultater.
The influence of context in implementation has received increasing attention in implementation research and is reflected in many theories, frameworks, and models (Damschroder et al., 2009; May et al., 2016; Moore et al., 2021; Nilsen, 2015; Nilsen et al., 2019; Pfadenhauer et al., 2015). The dynamic and complex characteristics of the specific context, an evidence-based intervention is to be implemented in, leads also to a discussion among scholars on finding the right fidelity-adaptation balance (Castro et al., 2004; Pérez et al., 2015; von Thiele Schwarz et al., 2019).

Implementation fidelity is “the degree to which interventions are implemented as intended by those who developed or designed the intervention” (Carroll et al., 2007). Whether an intervention’s lack of impact is due to the intervention’s shortcomings or deficient implementation can be determined by evaluating the fidelity with which an intervention is implemented (Carroll et al., 2007). However, Carroll (2020) points out that the real and the experimental worlds are different from each other, meaning complete fidelity in practice is not necessarily possible. Therefore, adaptation of an intervention can be necessary in order for the intervention to fit local context, such as being culturally sensitive (Castro et al., 2004).

National public health interventions are typically adopted evidence-based interventions or they are developed based on general understandings on what the country’s context looks like and they rarely consider the contextual differences between localities within a country (Ingemann et al., 2021; Nielsen et al., 2022; Redvers et al., 2015). This is the case in Greenland where national programmes rarely build on local resources and strengths (Ingemann et al., 2021; Ingemann et al., 2018b; Ingemann et al., submitted). Evaluations of Greenlandic public health interventions show how programme adherence rarely occurs or that interventions have not been sustained after initiation (Dyrløv, 2012; Ingemann et al., 2019a; Ingemann et al., 2018a; Ingemann et al., 2018b; Olesen et al., 2022). The challenges identified in these evaluations concern a lack of adaptability and misfit to local context. Additionally, the intervention recipients’ knowledge and needs are barely explored prior to the development of interventions.

Recipients’ knowledge and needs influences implementation and is described in determinant frameworks. In a review identifying contextual determinants in implementation frameworks, Nilsen et al. (2019) find that determinants considering the intervention recipients, which they categorise as a contextual determinant, are only included in two thirds of the frameworks. Moreover, recipients as a determinant in-
fluencing implementation are only addressed in three of the five most cited research frameworks in dissemination and implementation science (Damschroder et al., 2009; Greenhalgh et al., 2004; Kitson et al., 1998; Klein et al., 1996; Skolarus et al., 2017; Aarons et al., 2011). This is surprising since the involvement of patients, i.e. intervention recipients, in healthcare services has grown in importance and is associated with positive outcomes (Nilsen et al., 2019). The identified implementation frameworks advise that evidence on the recipients’ experiences and preferences should be regarded since it influences intervention outcomes (Damschroder et al., 2009; Greenhalgh et al., 2004; Kitson et al., 1998; Klein et al., 1996; Skolarus et al., 2017; Aarons et al., 2011), but implementation research has not highlighted recipients’ potential influence on implementation outcomes (Nilsen et al., 2019).

**Parenting programmes**

The First Thousand Days movement, which includes parenting programmes, has received increasing scholarly and public attention, also in Greenland. It has led to the development of many programmes internationally (Black et al., 2017; Kaminski et al., 2008) and many publications showing that parenting support is an effective entry point in promoting health for mothers and their new-borns (Pierron et al., 2018). Parenting programmes can be targeted specific at-risk sub-populations or be designed as universal programmes accessible to everyone (Cowan et al., 1995; Pontoppidan et al., 2016; Stewart-Brown et al., 2011). Gilmer et al. (2016) found in their review that “there was no compelling evidence to suggest that a single educational programme or delivery format was effective at a universal level”. However, universal programmes may be of value when parents can access the programme at a time and in a format that suits them (Gilmer et al., 2016; Stewart-Brown et al., 2011).

The Greenlandic parenting programme MANU 0-1 Year, which stands for *Meeraq Angajoqqaat Nuannaarneq* meaning 'child's and parent's happiness', henceforth MANU, was developed to provide expectant and new parents with information and reflections on parenthood through pedagogical exercises (God Barndom, 2016; Ingemann et al., 2021). MANU is a universal programme that intends to be accessible to all expectant and new parents in Greenland. The programme is based on developmental theories, international evidence on the First Thousand Days and intended to reduce the prevalence of vulnerable families in Greenland, but it is not an evidence-based programme, meaning its effect has not yet been
documented (Ingemann et al., 2021). Ultimately, MANU is expected to secure a healthy foundation for children’s development and to contribute to the prevention of adverse childhood experiences (Felitti et al., 1998; God Barndom, 2016). Parents’ perspectives were only explored to a limited extent during the development process of MANU. Furthermore, from the outset of MANU’s implementation a tension existed between the MANU team’s ambition for implementation fidelity and the local professionals’ need to adapt the programme to fit their local context and capacity (Ingemann et al., 2022; Ingemann et al., 2021).

Studies in Greenland increasingly show the importance of integrating cultural beliefs, values and local practices into Greenland’s public health and healthcare system (Olesen et al., 2020; Rink et al., 2021; Aagaard, 2017). Family, relationships, and community are fundamental in the Greenlandic culture (Mulvad et al., 2020; Ingelise Olesen et al., 2021; Tröndheim, 2010). In the Circumpolar regions, scholars and politicians are increasingly getting aware of the importance to develop interventions that are based on Indigenous values within different communities instead of adopting euro-centric models (Collins et al., 2019; Cueva et al., 2021; MacDonald et al., 2013; Wexler, 2014).

02.01 Objectives

Research on implementation processes of interventions in Greenland is scarce and insights to local implementation of national interventions are lacking. Based on the above presented literature, more research is needed to understand the influence of context and intervention recipients’ role in implementation research. Therefore, the aim of this project was to study the local implementation of the parenting programme MANU 0-1 Year and parents’ experiences with the programme in regard to expectations, needs, culture and values.

The aims of each Paper were:

Paper I To identify determinants that influence the implementation of the parenting programme MANU in Greenland from a national perspective, while its implementation was still underway and at its beginning.

Paper II To investigate how parents’ notions and experiences of parenthood are reflected and challenged in MANU.
Paper III  To explore what meaningful relations parents see in their child’s upbringing and how these relationships are shaped, and to discuss how these perspectives compare with MANU’s material and content.

Paper IV  To investigate how professionals experience the implementation of MANU into their local context, including how they manage the requirement of programme fidelity.
03 Background

This chapter expands on the topics addressed in the introduction and provides information on parenting programmes across the Circumpolar regions and specifically for Greenland. Then background information on MANU and its components are presented, followed by contextual information about Greenland as a country and its healthcare system. The chapter includes information and findings published in the PhD project’s first published article by Ingemann et al. (2021) and fourth article by Ingemann et al. (submitted). Additionally, findings from unpublished desk and literature reviews conducted prior to and during the PhD are described.

03.01 Parenting programmes

In the Circumpolar region an overview of the parenting programmes applied or developed is lacking. Therefore, the Centre for Public Health in Greenland organised a symposium on parenting programmes at the 17th International Congress for Circumpolar Health in 2018 (Ingemann et al., 2019b). Initiatives presented during the symposium included: the Canadian breastfeeding initiative built on traditional infant feeding practices in the Northwest Territories (Aurora Research Institute, 2018; Ingemann et al., 2019b); the First 1000 Days Australia (Arabena et al., 2019); and the Inunnguiniq parenting programme in Nunavut, Canada (Amagoalik, 2019; Qaujigiartiit Health Research Centre, 2012). Furthermore, with the symposium the Circumpolar Maternal and Child Health working group was initiated, which now is an active group under the UArctic thematic network on Health and Well-being in the Arctic (UArctic, 2022). In the following some of these Indigenous parenting programmes are described.

Indigenous parenting programmes

The First 1000 Days Australia is an Indigenous led programme conceptualised on Aboriginal’s and Torres Strait Islander’s cultural values (Arabena et al., 2019). Cultural domains, specific to the Australian context, are represented in the programme such as family engagement, knowledge exchange, Indigenous leadership and economic empowerment (Arabena et al., 2019). A cultural approach to the programme was chosen based on the understanding that “culture is the protective factor for families and the importance of strong identity, belonging, and fostering opportunities for people to transform their lives” (Arabena et al., 2019).
The First 1000 Days Australia model is being reconceptualised for Sámi families in Norway through collaborations with the University of Tromsø, Norway (Arabena et al., 2019). Here, a focus is put on teaching the Sámi language and culture to children by including extended family (e.g. Sámi grandparents) next to parents and expecting parents.

In Nunavut, Canada, the Inunnguiniq parenting programme was conceptualised and developed in collaboration with organisations and communities, which lead to an evidence-based and culturally responsive parenting programme (Amagoalik, 2019; Qaujigiartiit Health Research Centre, 2012). Inunnguiniq, meaning ‘the making of a human being’, is the socialisation process of Inuit (Tagalik, 2010). The programme is designed as facilitated group discussion for parents, caregivers, and extended family, where an elder is to be included in each session. As a minimum one session will incorporate land components and to support attending parents, childcare is provided. Some of the programme’s topics are relationship building, communication and nutrition (Amagoalik, 2019).

Another example are the resources for Inuit families and caregivers based on Inuit teachings outlined in Inunnguiniq developed by the National Collaborating Centre for Indigenous Health and the Aqqiumavvik Society (National Collaborating Centre for Indigenous Health, 2022). The booklets are aimed to provide guidance and help to parents in early childhood learning and healthy development (National Collaborating Centre for Indigenous Health, 2022).

**Parenting programmes in Greenland**

Historically, public health interventions in Greenland are most often adopted, typically from a Nordic Country (primarily Denmark) (Ingemann et al., 2021) or developed centrally in Greenland’s governmental institutions in the capital city Nuuk. Many of these interventions are typically based on national evidence pointing out areas in need of preventive and treatment initiatives, international theories on how to approach these problems, and developers’ experiences and generalisation of what the Greenlandic context looks like.

A desk review on the interventions implemented and studies completed on and around the First Thousand Days in Greenland was conducted [not published]. This review resulted in a timeline overview from about 2000 to 2017. Key professionals with a long work experience in the field of maternal and child health provided additional information as well as validated the generated overview. The overview can be found in Appendix 12.01. In the 1990s, the first prevention initiative in pre- and post-natal care for vulnerable families in Nuuk was initiated. In 2007 other private and
public initiatives followed. The delivery strategies of these programmes were selective, meaning that they were offered to at-risk families or teenage pregnancies (Ingemann et al., 2021). In 2009, the first universal parenting programme Klar til Barn, meaning Ready for Child, was adopted from Denmark. Based on an evaluation of Klar til Barn in 2012, the conceptualisation of MANU was initiated around 2015.

The need for culturally responsive interventions

MANU as a national programme is expected to be implemented in each of Greenland’s unique towns and villages (Ingemann et al., 2021). In respect to this, the aspect of adaptation in implementation research is relevant to consider. According to Castro et al. (2004) and Trickett et al. (2019), in the process of adapting an intervention the involvement of the community is necessary to ensure that the intervention is responsive to the community’s cultural needs.

This is in line with the PhD student’s findings from reviewing scientific literature investigating aspects influencing or important to consider when implementing health promotional interventions in Arctic Indigenous communities. Most of the studies identified point out the importance of ensuring interventions are culturally appropriate to the specific community (Alvarez et al., 2016; Collins et al., 2019; Gautier et al., 2016; Ingemann et al., 2018b; Mead et al., 2013; Redvers et al., 2015), that the community is involved at all stages (Alvarez et al., 2016; Collins et al., 2019; Healey, 2016; Mead et al., 2013; Redvers et al., 2015; Trout et al., 2018) and that the intervention recipients’ perspectives are investigated prior to intervention development or adaptation (Akande et al., 2021; Healey, 2016; Stoor et al., 2021). Applying a community-based participatory approach was most successful or recommended to be applied to meet the beforementioned aspects (Healey, 2016; Mead et al., 2013; Redvers et al., 2015; Trout et al., 2018).

03.02 Components of the parenting programme MANU

The development of MANU was led by an experienced midwife in Greenland and a Danish consulting firm (Ingemann et al., 2021). They involved a reference and steering group consisting of professionals located in Nuuk, but with experience from towns outside Nuuk, to review and approve materials to ensure that the programme fitted the Greenlandic context (Ingemann et al., 2021). The central coordination, i.e. the MANU team, was moved from the Board for Health and Prevention (Danish: Sundhedsledelsen) to the Ministry of Health and then to the Ministry of Children, Youth and Families. At the time, when this dissertation was written, the MANU team
was administratively placed in the division of children’s development (Danish: *Afdeling for Børns Udvikling*) in the Agency of Social Affairs (Danish: *Socialstyrelsen*) under the Ministry of Children, Youth and Families.

Since the development of the parenting programme MANU 0–1 Year in 2016, a range of other MANU materials have been developed (Ingemann et al., 2021). While the PhD project focused on MANU’s first item ‘MANU 0–1 Year’, awareness of the other MANU materials developed and disseminated during the project’s duration was important. The additional materials have added to the general complexity of MANU and indicate that the MANU team, consisting of the MANU coordinator and 1-2 employees, did not solely focus on the central coordination and local implementation of the parenting programme MANU 0-1 Year.

Although MANU is based on evidence and theories, it is not an evidence-based intervention. An evidence-based intervention is broadly defined as a programme, policy or practice that has been tested and found to be effective at improving individual or population-level health (Brown et al., 2017; Leeman et al., 2020). MANU was not tested nor piloted prior to dissemination and implementation (Ingemann et al., 2021).

In MANU, parents are provided with a book containing information and conversational exercises on the perinatal period and parenthood. A more detailed overview of the topics addressed in MANU are presented in Box 1. Midwives, public health nurses (Danish: *sundhedsplejerske*), or health assistants facilitate six antenatal and three postnatal 2.5-hour sessions (God Barndom, 2016; Ingemann et al., 2021). The book and sessions coincide in terms of content. MANU’s essential components have not been identified by programme developers (Ingemann et al., *submitted*).

Based on the findings by Ingemann et al. (2021) (Paper I) it can be concluded that the implementation strategy of MANU in practice became the dissemination of materials, including a detailed manual for carrying out group sessions, with the expectation that professionals implement MANU while waiting to receive or after having received the three-day introductory training. An actual implementation strategy was never documented. Additionally, support over email or phone by the coordinating MANU team in Nuuk was given when asked for or when informed that a professional struggles with programme fidelity. Implementation fidelity was urged by the developers of the programme and by the MANU team (Ingemann et al., 2021; Ingemann et
al., submitted; Proctor et al., 2013). Professionals described how practical things for implementing MANU locally were unclear and not in place when they attended trainings (Ingemann et al., submitted). This made local implementation an overwhelming task. Furthermore, in the programme’s early stage of implementation, local challenges with carrying out MANU were already anticipated or experienced by health professionals (Ingemann et al., 2021).

**Topics addressed in MANU:**

- Parents are provided with information on the pregnancy progress, both physical and mental
- Healthy nutrition, including the harm of consuming alcohol and hashish
- The development of the child’s brain; signs of birth and birthing phases
- A newborn’s needs
- The importance of care for the child’s development
- Bonding and sensitivity
- Having to travel to give birth
- Sex during and after pregnancy
- Practical preparations for the child’s arrival
- Sibling jealousy
- A typical day with a newborn
- Family network
- Reflections on one’s own childhood
- Setting boundaries
- Opportunities and challenges associated with receiving support and advice from extended family

**Box 1. Topics addressed in MANU.**

**MANU’s context**

Following the definition of Pfadenhauer et al. (2015) context in this project is defined as the environment, in which the parenting programme MANU is implemented. MANU is primarily implemented in the healthcare system with midwives and public health nurses carrying the responsibility for ensuring MANU is implemented in their town and accessible in their region. Thereby, the healthcare system is the organisation MANU is implemented in, while the context of the five different regions and their
respective towns and villages are the unique context of local communities of which professionals are part of and which they serve.

03.03 Kalaallit Nunaat

Kalaallit Nunaat (Greenland) is the largest island of the world of which 81 per cent is covered by ice. The total population is just about 57,000 and thereby Kalaallit Nunaat has the world’s lowest population density (Statistics Greenland, 2022). In terms of geopolitics, Kalaallit Nunaat is part of Europe and is a self-governing region within the Kingdom of Denmark. In 1721, Greenland became a Danish colony, in 1953 a Danish County, and in 1979 Home Rule was granted. Self-Rule was established on June 21st, 2009 (Statistics Greenland, 2022). The country has adopted the Nordic Model of social welfare. Kalaallit Nunaat is part of the Indigenous Arctic. The vast majority of the population, close to 90%, are Inuit (ethnic Greenlanders). Kalaallisut (Greenlandic) is the first language and Danish the second. Both languages are taught in schools.

Population and regions

All towns and villages are located along the coastline. Most of the population lives on the southern and west coast. This includes the capital Nuuk with around 19,000 inhabitants (Statistics Greenland, 2022). Greenland is divided into five municipalities, which are going from north to south: Avannaa, Qeqertalik, Qeqqa, Sermersooq, and Kujalleq. The municipalities and health regions coincide. About 60 per cent live in the five regional capitals: Nuuk, Sisimiut, Ilulissat, Aasiaat and Qaqortoq. Greenland’s towns and villages are isolated from each other and differ in their cultural context and availability of resources.

The healthcare system

The healthcare system is centralised into five regional hospitals located in each of the country’s five regional capitals. The national hospital is located in Nuuk. Towns and villages have depending on their population size either healthcare centres, healthcare stations or rural healthcare consultations, which consult with the corresponding regional hospital. Healthcare services, including prescription medicine and birth control, is free of charge for all Greenlandic citizens. Depending on the locally available services and the services needed, people can be transported to either the regional or national hospital, or in specialised or severe cases transferred to Denmark or Iceland.
When the Greenlandic healthcare system was first established in the 19th century, Greenlandic midwives were the system’s backbone. In the mid-20th century, public health nurses (Danish: sundhedsplejersker) took over postnatal care. To be educated as a midwife or a public health nurse, Greenlanders have to move to Denmark in order to obtain their degree. “Earlier perinatal and birthing assistants were trained in Nuuk, but this training is no longer offered. In Greenland’s nursing education, nursing students have an additional semester that trains them on becoming an ‘Arctic nurse’. Among other things, this includes learning how to conduct acute births.” (Ingemann et al., 2021)

“Up until 2020, when data were collected for the present project, women could give birth in the national hospital in Nuuk, the regional hospitals in Qaqortoq, Sisimiut and Ilulissat, or the health centre in Tasiilaq. Just one year earlier, in 2019, the regional hospital in Aasiaat closed its birthing facility function due to turnover in personnel, which could not be reemployed. However, a midwife and a public health nurse position remain in Aasiaat to provide perinatal care. From September 2022 to January 2023, the regional hospital in Qaqortoq temporarily closed its function as a delivery facility.” (Ingemann et al., submitted) A hospital or healthcare centre cannot function as a delivery facility, when it does not have the facilities nor the personnel to fulfil the perinatal guidelines (Persson et al., 2004).

“The midwives and public health nurses in the regional capitals and Tasiilaq are responsible for providing services to all towns and villages in their region by either visiting them, transporting women or through videoconference calls. Besides midwives and public health nurses, health assistant who have a lower education level are often included in maternal and child health work. In smaller towns and in villages health centres have fewer employees due to a smaller population, hence health assistants are involved in multiple areas of care.” (Ingemann et al., submitted)
In this chapter, the overarching frameworks and theoretical perspectives applied in the PhD project’s studies are presented. The choice of theoretical perspective shapes both the research design and the scope and level of knowledge understood and described (Patton, 2014). MANU is primarily implemented in the healthcare system but can also be applied within the municipality sector, thereby the setting MANU is implemented in is complex. Therefore, a complex adaptive systems perspective is useful when investigating such a dynamic and intertwined context. The Consolidated Framework for Implementation Research (CFIR) by Damschroder et al. (2009) and a Community-based participatory research approach following Wallerstein et al. (2018) and Reimer et al. (2020) were the overarching frameworks applied in the project, which shaped the projects’ theoretical perspectives, the conceptualisation of the research focus, selection of methods, and data analysis (Gear et al., 2018). Furthermore, the framework on adverse effects of public health interventions by Lorenc et al. (2014) is included as a critical lens towards the implementation of health promoting interventions.

04.01 Systems perspective

In implementation research, context is the environment or setting, in which an intervention is implemented (Nilsen et al., 2019; Pfadenhauer et al., 2015). Defining the boundaries between different contextual levels or between inner and outer setting can be ambiguous (Damschroder et al., 2009; Damschroder et al., 2022b). Applying a systems perspective ensures a holistic approach to the context of the research field (Plsek et al., 2001).

Complex adaptive systems are unpredictable (Plsek et al., 2001). Complexity theory is increasingly being used to explain and understand complex healthcare system behaviour. The Greenlandic healthcare system is embedded and co-evolves within other systems (e.g. municipality sector) and so do the professionals within the system. This leads to unexpected actions when change appears (Plsek et al., 2001).
The continuously emerging change from the interactions among health professionals and systems makes the implementation process unpredictable, requiring to abandon linear models and to respond flexibly to emerging opportunities (Plsek et al., 2001). In an attempt to reduce the complexity of MANU’s context, it is relevant to look into the implementation of MANU within specific regional context and their communities.

04.02 Determinant framework CFIR

Multiple theories, models and frameworks have been developed to gain insights into the mechanisms by which implementation is more likely to succeed (Nilsen, 2015). Determinant frameworks provide an overview of hypothesised or empirical categories that influence implementation outcomes (Damschroder et al., 2009; Damschroder et al., 2022a; Durlak et al., 2008; Greenhalgh et al., 2004; Nilsen, 2015). The Consolidated Framework for Implementation Research (CFIR) by Damschroder et al. (2009) was chosen with the aim that the project is comprehensive towards the different potential determinants that can influence the implementation of MANU. It provides an overarching systematic classification of implementation determinants that facilitate insights into “what works where and why across multiple context” (Damschroder et al., 2009). CFIR gives an overview of determinants influencing implementation outcomes by either hindering or facilitating implementation. This includes the domains intervention characteristics and characteristics of individuals, as well as the contextual domains process, inner setting and outer setting (Damschroder et al., 2009). In Table 1 an overview of the domains and constructs are provided. Damschroder et al. (2009) note that it is not necessary and possible to study all determinants within the framework and therefore appropriate to focus on the determinants relevant for the implementation context.

The CFIR was chosen for this project because of its breadth of included aspects that influence implementation. As the PhD student gained more knowledge throughout the project, an increasing focus was given to the determinants: adaptability, compatibility, cosmopolitanism and patient needs and resources. Besides the determinant adaptability, these determinants belong respectively to the contextual domains inner and outer setting. Adaptability is part of the domain intervention characteristics, but it addresses the intervention’s fit to the implementation context.
Table 1. Overview of the CFIR domains and constructs from Damschroder et al. (2009).

| Intervention characteristics | • Intervention Source  
| • Evidence Strength & Quality  
| • Relative advantage  
| • Adaptability  
| • Trialability  
| • Complexity  
| • Design Quality and Packaging  
| • Cost  |
| Outer Setting | • Patient Need & Resources  
| • Cosmopolitanism  
| • Peer Pressure  
| • External Policy & Incentives  |
| Inner Setting | • Structural Characteristics  
| • Networks & Communication  
| • Culture  
| • Implementation Climate (Tension for Change; Compatibility; Relative Priority; Organizational Incentives & Rewards; Goals & Feedback; Learning Climate)  
| • Readiness for Implementation (Leadership Engagement; Available Resources; Access to knowledge and information)  |
| Characteristics of Individuals | • Knowledge & Beliefs about the Intervention  
| • Self-efficacy  
| • Individual Stage and Change  
| • Individual Identification with Organization  
| • Other Personal Attributes  |
| Process | • Planning  
| • Engaging (Opinion Leaders; Formally appointed Internal Implementation Leaders; Champions; External Change Agents)  
| • Executing  
| • Reflecting & Evaluation  |

04.03 Community-based participatory research

In a community-based participatory research (CBPR) approach the focus is on creating partnerships and building trust between the researchers and the community people, who ultimately are meant to gain from the research (Jull et al., 2017; Reimer et al., 2020; Wallerstein et al., 2018). CBPR is still a fairly new approach applied in Greenland. The CBPR approach was developed as a reaction to the colonial history of research in Indigenous communities, where researchers from outside the community would collect data without the community’s involvement and leave the community without ever sharing research findings with the community (Reimer et al., 2020; Wallerstein et al., 2018). This, so called, ‘helicopter research’ maintains colonial positions of power, while potentially also leading to ethnocentric and misinterpreted results, since data is collected and analysed detached from its context and epistemologies (Healey et al., 2014; Jull et al., 2017; Reimer et al., 2020).
Practicing CBPR places research and its results in the hands of the community, who own and need the knowledge. Reimer et al. (2020) introduce five stages in CBPR, which are based on the CBPR principles described by Wallerstein et al. (2018). The five stages are as follows: i) community capacity/relationship building; ii) identification of the research question(s); iii) research design, including data collection strategies; iv) data analysis; and v) dissemination of the research findings. Reimer et al. (2020) described their successful CBPR practice in a Greenlandic community, which they conducted over a seven-year period, which built community relationships, trust and capacity in research.

**Stage 1: Relationship and capacity building**

The first step in CBPR is relationship building, which involves reflexivity, identification of the community involved in the study, who are partners and who are stakeholders. Furthermore, at this stage it is important to create and build participatory structures between academia and community.

**Stage 2: Identification of research question**

At the second stage the research questions of the project are identified by the community or in collaboration between community and academia. Here, community involvement can be created through advisory boards and meetings with a continual participation throughout the course of the study. Furthermore, mutual decision-making process of study elements is important.

**Stage 3: Selection of methods and data collection**

At the third stage the research design, including data collection strategies, is decided upon. This involves deciding on who should collect data within the community with consideration to training that person, issues of confidentiality and building relationships for research in the community.

**Stage 4: Data analysis**

In the fourth step the roles of researchers and community in data analysis is important to understand, in order to create steps that support a collaborative interpretation of data. The researchers provide expertise on data analysis and presenting data in a useable format for interpretation. The community holds the expertise in interpreting data in a way that is relevant to their context and that protects their community.
**Stage 5: Sharing and dissemination of results**

At the fifth and final stage accountability to and protection of the community is determined by how the results are interpreted. Then it is collaboratively decided upon where, how and who to share results with.

**04.04 Adverse effects of public health interventions**

Public health interventions can despite their good intentions potentially have unintended negative effects besides the often well described unintended positive effects (Broholm-Jørgensen et al., 2022; Lorenc et al., 2014). These negative effects are described as adverse effects or unintended harms (Bonell et al., 2015; Lorenc et al., 2014). To encourage the discussion on investigating and reporting on public health interventions’ adverse effects, Lorenc et al. (2014) introduce a conceptual framework of five unintended potential harms. These are: i) direct harms (e.g. sports participation causing injuries); psychological harms (e.g. campaigns generating damaging feelings like worry or guilt); equity harms (e.g. initiatives benefiting those with the least need); group and social harms (e.g. targeted interventions reinforce stigmatisation); and opportunity harms (e.g. public resources are spent on ineffective interventions) (Lorenc et al., 2014). Adding this theoretical perspective to the discussion of this dissertation will provide a critical lens for reviewing potential unintended adverse effects of MANU’s implementation.
05 Study design and methods

The PhD project has been performed in accordance with the Declaration of Helsinki, and the Greenlandic Scientific Ethical Committee (Danish: Videnskabsetisk Udvalg) granted ethical approval of the project. Furthermore, the Board for Health and Prevention (Danish: Sundhedsledelsen) gave permission to interview health professionals during workhours, to receive assistance for recruiting parents, and to get access to data on staffing norms.

The project applied a community-based participatory research (CBPR) approach along with qualitative methods. Data were collected through interviews, observations, document analysis, and a Sharing Circle. First, the project’s CBPR approach following the five stages presented in chapter 3 is presented. Then the qualitative methods applied are briefly described.

05.01 A community-based participatory research approach

This project aimed to apply CBPR in a three-year PhD project. However, relationship building to stakeholders and professionals began 2.5 years prior to the project’s official start. The motivation behind applying a CBPR approach was to ensure that stakeholders hold ownership of the research and that the generated results are relevant to the community. These are also some of the methodological aspects the community-engaged research by Reimer et al. (2020) has demonstrated. Table 2 provides a brief overview of the PhD project’s five CBPR stages.

Stage 1: Relationship building

Following the first key CBPR principle (Wallerstein et al., 2018), the community which this project recognises as a unit of identity is defined in three levels. First, the project identifies the Greenlandic community at large since the project investigates a national and universal programme. Secondly, the three of Greenland’s five health regions selected as study sites are recognised as each being their own regional community in which midwives and public health nurses collaborate with professionals and serve the families across towns and villages within their region. Third, each
town and village are a local community in itself of which each professional and parent is part of.

Relationship building with professionals in healthcare, policy and municipality institutions began in 2017 by building on the relationships the PhD student’s supervisor Christina VL Larsen introduced. Furthermore, the PhD student was working within the field of public health by evaluating healthcare and public health initiatives and conducting preliminary interviews and observations on MANU’s development and implementation (Ingemann et al., 2021). This activities contributed to relationship building and formed the PhD student’s positioning (Muhammad et al., 2015).

In Paper I, stakeholders in MANU’s development and implementation were identified through snowballing and conversations with the MANU coordinator. The building of relationships, capacity and trust continued throughout the project. It was deemed important for the first study and the formation of the project’s reference group that all stakeholders represented different professional and contextual positions within the healthcare system or the community at large.

Table 2. Overview of the PhD project’s five CBPR stages.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Title</th>
<th>Duration</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Stage 1: Relation-</td>
<td>2017 – ongoing</td>
<td>• Began 2.5 years prior to official project start.  • Formation of a reference group that followed the project from outset till end.</td>
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<td>ship building</td>
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<td>Stage 2: Identifica-</td>
<td>Oct. 2018</td>
<td>• At the first reference group meeting the focus of the PhD project was discussed and defined.</td>
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<td>tion of research</td>
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<td>questions</td>
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<td>Stage 3: Research</td>
<td>2017 – 2018; 2020</td>
<td>• The reference group selected study sites.  • Aspects on how to conduct interviews with parents was discussed with the reference group.</td>
<td></td>
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<tr>
<td>design and data</td>
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<td>collection</td>
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<tr>
<td>Stage 4: Data</td>
<td>2017 – 2023</td>
<td>• At reference group meetings excerpts of transcript or summaries of results were analysed and discussed.  • The PhD student collaborated with the Greenlandic interviewer and an Greenlandic researcher when analysing the interviews with parents and elders.</td>
<td></td>
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<tr>
<td>analysis</td>
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<tr>
<td>Stage 5: Dissemina-</td>
<td>2021 – 2023</td>
<td>• Lessons learned and recommendations based on the project’s results were discussed in different meetings with the reference group.  • All participants in the project were invited to receive a newsletter on updates and publications of the research conducted.  • Lay-person policy briefs have been disseminated, while an overall evaluation report is underway.</td>
<td></td>
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<td>tion of the research</td>
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<td>findings</td>
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Formation of the project’s reference group

Nine stakeholders were selected and invited to form the project’s reference group. Furthermore, to enable that the PhD student could build a participatory structure, trust and relation to the reference group members, criteria for selection was that the
stakeholder should be resident in Greenland and have experience with working in Greenland. The reference group members were heterogeneous in terms of employment in the health or social sector and held a management and/or practitioner position. All nine accepted the invitation.

From the original nine members in 2018 six remained as members throughout the project. Of these only one had changed their position from a managing health sector position to a managing municipality position, which was a position still relevant to this project. Three of the nine original members left at different times during the project due to changes in their position. Two of them were replaced with the new person in the same position and the third member was replaced by a professional working in one of the municipalities’ family centres.

Over the period of the project, six meetings were held from 2018 to 2023. If members could not attend a meeting, individual follow-up meetings were held to orient them and ensure their input was included.

Stage 2: Identification of the research questions

At the first reference group meeting members were introduced to the general idea of investigating the implementation of MANU and how the reference group will be involved in the project. It was in this first meeting that through discussions with the members on their perceptions of MANU and the barriers and strengths they see in its implementation that the aim of this project was defined.

Stage 3: Research design and data collection

The project’s reference group selected three of the five regions as study sites for data collection. The reference group did not decide which methods should be applied but agreed with applying qualitative methods as suggested by the researcher. Applying a qualitative study design was an obvious choice, since the project was interested in understanding determinants influencing local implementation (Greenhalgh et al., 2016; Hamilton et al., 2019). Qualitative interviews were selected as the primary means to collect professionals’ and parents’ perspectives.

The reference group was involved in aspects on how to conduct the interviews. In a reference group meeting prior to data collection, two issues of concern regarding interviewing parents were addressed. First, the reference group members were asked to share their opinions on whether an interpreter should assist the PhD student in conducting interviews with parents, who prefer speaking Greenlandic, or if a Greenlandic interviewer should interview parents in close collaboration with the PhD
student. The members agreed that collaborating with a Greenlandic interviewer would be best in order to make the conversation for participants more comfortable. Since using an interpreter was expected to make interviews lengthy and less dynamic. The second issue addressed was the operationalisation of engaging parents in interviews to describe values important to them in child-rearing. Here, members suggested that the questions regarding this topic should ask about participants kinship by, for example, mapping their kinship or by asking about the activities they do together with family members.

**Stage 4: Data analysis**

The reference group was involved in the analysis of all three studies either by reading depersonalised excerpts of transcripts or being presented summaries of the data. When presenting and discussing results with reference group members, the PhD student drew attention to the importance of not sharing these results before they are published and to treat preliminary results with confidentiality.

**Collaborating with research partners**

For the analysis of the interviews with parents, the PhD student decided to work closely together with Ingelise Olesen and Else Jensen. Jensen is Greenlandic and experienced with collecting data for various health studies in Greenland. She was also the Greenlandic interviewer the PhD student collaborated with during data collection. Olesen is an Indigenous knowledge holder and researcher, who formerly has worked as a midwife in Greenland. In public health research it is important to acknowledge Indigenous epistemologies and methods, and to combine them with western sciences in a way that is meaningful for the community of interest. Acknowledging communities’ values, knowledge and resources in the Arctic in research is important in order to create engaging and relevant results. The PhD student recognises her position as a non-Greenlandic researcher who is increasingly learning about the Inuit and Greenlandic epistemologies but will presumably primarily remain within Western epistemologies. However, Olesen and Jensen hold Greenlandic and Inuit epistemologies. Collaborating with them has meant that the findings presented in Papers II and III stay true to participants’ descriptions and are to a greater extent described from Greenlandic and Inuit epistemologies than Western epistemologies (Healey et al., 2014; Reid, 2020). The motivation to work in this way and the awareness of epistemologies also stems from the PhD student’s stay at the Arctic University of Norway (UiT) in Tromsø, where she was in close contact with her co-supervisor Siv Kvernmo. Here, the observed similarities and differences between
Greenlandic and Sámi families were discussed. Kvernmo enabled a meeting with Asta Balto in Kautokaino, who has studied values in child-rearing in Sápmi (Balto, 1997; Balto et al., 2012). The insights gained from this stay have formed the analysis approach of the interviews with parents.

**Stage 5: Dissemination of the research findings**

At the reference group meetings where the analysis of results was discussed, the members also reflected on lessons learned or next steps in research and practice. When the results of the preliminary investigation were presented, the members identified five recommendations, which all members approved prior to dissemination in the policy briefs summarising the studies in Greenlandic and Danish (Appendix 12.02). The same applies to the policy brief based on Paper II (Ingemann et al., 2022) (Appendix 12.03). The reference group agreed to the idea that a comprehensive evaluation report of the findings in this PhD project should be formed including lessons learned and recommendations for practice and research, which the members identified at the final reference group meeting. The evaluation report is underway and will be made available in Greenlandic and Danish.

Finally, all stakeholders and study participants were invited to receive an e-mail newsletter on updates and results of the project. This newsletters have been distributed and continue to be sent out, when Papers or policy briefs or similar information are being published.

**05.02 Qualitative methods applied**

In this section the qualitative methods applied in the project’s studies are shortly presented, but more detail can be found in the respective papers of the studies (Ingemann et al., 2022; Ingemann et al., 2021; Ingemann et al., *under review*; Ingemann et al., *submitted*). An overview of the methods applied in each paper is given in Table 3.

Data were primarily collected in the three regional capitals, while a few smaller towns were included through phone interviews or if a participant was visiting the regional hospital during the researcher's stay in the regional capital (Ingemann et al., 2022; Ingemann et al., *under review*; Ingemann et al., *submitted*). In 2020, data collection on each site lasted about two to four weeks.
Table 3. Overview of methods applied.

<table>
<thead>
<tr>
<th>Study</th>
<th>Paper</th>
<th>Methods</th>
<th>Study participants</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study 1</td>
<td>Paper I</td>
<td>Document analysis</td>
<td>30 documents</td>
<td>February 2017 to December 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Open-ended &amp; semi-structured interviews</td>
<td>17 stakeholders</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Observations</td>
<td>2 trainings</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>4 sessions</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>8 health professionals</td>
<td></td>
</tr>
<tr>
<td>Study 2</td>
<td>Paper II + III</td>
<td>Semi-structured interviews' Sharing Circle</td>
<td>38 mothers</td>
<td>March to November 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 fathers</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>5 elders</td>
<td></td>
</tr>
<tr>
<td>Study 3</td>
<td>Paper IV</td>
<td>Semi-structure interviews</td>
<td>11 midwives</td>
<td>March to November 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 public health nurses</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>3 health assistants</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>6 managers</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>4 municipality personnel</td>
<td></td>
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</table>

Data collection

A semi-structured interview design was applied in the interviews with parents and professionals (Brinkmann et al., 2015). A semi-structured design was chosen due to pre-defined topics of interest within the studies and the professionals’ interview guide also based on the determinant framework CFIR (Ingemann et al., 2022; Ingemann et al., under review; Ingemann et al., submitted).

Study 1 on MANU’s development and initial implementation

In meetings and conversations with identified stakeholders, information relating to the parenting programme MANU’s development and implementation were documented. Stakeholders were able to direct the conversation into topics related to MANU that they found relevant (Ingemann et al., 2021). Furthermore, two three-day MANU trainings were observed focusing on the facilitation of the training and professionals’ interaction, while also conducting explorative interviews with eight professionals on their experienced or anticipated challenges in carrying out MANU locally. Four MANU sessions for parents were observed focusing on the facilitation and parents interaction (Given, 2008; Ingemann et al., 2021). Finally, a document analysis on MANU’s conceptualisation and development process was conducted (Ingemann et al., 2021).

Study 2 on parents’ perspectives

Parents could choose to be interviewed in Greenlandic or Danish. The semi-structured interviews were conducted primarily in Greenlandic by Else Jensen, while the PhD student observed. 40 interviews with 38 mothers and twelve fathers either individually or in couples were held.
A sharing circle for fathers on two study sites were organised due to challenges with recruiting fathers (Ingemann et al., 2022; Ingelise Olesen et al., 2021; Rothe et al., 2009). It was anticipated that by gathering fathers in a group, participants would feel less confronted and thereby motivate them to share their perspectives. On the first site only one father turned up, who then was individually interviewed. On the second site a Sharing Circle with three fathers was conducted. Jensen facilitated the Sharing Circle, while Ingemann observed (Ingemann et al., 2022).

Initially it was the plan to interview the same number of parents who have attended MANU sessions and parents who have chosen not to participate in MANU. However, it was not easy to distinguish between parents' attendance, since many rarely remembered the precise number or which one of the nine MANU sessions they had attended. (Ingemann et al., 2022)

In the first interviews with parents, Ingemann was intrigued by the value and importance parents put in their own relationship to their grandparents and how they want their own child to also experience a loving grandparent relationship (Ingemann et al., 2022; Ingemann et al., under review). Based on this curiosity, Ingemann decided to conduct a few explorative interviews with elderly people who are grandparent on their perceptions on child-rearing, parenthood, and their relationship to their grandchildren. Jensen conducted a group interview in Greenlandic with three grandparents in an elderly home on the first study site, while Ingemann observed. On the second site two grandparents, who Ingemann met by chance during her stay, were individually interviewed one in Greenlandic by Jensen and the other in Danish by Ingemann (Ingemann et al., under review). This demonstrates the openness with which Ingemann approached interviews with parents. Being open to surprises and newfound angles in the study and investigating them is an important aspect of qualitative research (Given, 2008; Kvale et al., 2009; Timmermans et al., 2022).

**Study 3 on professionals’ perspectives**

Semi-structured interviews were conducted with eleven midwives, four public health nurses, three health assistants, six managers and four municipality personnel in Danish by the PhD student (Ingemann et al., submitted; Kvale et al., 2009). Most interviews were held individually, only a few were in couples because the participants preferred it this way. Additionally, to support midwives and public health nurses’ descriptions, the PhD student collected the staffing norms and actual annual work preformed of these two professions in 2020 (Ingemann et al., submitted).
Data analysis

Timmermans et al. (2022) describe how data analysis begins with the first interview and continues until the writing up of the study is finalised. Considering this, the overall analysis of this project and its data began with the first conversations with stakeholders and observations made of the parenting programme and will end with the last publication that will be written on this project.

Content analysis of MANU materials

A qualitative content analysis (Elo et al., 2008) of different MANU materials was applied with a focus on extracting information regarding the MANU materials content and aim. Moreover, the materials were thematically coded regarding topics addressed in the informational text and exercises. This way the materials content could later be compared with topics addressed by parents and grandparents. The MANU materials investigated were i) the parent book, professionals' manual and animation videos of the parenting programme MANU 0-1 Year, ii) the MANU grandparents' booklet, and iii) the facilitator manual and animation video of the MANU community meeting.

Study 1 on MANU's development and initial implementation

The transcriptions of notes and interviews were thematically analysed in an iterative process going back and forth between transcripts, codes and summaries. A combined theoretical framework consisting of Plsek et al. (2001) systems perspective, Nilsen et al. (2019) review on contextual determinants in implementation, and Damschroder et al. (2009) determinant framework CFIR led the deductive analysis approach. The final five main themes of the results were then presented to the reference group. The group validated the presented results and discussed lessons learned.

Study 2 on parents' perspectives

The majority of the interviews with parents were held in Greenlandic by Else Jensen, who also transcribed and translated most of them. There were some interviews conducted in Danish by the PhD student on the first two sites, but most of the Danish interviews were conducted on the third study site. The first interviews Jensen held were directly transcribed and translated afterwards in order for Ingemann and Jensen to reflect on interview techniques, adjustment of questions and participants responses (Ingemann et al., 2022). However, as data collection picked up it was no
longer possible to transcribe and translate directly after interviews. Therefore, interviews were evaluated directly after they were conducted, where Jensen shared some of the aspects the participants had shared while the PhD student contributed with the observations she made during the interview. The main points from these oral evaluations were noted as fieldnotes. This way a collaborative analysis of the data begun and data saturation was assessed jointly (Timmermans et al., 2022).

After all transcriptions were completed, a few transcripts were thoroughly read by Ingemann, Jensen and Olesen with the aim to collaboratively identify general themes (Ingemann et al., 2022). During these first analytical discussions it became clear that the narratives relating to the role of kin should be analysed at a later stage and published in another paper. All transcripts were then coded in NVivo by the PhD student, based on the identified themes. Then four excerpts of different transcripts were selected and presented during a reference group meeting, where the group analysed and discussed these transcripts. Based on the reference group’s input the pre-identified themes were revised and transcripts revisited. Finally, during the drafting of Paper II and based on the feedback from co-authors the final five themes were decided upon.

Five analysis meetings with Olesen and Jensen were organised for the analysis of parents’ responses relating to the role of kin in child-rearing. For this analysis, which is described in Paper III (Ingemann et al., under review), ten parent interviews were selected based on the criteria that (i) they should contain rich descriptions of the roles of the people in their network and of their own childhood experiences; (ii) the participant has children but is not currently pregnant (Ingemann et al., under review). During the writing up of results and co-authors reviewing drafts of the manuscript the final four themes were identified.

**Study 3 on professionals’ perspectives**

All interviews with professionals were conducted by the PhD students. Transcription of the interviews began during data collection. This way Ingemann was continuously aware of the data gathered and small improvements to the way of interviewing occurred along the way. First analytical ideas were noted down as well and no more interviews were conducted when data saturation was met (Timmermans et al., 2022).

Audio recorded interviews were primarily transcribed by Ingemann with assistance from a Danish student assistant. Ingemann first coded the data based on CFIR (Damschroder et al., 2009) and summarised them into three overarching themes. Summaries of these themes along with selected quotes were then presented to the
reference group. The group discussed the identified overarching and sub-themes presented and validated or pointed out missing aspects within the results. Reference group members agreed with the presented results and continued reflecting on next steps in practice and research. Finally, in writing up the results and in collaboration with co-authors the final five main themes were identified.
This chapter begins with Table 4, which provides an overview of the four papers in this PhD dissertation and each paper’s main findings. Then summarises of the findings relevant for the discussion of this PhD dissertation are presented. First, parents’ perspectives on parenthood and child-rearing are described. Then both parents’ and professionals’ experiences with MANU regarding MANU’s format, content and accessibility are outlined. Finally, professionals’ perspectives on implementing MANU in their local context is presented. The chapter includes findings from the PhD project’s first and second published articles by Ingemann et al. (2021) and Ingemann et al. (2022) as well as from the third and fourth articles under review by Ingemann et al. (under review) and Ingemann et al. (submitted).

### Table 4. Overview of findings of Papers I to IV.

<table>
<thead>
<tr>
<th>Paper</th>
<th>Title</th>
<th>Summary of findings</th>
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<tbody>
<tr>
<td>I</td>
<td>An in-depth implementation study of the Greenlandic parenting program MANU’s initial stages of implementation</td>
<td>“MANU was conceptualised in a context where parenting skills were seen as a public health issue with a political interest to improve children’s well-being. However, families’ perspectives on what they need for transitioning to parenthood were not included in the development of the program. The first years of MANU focused on disseminating material, training professionals, and developing more MANU related material. The MANU team worked intently to meet the conceived need for Greenlandic parenting material and ensure all relevant personnel has received training, local implementation was delegated to the individual professional. Program fidelity was urged, but many local barriers were anticipated and experienced.” (Ingemann et al., 2021)</td>
</tr>
<tr>
<td>II</td>
<td>Parents’ perspectives on preparing for parenthood: a qualitative study on Greenland’s universal parenting programme MANU 0–1 Year</td>
<td>“Based on the parents’ perspectives presented in this study, we conclude that parents’ notions and experiences of parenthood are generally addressed in the parenting programme MANU, but the experience and attendance of MANU depends on how it is organised and offered locally. The conversational exercises in MANU challenged parents’ notions of parenthood, but only in the sessions that parents attended, since barely anyone used the MANU book outside sessions. MANU has the possibility to create a space for parents to reflect and prepare. However, for MANU to be universal as intended and to reach both parents, the facilitation of sessions could be revisited, for example, with inspiration from other Arctic parenting programmes or making information accessible on multiple platforms to meet parents’ different ways of learning and accessing information.” (Ingemann et al., 2022)</td>
</tr>
<tr>
<td>III</td>
<td>Parents’ perspectives on the role of kin in child-rearing: a qualitative study on Greenland’s universal parenting programme MANU 0–1 Year</td>
<td>“Parents’ own network forms the basis of the network they shape for their child and the relationships they choose to nourish. The parents’ personal experiences can lead to withdrawing from relationships when transitioning into parenthood. This can result in a loss of support and missing out on the opportunity to pass on intergenerational and familial connectedness to their child. The MANU materials address aspects in the role of kin that parents and grandparents described in interviews, such as conflicts that can arise when modern and traditional ways of child-rearing are confronted between parents and grandparents. However, even though the format and delivery of MANU aims to be universal, it seems to mostly address Western epistemologies, while both Western and Inuit epistemologies</td>
</tr>
</tbody>
</table>

06 Results
exist in Greenland. Furthermore, MANU does not address the importance of connecting with nature and kinship in child-rearing. This article creates a window into the existing context that parents navigate in terms of child-rearing and parenthood and in which families live.” (Ingemann et al., under review)

“Overall, findings of the study show that there is a general recognition of MANU as an impressive product and a relevant health promoting initiative. However, in all study sites, adaptations to MANU’s content and frequency were made. Adherence to MANU’s full coverage has not been reached yet. The identified determinants hindering local implementation link back to MANU’s complexity and inadequate preparatory investigations made into aspects influencing implementation during MANU’s conceptualisation and development. Many of the barriers identified could have been prevented by involving local community perspectives from professionals and families from the outset of MANU.” (Ingemann et al., submitted)

### 06.01 Parents’ perspectives on parenthood and child-rearing

The second and third paper present and discuss results of 40 interviews with parents. The interviews were held either individually or as a couple with 38 mothers and 12 fathers (Ingemann et al., 2022; Ingemann et al., under review). Additionally, explorative interviews with five grandparents were held (Ingemann et al., under review).

For parents, parenthood began with the decision to be pregnant whether the pregnancy was decided upon beforehand or came as a surprise (Ingemann et al., 2022). Some described that their decision to become parents was connected to taking the next step as a couple and wishing to create a caring family. Becoming a parent was lifechanging. Parents described they had to leave their freedom behind in exchange of a lifelong responsibility. This involved losing friendships, no longer finding joy in solitude and changing their lifestyle. The latter was often described in connection with not partying anymore and refraining from alcohol. For some this meant breaking free from an addiction. Lastly, a few parents pointed out that they were surprised about how mentally tough it is to put their child’s needs before their own (Ingemann et al., 2022). Furthermore, becoming pregnant led to the desire to be economically independent, such as securing a job, getting an education and finding appropriate housing.

**Toqqissisimaneq and ataatsimoorneq in child-rearing**

In the interviews, parents described different aspects that were important to them for their child’s upbringing. These aspects were grouped into **toqqissisimaneq** (Danish: tryghed; English: security and care) and **ataatsimoorneq** (Danish: fællesskab; English: community or sense/feeling of togetherness).
Parents defined toqqissisimaneq mainly as providing a secure environment for the child to grow up in, which was pointed out to be a home free of alcohol, hashish and violence. Parents explained to want to ensure a calm home with stability and a space that prioritises the child’s needs. Parents, who specifically pointed out that they wanted to create a home free of alcohol and hashish, shared that they have had or experienced others in their community with adverse childhood experiences. Therefore, parents wanted to prevent their own child from experiencing such adversities. Parents also shared other aspects important to raising their child, such as respect, knowing your boundaries, independence and self-confidence (Ingemann et al., 2022).

Ataatsimoorneq as a feeling of togetherness came forward in parents’ responses when they mapped out and described the relations they see important in their child’s upbringing, and when they described their own connectedness to elders in childhood (Ingemann et al., 2022; Ingemann et al., under review).

On average, parents placed seven relations in their child’s network, and some noted up to 19 (Ingemann et al., under review). After writing down all relations important to their child’s upbringing some were surprised at how many they actually included, and a few stopped themselves from filling in more, since they felt the list was endless (Ingemann et al., under review). Grandparents were described as the closest extended family members to the child, but besides grandparents’ relation to the child, they also played an important role for new parents (Ingemann et al., 2022; Ingemann et al., under review). Parents described how grandparents, and for some also other family members, provide support when necessary, give advice when needed, and help with practical tasks. Grandparents are typically the head of the family and function as a gathering point for the whole extended family, where a sense of community follows.

Parents characterised experiencing community through practices such as sharing meals with family members on a regular basis, gathering family on holidays and spending time in nature together as important values in their child’s upbringing (Ingemann et al., 2022; Ingemann et al., under review). Furthermore, parents found it important to teach their children about their kin network and marking important relations with personal names (Ingemann et al., under review). These values contribute to the sense of belonging.

From the interviews, it stood out how parents most often voiced whether or not they had a vulnerable upbringing (Ingemann et al., 2022; Ingemann et al., under review). Parents’ own (adverse) childhood experiences can influence and complicate how parents place themselves and their own new family within the bigger extended family.
For some, distancing themselves from their extended family has led to the loss of community (Ingemann et al., under review).

06.02 Experiences with MANU

In this section MANU’s format, content and accessibility from parents’ and professionals’ perspectives from Papers II, III and IV are summarised.

MANU’s format

Professionals found that having a universal programme like MANU valuable (Ingemann et al., 2021; Ingemann et al., submitted). Receiving MANU in group sessions together with other parents was appreciated by parents who like learning from others. This was also mentioned as a strength of MANU by some health professionals. But positive group experiences also depended on the group dynamics, which can be influenced by parents being rather introvert or extrovert (Ingemann et al., submitted) and can depend on parents’ consistent or inconsistent participation in the sessions (Ingemann et al., 2022). Furthermore, the professionals’ facilitation skills were crucial for parents having a positive experience of the MANU sessions (Ingemann et al., 2022). The MANU book is barely read and used by parents (Ingemann et al., 2022; Ingemann et al., submitted).

Professionals expressed how MANU makes young people aware of their attitudes towards parenthood and gives them food for thought (Ingemann et al., submitted). This was also reflected in parents’ descriptions, where MANU created a space for them to reflect, and some even described that they felt less alone with their concerns (Ingemann et al., 2022). For some couples, reflecting on topics addressed in MANU felt natural, while for others it was new. Professionals as well as parents described how fathers are rather quiet and find it difficult to express themselves (Ingemann et al., 2022; Ingemann et al., submitted). Men rarely seek guidance and advice in their network, even though male participants expressed that they would like to share thoughts with other men (Ingemann et al., 2022).

MANU’s content

Even though professionals applauded that MANU’s illustrations and animations were Greenlandic, they found that its’ content represented a Nuuk context seemingly disconnected from the different contexts existing in the smaller towns and villages in Greenland (Ingemann et al., 2021; Ingemann et al., submitted). The language used
in MANU was perceived by some professionals as easy to read, while others expected it difficult for some parents to comprehend. (Ingemann et al., 2021)

The MANU materials address aspects of the role of kin in child-rearing that parents discussed in interviews (Ingemann et al., *under review*). However, MANU focuses mainly on the nuclear family while many in Greenland coincide being a nuclear family with an involved extended family (Ingemann et al., *under review*). “Furthermore, the importance of being together in nature and being with extended family, which creates connectedness, are aspects that are lacking or barely addressed in MANU” (Ingemann et al., *under review*). Since MANU is a universal programme, meaning accessible to everyone, the topics are addressed broadly and mainly encourage parents to reflect. However, how much topics are reflected upon depends on parents’ engagement and the topics facilitators choose to address in sessions (Ingemann et al., 2022; Ingemann et al., *under review*; Ingemann et al., *submitted*).

Professionals had different experiences and opinions about MANU’s exercises and topics. “On the one hand, some found the material to be repetitive or too contemplative for parents to comprehend. On the other hand, others experienced positive reactions from parents on different exercises. Professionals would have liked more illustrations, activities, and games to draw on to meet parents’ different ways of learning.” (Ingemann et al., *submitted*)

Parents mentioned several and different topics that they appreciated and continue to think of. However, many participants expected to receive more hands-on preparation in terms of how to bathe and hold a newborn. Participants also mentioned to seek information through the internet, Facebook groups, smartphone applications and podcasts. (Ingemann et al., 2022)

**MANU’s accessibility**

Almost all interviewed parents had been offered to attend MANU (Ingemann et al., 2022). Few recalled having attended all nine sessions of MANU, while those who mentioned to only have attended a couple of sessions explained that work, illness or other personal hindrances prevented them from attending more often; this was particularly the case for men (Ingemann et al., 2022). This was also reflected in interviews with professionals (Ingemann et al., 2021; Ingemann et al., *submitted*). Health professionals often experienced how parents forgot to attend group sessions despite numerous reminders, and how parents did not prioritise coming to MANU, or could not attend sessions due to work (Ingemann et al., *submitted*). Furthermore, some professionals expressed how MANU is not accessed by those “who really need it” (Ingemann et al., *submitted*). Some midwives also discussed the possibility of par-
ents being overwhelmed by attending MANU sessions on top of regular consultations (Ingemann et al., submitted). Parents mentioned that sessions had been cancelled due to Covid-19, illness among personnel and too few parents having signed up for MANU (Ingemann et al., 2022), which were reasons also described by professionals (Ingemann et al., submitted).

06.03 Professionals’ perspectives on local implementation

Papers I and IV present results from the professionals’ perspective, who are responsible for or take part in the implementation of MANU (Ingemann et al., 2021; Ingemann et al., submitted). The professionals, who were interviewed, included midwives, public health nurses, health assistants, managers and municipality personnel. In the first study, 22 professionals from four different regions gave their perspective on MANU’s first years of implementation, where anticipated or already experienced determinants influencing local implementation were identified (Ingemann et al., 2021). These findings were then confirmed in the study of Paper IV, which was conducted two years later (Ingemann et al., submitted).

Context and organisational structures

Determinants connected to the organisational structures of the healthcare system made adaptation of the programme inevitable (Ingemann et al., submitted). High turnover is one of the main barriers, which make it difficult to implement and sustain MANU (Ingemann et al., submitted). This was also mentioned in the first study (Ingemann et al., 2021). Even the MANU coordinator described how she was aware off professionals not considering local implementation feasible due to high workload, high turnover and limited resources. Yet she perceived professionals’ low motivation to be the biggest barrier to local implementation (Ingemann et al., 2021). Professionals outside Nuuk felt that adherence to implementing MANU as designed is only feasible in Nuuk, where staffing norms for midwives and public health nurses is more than double the amount than in other parts of Greenland (Ingemann et al., submitted). MANU is intended as a national programme accessible to everyone, but already with the implementation challenges met in towns MANUs implementation in villages seems infeasible to professionals (Ingemann et al., submitted).

In most places one professional carried the lone responsibility for ensuring the implementation of MANU, this was described as a burden by some. However, some found ways to collaborate within their organisation (e.g. midwife and public health nurse, or midwife from the regional health centre supporting health assistants in
smaller towns) or across sectors where municipality personnel worked together with health professionals (Ingemann et al., submitted). In places where collaboration was functioning well, it facilitated the implementation of MANU. Municipality personnel in family centres mostly only use elements of MANU for their clients and incorporate these elements in their own developed parenting programmes (Ingemann et al., submitted).

**Prioritising limited resources**

Professionals agree that having a universal programme is important (Ingemann et al., 2021; Ingemann et al., submitted). However, when it came down to allocating already limited resources, since resources for local implementation did not come with the programme, professionals prioritised based on the needs they perceived locally (Ingemann et al., submitted). Subsequently this led to MANU becoming a low priority. Professionals rather prioritised efforts targeted vulnerable families.

MANU is not compatible with health professionals’ existing workflows, which challenges implementation fidelity that is urged by the MANU team (Ingemann et al., 2021; Ingemann et al., submitted). Professionals had to adapt the programme’s scope in order to be able to offer MANU to parents (Ingemann et al., submitted). Local adaptations made were accepted as a temporary solution but not supported by the MANU team (Ingemann et al., submitted).

In the first study, the group, who developed MANU, described how they experienced a prevailing demand for Greenlandic maternal and child health materials among professionals, which led them to tenaciously produce more subsequent MANU materials (Ingemann et al., 2021). On the contrary, in the study of Paper IV, health professionals expressed intervention fatigue (Ingemann et al., submitted). They experienced receiving new subsequent MANU materials along with an expectation that they will master and implement them immediately. Mastering the parenting programme MANU already required much time and practice of health professionals due to the extensive material (Ingemann et al., submitted).

**Professionals’ need for support and skills**

Providing professionals with detailed material and an introductory training was the MANU developers’ response to the barriers in implementation identified in the evaluation of Prepared for child (Danish: Klar til Barn) (KTB) (Ingemann et al., 2021). KTB is the universal parenting programme that existed prior to MANU. KTB’s evaluation pointed at poor organisational support in implementation and lack of adaptability to
local context, which influenced midwives motivation and belief in the programme (Ingemann et al., 2021).

In the first two years of implementation the MANU team focused on disseminating materials and training professionals (Ingemann et al., 2021). Professionals, who were interviewed at observed introductory trainings, described the training to be providing them with a good introduction and motivated them. Furthermore, the training has initiated some networking across sectors and communities for them (Ingemann et al., 2021). Professionals interviewed in their local context after having received training, described the training as informative but not providing them with the necessary skills (Ingemann et al., submitted). Some professionals pointed out that MANU requires more than training, professionals need to be motivated and passionate about it (Ingemann et al., submitted).

In 2018, at least one professional has received MANU training in twelve of the 16 towns in Greenland, but the MANU coordinator considered MANU to be operating as planned in only seven towns (Ingemann et al., 2021). Local contexts conditioned professionals’ ability to implement MANU (Ingemann et al., 2021; Ingemann et al., submitted). In connection to this, health professionals in the first study expressed how support from local managers was lacking (Ingemann et al., 2021). Since local managers did not fully understand the relevance of MANU and the resources implementation requires. The MANU team provided unsystematic support to individual professionals (Ingemann et al., 2021). Health professionals described how they experience the MANU team’s support to be available and accessible, but rarely applicable to their local context. Furthermore, professionals encountered to be admonished for not adhering to implementing MANU fully, therefore they demanded to be recognised for the efforts they put into making MANU work in their local contexts (Ingemann et al., submitted).
This chapter discusses the PhD project’s findings in light of the frameworks and approaches presented in chapter 3 ‘Conceptual framework’. Aspects of the following discussions have also been addressed in the Papers I to IV (Ingemann et al., 2022; Ingemann et al., 2021; Ingemann et al., under review; Ingemann et al., submitted). First the PhD project’s results are examined all together under the first point National programmes’ disconnection from local contexts. Then the applicability of implementation frameworks is discussed in relation to the intervention recipients’ perspective and the Arctic context, followed by the consideration of applying CBPR as an integral part of implementation research. Finally, under methodological and ethical considerations strengths and limitations of the PhD project are discussed.

07.01 National programmes’ disconnection from local contexts

Even though MANU is perceived by professionals and demonstrates to be an improvement to its predecessor’s design and implementation strategy, the centrally designed and national distributed programme is disconnected from the different local contexts. A disconnection that hinders implementation fidelity, which was urged by the developing team. This disconnection is discussed in Paper IV with the principle ‘It Seemed Like A Good Idea At The Time’ introduced by D’Lima et al. (2020).

D’Lima et al. (2020) describe the importance and mechanisms of behaviour change in implementation research. MANU as well as other national initiatives (Ingemann et al., 2019a; Ingemann et al., 2018b) built on the assumption that an initiative will be sustainably implemented by disseminating materials and by sending professionals on trainings to gain new skills with the expectation that this will lead to behaviour change. However, findings from this implementation study show how a centrally defined programme, which intends to be nationally implemented and accessible, needs to be adaptable to the different local contexts in regards to the available resources, needs and culture of the respective community (Ingemann et al., 2022; Ingemann et al., 2021; Ingemann et al., under review; Ingemann et al., submitted).

High turnover of staff in the healthcare system and other sectors is a persistent challenge for management, permanent staff and service users in Greenland and in other remote communities in the Arctic, which challenges the implementation of initiatives (Gautier et al., 2016; Ingemann et al., 2018b; Mead et al., 2013). Furthermore, with
limited resources professionals continuously estimate what tasks to prioritise according to the community’s current needs (Ingemann et al., submitted). In the case of Paper IV, MANU is not a high priority compared to acute tasks like births and initiatives supporting vulnerable families. Prioritising more urgent matters was also a barrier to implementation of an initiative in another Arctic study (Akande et al., 2019). Interviewed professionals found that MANU does not attract the parents they perceive “really need it” (Ingemann et al., submitted). In connection to this, it also stood out that a confusion among some professionals existed regarding whether MANU was replacing the selective programme for vulnerable families *Tidlig Indsats* (English: Early intervention) or what the difference or benefit is of having both a selective and a universal parenting programme. While a targeted programme can provide direct and selected assistance to vulnerable families, it still will not reach out to all families in need for additional assistance (Dahlberg et al., 2023; Pontoppidan et al., 2016). Therefore, a universal programme that targets the whole population can reach both the families with an average socioeconomic position and the families who are in a more vulnerable position or in need for support. A universal programme also prevents potential stigmatisation, which selective initiatives can bring about. But why do health professionals then experience that MANU does not benefit all parents?

**Universality includes equitable access**

The findings from Papers II, III and IV, which describe parents’ perspectives and the professionals’ perceptions of parents, identify aspects hindering MANU from being universal (Ingemann et al., 2022; Ingemann et al., under review). Scholars point out that for a parenting programme to be universal, parents should be able to access the programme at a time and in a format that suits them (Gilmer et al., 2016; Stewart-Brown et al., 2011). Both parents and health professionals report that parents rarely attend all offered MANU sessions, reasons given for this are not having the time to attend since sessions take place during working hours. MANU’s format indicated to meet some of the parents’ needs but was also disapproved by parents and professionals (Ingemann et al., 2022). The parent book was not used by parents and the sessions were by some described as lengthy and inactive. However, group sessions have the potential to provide parents with a space to reflect and a place where they can learn from others. A positive group experience was mentioned to depend on both father and mother attending the sessions, a good group dynamic and an engaging facilitator (Ingemann et al., 2022). Especially men found it difficult to express themselves when in groups, but also when with their partner, family and friends. Even though fathers have expressed to want to share their experiences with others, especially with other fathers, they found it difficult to do so, since in general men
keep rather quiet (Ingemann et al., 2022). Parents seek and understand information in different ways and through different means. In interviews parents reported to access information through family and friends, internet, books recommended by friends, phone applications, the internet and podcasts. It would be relevant for MANU to explore different platforms to reach out to parents and which engages parents in the information and reflections MANU aims to provide them with.

The fact that professionals’ perceive that MANU does not reach all parents (Ingemann et al., submitted), namely not being universally accessible and relevant to parents, indicates that MANU creates equity harm. Equity harms are understood as interventions that “benefit those who are in least need of them” and thereby worsen health inequalities (Lorenc et al., 2014).

While topics addressed in MANU are general and open, it depends on the individual parent and the facilitating professional how much topics are reflected upon and discussed. The topics addressed by interviewed parents regarding aspects in their transition to parenthood and aspects important to them in child-rearing were largely represented in MANU’s materials (Ingemann et al., 2022; Ingemann et al., under review). However, the importance of the child experiencing to be together with family in nature and to be with and learn from extended family are lacking or barely addressed in MANU (Ingemann et al., under review). Arctic scholars have described the important role that the nature plays in Indigenous populations’ well-being (Redvers, 2020; Steenholdt, 2021). Redvers (2020) describes the role of nature, while also pointing out how nature is not accessible to everyone, since going hunting and sailing are expensive. This was also mentioned by some parents, who value being in nature and want their child to experience it, but they do not have the resources to go hunting nor sailing. Besides money, a resource can also be living in the same town as extended family who do have a boat. Finally, MANU is based on Western epistemologies, even though Western and Inuit epistemologies in Greenland coexist and is something parents navigate between or combine on a daily basis (Healey et al., 2014; Ingemann et al., under review). How these epistemologies coexist in Greenland is described as a feature in different studies (Ottendahl et al., 2021; Rink et al., 2021; Schlütter, 2016; Tröndheim, 2010) and it is also widely discussed in relation to Greenland’s colonial history. However, a further insight into this phenomena could be investigated by the application of a phenomenological approach.
Equitable involvement in programme development

How could MANU have been developed to better meet parents’ needs and resources?

MANU was developed on relevant and evidence-based theories, but in the development phase only about ten parents were asked about their needs and interest in a parenting programme. The suggestions made by these parents were included in the programme’s material. But this does not necessarily represent the perspectives of all parents in Greenland, neither does this qualitative study. Parents should not only be asked about what they need, but they should be actively involved in the conceptualisation and development of programmes that aim to promote well-being and thriving families. Since the extended family was mentioned to be of importance in the transition to parenthood and throughout child-rearing, it is also important to consider the involvement of grandparents and the local community in the development of health promoting programmes targeting families (Ingemann et al., 2022; Ingemann et al., under review; Olesen et al., 2020; Rink et al., 2021; Aagaard, 2017).

07.02 The applicability of implementation frameworks

Internationally developed and tested implementation science frameworks and theories were applied and discussed in this project’s papers with the main focus on the Consolidated Framework for Implementation Science (CFIR) by Damschroder et al. (2009). In the final stages of the PhD project, two updates to the CFIR were published: the CFIR Outcomes Addendum (Damschroder et al., 2022a) and the Updated CFIR (Damschroder et al., 2022b). The updates made are here discussed in relation to the limitations of implementation frameworks this project has identified. Furthermore, as this PhD project took place in an Arctic Indigenous context where some research projects continue to retain colonial power structures (e.g. helicopter research) it was important to apply a community-based participatory research (CBPR) approach (Reimer et al., 2020; Wallerstein et al., 2018) that builds on partnerships and ensures ownership of the research within Greenland. It was also the project’s reference group that drew attention to focusing the research on parents’ experiences of MANU next to investigating local professionals’ experiences with implementation.

The CFIR was overall a useful framework in this project, since it is comprehensive in terms of the many different determinants it includes, while also structuring them into different domains and contextual levels (Damschroder et al., 2009). Damschroder et al. (2009) describe the importance of context and define it as “the set of circumstances or unique factors that surround” the implementation effort, but according to
the PhD student’s opinion the complexity and dynamic characteristics of context and complexity of systems, like the healthcare system, were not sufficiently presented. Therefore, the complex adaptive systems perspective presented by Plsek et al. (2001) aided a fundamental understanding of context in this project. Complex systems are unpredictable, non-linear and are interwoven with other systems, where small changes can affect multiple systems and individuals, leading to expected and unexpected changes (Plsek et al., 2001). The Updated CFIR material provides an improved description of the dynamic and multiple levels in the implementation context (Damschroder et al., 2022b).

Implementation determinant ‘Patient’s needs and resources’

As this project besides focusing on the local professionals’ experiences with implementation also investigated parents’ perspectives, the PhD student found that the determinant ‘patient needs and resources’ under the domain ‘outer setting’ was sparse, in comparison to the many other determinants described and elaborated upon, such as the individuals (e.g. the professionals) and the organisational environment. In CFIR and other implementation frameworks the determinant addressing recipients’ characteristics is typically described as the extent to which recipients’ needs are met and known by the organisation regarding the intervention outcome. This perspective on recipients indicates that the professionals’ and organisation’s knowledge about and perceptions of recipients’ characteristics, needs and resources is of interest to the development and implementation of the intervention, but as such the involvement of the recipients directly in the intervention is not.

Parents have not been involved in the development and implementation of MANU. Besides conversations with ten parents about their needs and interest in a parenting programme, MANU was developed and implemented based on the developing team’s and reference group’s perceptions of parents (Ingemann et al., 2021). Findings of the present research indicate that MANU’s format, content and accessibility does not entirely match with the needs, values and resources parents shared in interviews (Ingemann et al., 2022; Ingemann et al., under review). Additionally, interviewed professionals were also asked to describe how they perceive parents’ experience of MANU, where their response also indicated a mismatch between the universal parenting programme and parents’ characteristics and resources (Ingemann et al., submitted).

In the CFIR Outcome Addendum, Damschroder et al. (2022a) clarify that the CFIR is an implementation determinant framework aiming to inform implementation out-
comes and not intervention outcomes. They continue that “data collected from recipients not involved in implementation should be a source of information for innovation determinants and outcomes” (Damschroder et al., 2022b). However, this project finds that parents reported on determinants influencing implementation outcomes. The interviews with parents brought forward how parents’ values and needs are or are not represented in MANU’s materials, while also clarifying if the programme met their expectations and if they made use of the materials and sessions available to them (Ingemann et al., 2022; Ingemann et al., under review). Furthermore, parents’ responses also gave an indication on how or if MANU was implemented in their town or village, such as whether they were offered to attend MANU, if group sessions were held or if they even know about MANU. Parents also reported on professionals’ skills to facilitate MANU sessions and how this influenced their experience.

Identifying where implementation begins and ends

Whether recipients, who are not part of the implementation team, can provide information relevant to implementation outcomes or not involves a discussion on where implementation begins and where it ends. Nielsen et al. (2022) distinguish between the implementation approach of social science and health science. Implementation in health science is typically perceived as a linear process going from the development phase of the intervention to testing and adapting it, and then to the implementation phase (Nielsen et al., 2022). In social science implementation is perceived as an integrated and iterative process (Nielsen et al., 2022). This project took an integrative perspective on the implementation process. However, when the implementation phase ends and the sustainment phase begins is yet unclear in implementation literature (Moore et al., 2017; Aarons et al., 2011). Based on a knowledge syntheses of reviews, Moore et al. (2017) identified five constructs defining sustainability: i) after a defined period of time, ii) the intervention and/or implementation strategies continue to be delivered, iii) individual behaviour change is maintained, iv) the intervention and behaviour change may evolve or adapt while v) continuing to produce benefits for individuals/systems.

Based on the parenting programme MANU’s implementation strategy, which was not described by the developing team but identified based on this project’s findings, the implementation phase of MANU began when MANU materials were disseminated and professionals sent off for attending the three-day introductory training. However, identifying when the implementation phase of MANU ends is difficult due to the fact that the developing team has not defined criteria of implementation success and the high turnover of professionals makes it in general difficult to sustain programmes. When applying the five sustainability constructs (Moore et al., 2017) to MANU’s
current status of implementation, the following can be concluded: i) no official implementation plan describing a time period of the implementation phase exists; ii) MANU continues to be delivered in the largest towns but not in all towns and villages as MANU sets out to be a national programme, and it is mostly delivered in an adapted version despite the developing team urging for implementation fidelity; iii) permanent employees, who have become familiar with MANU, continue to run MANU, but due to the high turnover individual behaviour change is lost and new employees need to be introduced; iv) in towns with permanent employees, who are comfortable with MANU, their workflow and MANU have become compatible; v) the benefits MANU is intended to provide have not been explicitly defined.

**Sustaining interventions when turnover is high**

Considering the high turnover of staff, it is important to not place the responsibility of carrying out MANU on a single professional. Based on this project’s results (Ingemann et al., 2021; Ingemann et al., submitted), it is suggested that by ensuring programmes are compatible with local workflows and resources the programmes will become part of the system and less dependent on the ongoing turnover. This requires partnering with the local organisations (e.g. healthcare centre) already during the development of the intervention in order to think potential barriers to implementation and sustainment through from the start.

In light of Ingemann et al. (submitted) findings on how professionals experienced intervention fatigue, lacked support and skills to implement MANU, and inadequate recognition for the efforts they put in to making it work are all aspects influencing professionals motivation, well-being and retention in their position. As Bodenheimer et al. (2014) point out: “Care of the patient requires care of the provider”. In order to optimise health system performance through enhancing patient experience, improving population health and reducing costs, it is necessary to also aim for improving the work life of healthcare providers (Bodenheimer et al., 2014).

As the earlier mentioned potential equity harm MANU has created, this is followed by the likely opportunity cost harms ensued unintentionally. Opportunity cost harms are “the potential benefits which may be foregone as a result of committing resources to ineffective or less effective interventions” (Lorenc et al., 2014). Costs for developing and implementing MANU were budgeted for in the 2016 Financial Act (Ingemann et al., 2021). Since 2016, public resources have been spent on developing MANU materials, providing professionals with trainings, and centrally coordinating MANU. Much effort has been put in by the MANU team to use these resources as meaningful as possible and with the best intentions. However, the results of this project show
retrospectively that some resources could have been spent differently by focusing more on local implementation and partnering with communities, parents and professionals to develop or adapt MANU to fit each regions or towns specific context in terms of needs, resources, culture and values.

07.03 CBPR as an integral part of implementation research

In the CFIR updates, the authors emphasise the relevance of including intervention recipients in the implementation team (Damschroder et al., 2022a; Damschroder et al., 2022b). This is reflected in the updates made to the CFIR by dividing the determinant patient needs and resources and giving intervention recipients a role, while also moving them from the domain outer to inner setting (Damschroder et al., 2009; Damschroder et al., 2022b). Furthermore, Damschroder et al. (2022b) address the need to ensure equity in implementation by collaborating with “equity experts to combine use of equity, justice, or non-discrimination theories with the CFIR as a lens through which to view all facets of implementation”. This project did not work with equity experts but applied a CBPR approach. It is highly relevant to apply this approach to implementation research since it does not only ensure equity in implementation, but it most likely will strengthen the implementation outcomes and thereby sustainment of the intervention.

Applying a community-based participatory approach in the development of health promoting initiatives, such as a parenting programme, is a meaningful and inclusive approach that could contribute to preventing this study’s identified barriers in implementation and the mismatch of MANU’s universality with parents different needs and resources (Ingemann et al., 2022; Ingemann et al., 2021; Ingemann et al., under review; Ingemann et al., submitted). This would require building partnerships through CBPR with each region and/or town in Greenland, when working with a national programme. Thereby a bottom-up approach instead of top-down approach is taken, which works with defining needs and finding solutions based on local perspectives, experiences and values (Nielsen et al., 2022). This is argued based on the CBPR principles (Wallerstein et al., 2018), which in Table 5 are presented in relation to the implementation determinants identified in this project.

CBPR as an approach or the fact of partnering with community in intervention development and implementation has been argued for or applied in Arctic communities. Partnering with communities creates ownership of the intervention, ensures the intervention is culturally sensitive to the specific community and builds on local resources that support intervention sustainment (Alvarez et al., 2016; Collins et al.,...
Intergenerational and family connectedness are important for a child’s upbringing according to the parents and elders interviewed in this project (Ingemann et al., 2022; Ingemann et al., under review). The role of community in child-rearing is also addressed in MANU community meeting material (Ingemann et al., under review).

Therefore involving community members, e.g. elders, besides parents in the implementation team, when applying a CBPR approach, can ensure the cultural sensitivity of the intervention. However, scholars point out that in the field of parent and family interventions, effective ways to culturally adapt these evidence-based interventions are lacking (Baumann et al., 2015; Kumpfer et al., 2002).

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<tr>
<th>Table 5. Identified barriers in MANU’s implementation set against Wallerstein et al. (2018) ten key principles in CBPR.</th>
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<tr>
<td><strong>The CBPR key principles</strong></td>
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<tr>
<td>1. CBPR recognises community as a unit of identity.</td>
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<tr>
<td>2. CBPR builds on strengths and resources within the community.</td>
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<tr>
<td>3. CBPR facilitates collaborative, equitable partnership in all research phases and involves an empowering and power-sharing process that attends to social inequalities.</td>
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<tr>
<td>4. CBPR promotes co-learning and capacity building among all partners.</td>
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<td>5. CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners.</td>
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<tr>
<td>6. CBPR emphasises public health problems of local relevance and ecological perspectives that attend to the multiple determinants of health and disease.</td>
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<td>7. CBPR involves systems develop-</td>
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ment through a cyclical and iterative process.  

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<td>8. CBPR disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process.</td>
<td>There is a need for a broader selection of information delivery to meet parents’ different ways of learning.</td>
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<tr>
<td>9. CBPR requires a long-term process and commitment to sustainability.</td>
<td>Developers have not planned beyond the training and left local implementation up to the individual professional. Professionals lack constructive feedback and supervision on their efforts to implement MANU. MANU team is visible for support, but the support they can give is not always applicable. Professionals are not receiving due credit for their efforts.</td>
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<tr>
<td>10. CBPR addresses issues of race, ethnicity, racism and social class and embraces ‘cultural humility’.</td>
<td>MANU is based on a Western epistemology, while both a Western and an Inuit epistemology coexist in Greenland. There are mixed opinions about the intellectual level of information and exercises in MANU. There is a need for a broader selection of information delivery to meet parents’ different ways of learning.</td>
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07.04 Methodological and ethical considerations

In this section the strengths and limitations of the project’s CBPR approach and the applied qualitative methods are discussed.

**Strengths of working with the project’s reference group**

Applying a CBPR approach has strengthened this PhD project’s research approach in various ways. The key CBPR element being the reference group. The reference group members have with their input, discussion and reflections highly contributed to making the research focus relevant for practice and to the Greenlandic context; securing an appropriate approach to data collection; validating results to be appropriate to the Greenlandic context; ensuring that the concluding recommendations hold the needed information and that they are applicable.

Throughout the collaboration with the reference group the PhD student has had many reflections both prior to reference group meetings on how to present information and how to engage the group in the project. Each meeting provided valuable insights and engagement by members in the project. Members’ knowledge on the project’s research field, their understanding of acknowledging local context and values increased with every meeting, despite their different backgrounds and prior research knowledge. Still it was of importance that the PhD student reminded the reference group about their role and importance in the project at every meeting, since engaging stakeholders in research in this way is still uncommon in Greenland. This is also an aspect Reimer et al. (2020) experienced in their community-engaged
research. This addresses the second, third and fourth CBPR principle: building on strengths and resources within the community; facilitating collaborative, equitable partnership in all research phases and involving an empowering and power-sharing process that attends to social inequalities; promoting co-learning and capacity building among all partners (Wallerstein et al., 2018).

At the reference group’s final meeting, the benefits of having been a member of this project’s reference group were talked over. The members described to appreciate very much: the possibility to gain insight and learn about new findings within the project on an ongoing basis; getting input for improvements and new ways to approach issues; and having influence on what is being researched.

**Challenges with establishing local reference groups**

As defined in the ‘study design and methods’ chapter, this project sees the Greenlandic community at large as a unity of identity, but the project also recognises the different health regions and towns as units of identity, namely as individual communities. To begin with the project’s reference group was very centrally based with no municipality participation. Therefore, the project initially aimed to also involve stakeholders on each study site by establishing local reference groups in the communities. Here, the local prevention committees were identified as a potential forum to initiate local relation building. Local prevention committees consist of local representatives from the different institutions in town (Ingemann et al., 2018b). For example, this includes representatives from the local healthcare centre, the family centre, the police, and the school. How well functioning a local prevention committee (LPC) is varies (Ingemann et al., 2018b). On two study sites the PhD student was invited to attend the local LPC meeting. At the meeting the reason for meeting with the LPC, the topic of the project and how it is planned to be conducted in their town was presented. Thereafter, the LPC was invited to provide feedback, to explain how they collaborate across sectors and to describe the LPC’s potential involvement in MANU. On one study site it was not possible to meet with the LPC, but with the secretary of the LPC. This secretary had in her previous position worked with MANU and shared her insights.

It is a strength of this project that the local LPC on each study site were informed about the project’s focus. This way representatives of each sector represented in the LPC were aware of the ongoing research in their community. Furthermore, LPC members gave valuable input on how to approach parents and insights on cross-sectoral collaboration in their community. However, due to the short stays on the study sites, it was difficult to build trust, capacity and relations with the LPCs. Being
accessible and physically present in the community matters to the relationship and amount of trust a researcher is able to build (Rink, 2016).

**Ethical considerations**

It is ethically challenging that a CBPR approach typically assumes that community members have the capacity and skills to engage in research activities (Wilson et al., 2018). In Greenland, where community-engaged research is only at its beginning, it is important to find ways to build capacity and facilitate equitable partnerships by acknowledging the knowledge partners hold as equal to the researchers competences, and to initiate a sharing of skills and knowledge (Reimer et al., 2020; Wilson et al., 2018).

The PhD student was not directly involved in MANUs development or implementation. However, through the ongoing conversations with the MANU coordinator and the involvement of the reference group, the implementation process might indirectly have been influenced, since the MANU team and other stakeholders gained knowledge and became aware about implementation processes.

**Strengths and limitations of the applied qualitative methods**

The following section briefly summarises the strengths and limitations discussed in the Papers I – IV (Ingemann et al., 2022; Ingemann et al., 2021; Ingemann et al., under review; Ingemann et al., submitted).

This research project is comprehensive and has a strong validity considering the different methods applied and combined, sources of information included and data collected over time (2017-2018 and 2020). There is a broad representation of participants from the three included health regions. Professionals and parents from both the regional capitals and smaller towns participated. This supports internal generalisability (Maxwell, 2020). Considering Greenland's small population size, which challenges depersonalising information, differences in perceptions and experiences based on location were mostly not reported. Even though the number of participants is relatively large considering this is a qualitative research project, when differentiating between regions or even towns then the number of participants is small. However, perspectives were equally described despite perspectives being represented by only one participant or by many. Following the definition of internal generalisability by Maxwell (2020), this equal representation of perspectives further strengthens the findings internal generalisability.
Collaborating with Else Jensen (the Greenlandic interviewer) has been crucial for the recruitment of parents and ensuring participating parents a comfortable in the interview setting. This way parents could speak in their preferred language without interruptions (e.g. in contrast to using an interpreter). Furthermore, collaborating with Jensen and Ingelise Olesen (Indigenous researcher) on the analysis of parent and elder interviews prevented an ethnocentric perspective on findings. Present findings are to a greater extent described from Jensen’s and Olesen’s Greenlandic epistemology (Healey et al., 2014).

Data collection of the Papers II to IV was conducted during the first year of the COVID-19 pandemic. The implemented restrictions preventing infection spread, lead to the cancelation of MANU sessions. This has possibly influenced participants’ perspectives of MANU. Furthermore, participants were in interviews asked about past events, for example, parents who have given birth reported on their experience during pregnancy and attending MANU, and professionals who have attended in MANU trainings some years ago were asked about their experience from back then. Reporting on events and perspectives from the past are likely influenced by the present, thereby participants’ responses could likely have been biased by recent events. Finally, both the PhD student and Jensen are female, which potentially influenced the rather small number of male participants interviewed compared to the number of female participants in the project.

**Ethical considerations**

Each participant was provided with an informed consent form in either Greenlandic or Danish, and the content was explained. The PhD students position as a researcher and the role of the reference group members in the project were clarified. This was especially important in interviews with professionals in order to ensure them that no raw data were shared with the MANU team or other stakeholders in management positions, since this could influence their responses regarding how critical and honest, they dare to be (Brinkmann et al., 2015).

In regard to interviews with parents the interviewers were aware of that some interview topics could be sensitive, since they are connected to a person’s identity, opinion and own life experiences. Additionally, parenthood and child-rearing are topics widely discussed in society about which the public has many opinions on what is right and wrong (Brinkmann et al., 2015). The interviewers experienced how a few participants became emotional during the interview but expressed gratitude at the end of the interview for being able to share their experiences and thoughts.
Prior to interviewing professionals, the PhD student had a few ethical concerns. First, that professionals will be spending time on this project instead of providing healthcare services. Therefore, it was made clear to professionals that the study will conform to their schedule to prevent disruptions to their daily work. Secondly, it was important that Ingemann positioned herself as a researcher from the University and not in connection to the governmental institutions that manage MANU (Kvale, 2016). Moreover, Ingemann stayed transparent about members in the reference group being from governmental institutions involved in MANU, but that the members will not have access to any raw and person-identifiable data.
This PhD project aimed to study local implementation of the parenting programme MANU 0-1 Year and to investigate parents’ experiences with MANU regarding their expectations, needs, culture and values. A community-based participatory research (CBPR) approach was applied and data were collected through qualitative methods in three of Greenland’s five health regions. Three studies were conducted resulting in four Papers that are included in this dissertation.

Paper I identified determinants in MANU’s first years of implementation. In the study the conceptualisation and development of the programme was investigated retrospectively through a desk review and interviews with key stakeholders. Furthermore, through observations of trainings and MANU sessions along with few exploratory interviews with professionals, implementation determinants were identified while implementation was underway.

In the second study parents were interviewed regarding their perspective on parenthood and child-rearing as well as their experiences with MANU. This resulted in two papers. Paper II investigated how parents’ notions and experiences of parenthood are reflected and challenged in MANU. Paper III explored the meaningful relations parents see in their child’s upbringing and how these relationships are shaped. Furthermore, the third paper discusses how these perspectives compare with MANU’s material and content.

Paper IV investigated through interviews with professionals how professionals experience implementing MANU into their local context. Additionally, with a focus on how the national standards and vision for implementation fidelity set by the MANU team, were managed and handled in practice at the local level.

Findings of this project point to a disconnection of national programmes from local contexts as well as a mismatch of MANU’s format, content and accessibility with parents’ needs and resources. These findings are comparable with evaluations of other public health interventions in Greenland and internationally. The mismatch was identified through experiences described by interviewed parents and descriptions provided by professionals on their perceptions of parents’ experiences. Findings suggest that MANU has brought about unintended adverse effects. This is not uncommon for public health interventions internationally, but it is rarely investigated and reported in research literature.
The project applied the Consolidated Framework for Implementation Science (CFIR) by Damschroder et al. (2009). Based on the use of the CFIR and an examination of implementation frameworks, this dissertation argues that applicability of implementation frameworks in Greenland or the Arctic in general requires that intervention recipients should be involved and included from the beginning of the intervention. Preferably, the community, which in the case of MANU would mean the inclusion of professionals across sectors, parents, families and elders. To achieve this, a CBPR approach is appropriate for ensuring equity in implementation through partnerships, building of trust, capacity building and cultural sensitivity.

It is concluded that by putting families and local professionals at the heart of implementation research, interventions will more likely be culturally sensitive and increasingly relevant to local contexts. Furthermore, potential barriers in implementation and adverse effects of an intervention could be addressed early on and likely prevented.
In this final chapter implications for research and public health practice are presented based on the PhD projects findings.

09.01 Implications for research

The findings in this dissertation indicate that barriers to implementation of the national parenting programme MANU could have been prevented if parents and local professionals, who are responsible for implementing and sustaining MANU, were involved in the development and implementation of the programme. This result is key to understanding how the development of public health interventions can be adjusted moving forward. It is suggested that by involving local community in these processes through, for example, applying a CBPR approach, barriers to implementation are likely to be prevented and interventions are expected to be increasingly culturally sensitive and contextually applicable.

Advancing implementation research

This dissertation points at two knowledge gaps in implementation research. The first concerning intervention recipients' involvement in implementation and, secondly, the need for reviewing Arctic implementation studies.

A review on intervention recipients' role and position in implementation frameworks could potentially support this project’s suggestions of intervention recipients being overlooked or not prioritised in this field. This also aligns with Nilsen et al. (2019) finding that implementation science does not emphasise research on the intervention recipients' influence on implementation. Additionally, Damschroder et al. (2022a) also address the need for ensuring equity in implementation through, for example, involving intervention recipients in the implementation process.

Another review should focus on implementation research in the Circumpolar regions. The PhD student has conducted a preliminary review on this topic, presented in chapter 03.01. A prospective study should systematically review intervention and implementation studies conducted within the Circumpolar regions to compare approaches and implementation determinants identified. By gathering this knowledge, recommendations for future research and for intervention and implementation prac-
tives specific to the indigenous communities and contextual characteristics in the Circumpolar regions can be brought forward.

**Advancing Circumpolar maternal and child health research**

This research project is placed within the field of maternal and child health, due to the fact that it investigates the implementation of a parenting programme facilitated by midwives and public health nurses. The findings indicate a mismatch between parents’ resources, needs and expectations with MANU’s format, content and accessibility. Furthermore, the parenting programme has an influence on professionals’ daily work and interactions with parents. Therefore, it is suggested that future research should advance maternal and child health research in the Circumpolar regions, where the regions infrastructures and health systems’ challenges often are comparable. By advancing knowledge sharing across the regions, lessons learned in health system services and public health practices can be shared and inform each other. Future research and increased collaboration on research and education across the Arctic must contribute to closing this knowledge gap to strengthen the field of maternal and child health research which has been identified as a key area for community health and well-being in the Arctic (United States Arctic Research Commission, 2023).

The PhD student has together with Circumpolar research colleagues established the Circumpolar Maternal and Child Health (CMCH) working group. The group aims to promote research that informs the sustainability and revitalization of values based and culture informed maternal and child health and wellness programmes in Circumpolar regions. The research collaboration involves care providers, Indigenous knowledge holders and researchers. In connection with the CMCH, an anticipated research project will review and compare parenting programmes across the Circumpolar regions. Specifically, a comparison study of the Greenlandic parenting programme MANU and the Inunnguiniq parenting programme from the Qaujigiartiit Health Research Centre in Nunavut (Canada) (Qaujigiartiit Health Research Centre, 2014) is planned. While more comparative studies like this are needed.

Furthermore, the PhD project’s findings show that MANU does not reach all parents, thereby suggesting that it is not truly universal. Gilmer et al. (2016) and Stewart-Brown et al. (2011) point out that for a programme to be universal it has to be accessible in a format and at a time that fits the parents. Prospective research should investigate aspects of successful universal programmes in regard to what universality requires and how it is achieved.
Monitoring the effectiveness of interventions in Greenland

Future quantitative research in Greenland should look into ways of measuring the effect of national public health interventions. For example, attendance in MANU and other programmes within the healthcare system is as a rule registered in patients’ electronic patient journals. However, as professionals described in the present project, attendance is not registered in the same way or systematically across individual professionals and regions. A future study should assess registration practices across sectors and investigate practices for quality assurance of data registered in existing registries. Based on such a study and provided the study’s results are implemented, registry studies reporting on pre-identified indicators can report the effectiveness of interventions.

09.02 Implications for practice

The PhD project’s reference group discussed lessons-learned and potential recommendations in meetings throughout the project. At the final meeting the reference group members shared how they already are thinking about making adjustment to MANU and other intervention activities based on the presented findings. This section presents input from the reference group together with the PhD student’s own considerations on recommendations for MANU, which also are applicable to other health promoting interventions.

Recommendations targeted community levels

The project finds that even though the MANU team urged implementation fidelity, professionals needed to adapt MANU’s format in order to make it fit their local context. It would be relevant for practice to investigate and compare how professionals adapted MANU to their local context. This knowledge could inform potential revisions of MANU to make it more relevant from the perspective of professionals. Furthermore, this could also inform which elements or topics within MANU are perceived as essential by professionals. Since identifying an interventions essential elements is substantial when the aim is to promote and later measure implementation fidelity (Carroll, 2020).

Based on this dissertation’s discussion, it is necessary to involve parents, families and community members in the revision of MANU’s content, format and scope in order to ensure MANU is truly universal and accessible to all expecting and new parents in Greenland. This could be done by working in partnerships with regions as well as towns and villages in order to identify strengths, needs, values and resources.
within each community. Applying the CBPR principles in these partnerships will ensure an equitable approach and potentially increase ownership to the programme.

In connection to MANU’s aim to be universal and a programme targeted equally the mother and the father, this project finds that fathers rarely attend MANU sessions. This is partly due to fathers being unfamiliar with reflecting on thoughts and feelings, sharing these reflections in a group setting and having to work when MANU sessions typically take place. The reference group addressed how this is not an issue MANU can address by itself, but that on a political level fathers need to receive equal parental leave as mothers in order to be able to take an equal position in care for their child. This includes being able to attend preparational programmes with the support from their employer. Moreover, as already considered by the MANU team and professionals, MANU group sessions could be offered outside workhours to increase accessibility. However, this would potentially require a community effort since childcare must be provided in order for parents to attend and for many professionals it can be difficult to readjust their working hours to fit such a format. Improving MANU’s universality will potentially resolve the unintended adverse effect of equity harm, which this dissertation claims MANU has unintentionally brought about.

**Recommendations targeted structural levels**

On a systems level different approaches to the development and implementation of should have been taken beforehand. The organisational structures and capacity need to be thoroughly considered during the development phase of an intervention, which requires understanding of implementation processes. In the case of MANU it would have been favourable if the existing interventions that MANU is to co-exist with or was intended to replace would have been mapped out to begin with. This would have prevented challenges to implementation identified in this project.

As this research has shown, Greenland’s unique contexts require that interventions are adaptable and build on local culture and capacity. Furthermore, to sustain MANU despite the high turnover, the reference group pointed out the importance of providing E-learning to especially new employees. It is also suggested that the distribution of resources and needs for resources should be thoroughly assessed and openly discussed throughout implementation. This suggestion for intervention practice was given by the reference group based on the PhD projects findings, which point that professionals lack resources to implement MANU locally.

Finally, this dissertation claims that the implementation of MANU likely has brought about unintended opportunity cost harm (Lorenc et al., 2014). Opportunity cost harms are “the potential benefits which may be foregone as a result of committing
resources to ineffective or less effective interventions” (Lorenc et al., 2014). The PhD student argues that if the presented recommendations for practice as well as implications for research are met, the improvements made to MANU as well as future health promoting interventions will lead to effective, relevant and culturally sensitive interventions for communities with resources well spent.
10 References


education” at the ICCH17. *International Journal of circumpolar health*, 78(1), 1604062.


11 Papers I to IV
An in-depth implementation study of the Greenlandic parenting program MANU's initial stages of implementation

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An in-depth implementation study of the Greenlandic parenting program MANU’s initial stages of implementation

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ABSTRACT

In Greenland, the universal parenting programme MANU was developed in 2016. After documenting the initial years of MANU’s implementation, this study aimed to identify implementation determinants focusing on i) which context MANU was conceptualised in and how it was developed and ii) how MANU was implemented and initially received in the healthcare system. A qualitative in-depth implementation study was conducted: document analysis, 38 interviews, one focus group discussion, and observations at two trainings for professionals and four parent sessions. Participants included stakeholders from both the health and social sector and from management to practitioner level. MANU was conceptualised based on a political desire to ensure children’s well-being by providing parents with the essential parenting skills, and a desire to create a programme for the Greenlandic context. Professionals welcomed the MANU materials, but anticipated or experienced barriers in implementing MANU. The first years of MANU focused on disseminating material and training professionals. Despite political support and financial security enabling implementation, an assessment of the implementation capacity from the very beginning could have prevented some of the implementation challenges identified. Insights on parents’ perspectives and local implementation are lacking and need to be brought to the forefront of the implementation process.

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Introduction

The first thousand days of a child’s life, from when it is conceived and until its second birthday, are critical for shaping the foundation for health and development [1]. Focusing on maternal and early childhood health contributes to creating human capital and growing economies [1,2]. While the United Nations’ thousand days movement primarily focuses on nutrition [1], existing parenting programmes from pregnancy to five years of age focus more broadly on the transition to parenthood and positive parenting [3,4]. Britto et al. [4] describe that parenting interventions aim at improving parenting interactions, knowledge and practices. The delivery strategies of programmes can be indicated, that is, identified by screening, selective meaning available to sub-populations at risk, or universal meaning available to all [2]. In the meta-analyses by Kaminski, et al. [5] and Piquero, et al. [6] the effect of parenting programmes was found to be promoting children’s social development. However, the realist review by Gilmer, et al. [3] investigating universal parenting programmes found no strong evidence to suggest that a one-size-fits-all approach is effective.

Parenting programmes in Greenland

Greenland is the largest island and least densely populated country in the world with a total population of 56,081 and a fertility rate of 2.1 in 2019 [7]. The vast majority of the population, close to 90%, are ethnic Greenlanders (Inuit). With no connecting roads Greenland’s 16 big communities and approximately 60 small communities, which are situated along the coastal strip, are isolated from each other and only connected by air or in some cases by sea. Countrywide, there are marked socioeconomic and

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List of abbreviations
CFIR = Consolidated Framework for Implementation Research; FGD = Focus Group Discussion; KTB = Klar til Barn (Prepared for Baby); MANU = Meeraq Angajjoqaat Nuannaasmeq (child’s and parent’s good life

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infrastructural differences between larger and smaller communities [8]. Greenland is a former Danish colony, which gained Home Rule in 1979 and Self Rule in 2009, but still is part of the Kingdom of Denmark. It has roughly adopted the Danish welfare-state model and healthcare system. The healthcare system has been fully administered by the Greenlandic government since 1992. The national language is Kalaallisut (Greenlandic), and both Danish and Greenlandic are taught in schools. In bigger communities and the healthcare system, Danish is usually the primary working language.

Greenlandic midwives were the backbone of the Greenlandic healthcare system when it was first established in the 19th century. In the mid-20th century, public health nurses (Danish: sundhedsplejersker) took over postnatal care. In the 1990s, the first prevention initiative in pre- and postnatal care for vulnerable families in Nuuk was initiated, following other private and public initiatives in 2007. These programmes had indicated or selective delivery strategies and were offered to vulnerable families with a caregiver having an addiction or abusive behaviour, or to teenage pregnancies.

In 2009, the first universal parenting programme “Klar til Barn”, meaning “Ready for Baby” and from here on out referred to as KTB, was adopted from Denmark [9]. The need for a universal programme was determined by a steering committee developing recommendations for children and family policies, based on a survey study describing children’s and families’ well-being in Greenland [10]. The steering committee consisted of the three ministries, the Ministry of Social Affairs, Ministry of Education and Ministry of Health, and representatives from relevant institutions (e.g. healthcare system) and organisations (e.g. civil society organisations) [11].

**Box 1. MANU’s materials and content.**

Following KTB’s evaluation in 2012, the Greenlandic parenting programme MANU was developed [15]. MANU stands for Meeraq Angajoqqaat Nuannaarneq meaning “child’s and parent’s good life”. MANU focuses, as other international parenting programmes, on the transition to parenthood and positive parenting in the child’s first thousand days. MANU’s content builds on evidence from the first thousand days movement and theories from psychology. The programme is divided into two parts, namely 0–1 years, covering the period from conception to nine months of age, and 1–2 years. It is offered to both the child’s mother and father. Parents and professionals receive various guiding materials, see box 1. In (group) sessions, which are facilitated by midwives or public health nurses, parents are encouraged to reflect on their own childhood and together find their own healthy parenting style. Once implemented, MANU is expected to secure a healthy foundation for children’s development and contribute to the prevention of adverse childhood experiences [15,16].

**Study objective**

Several studies describe how interventions often fail to achieve the expected effect due to challenges associated with the implementation process [17–20]. Quantitative methods are predominantly used in intervention research and most often applied with the focus to determine the success of an intervention by its ultimate outcomes. Furthermore, in the past decade increasing attention has been given to intervention’s implementation capacity and process. The implementation process is largely decisive for whether or not an intervention creates the intended change [18,21,22]. In the 2017 Lancet Series on Advancing Early Childhood Development, the reviews found existing gaps between policies and integrated implementation capacity, and how implementation of parenting programmes often are fragmented and lack coordination [2,4,23]. Richter, et al. [23] conclude that “often, even when high-level horizontal coordination is achieved, implementation and integration frequently fall short at the local level. Therefore, vertical coordination to local levels is also needed to ensure effective implementation”.

The objective of the study was to identify determinants that influence the implementation of the parenting programme MANU in Greenland from a national perspective, while its implementation was still underway and at its beginning. The study took a whole-system approach focusing on the following research questions: i) which context MANU was conceptualised and developed in, and ii) how MANU was implemented and initially received in the healthcare system. In this study, only MANU 0–1 years was studied. The project
was initiated and developed in close collaboration with central stakeholders from central management and practitioner level, who also participated in the study.

**Theoretical framework**

This study takes a national perspective on the parenting programme MANU. In order to study the whole system [24], we considered it useful to combine three theoretical approaches, which guided data collection and analysis: the Complex adaptive systems perspective by Plsek and Greenhalgh [25], Nilsen and Bernhardsson [26] review on the contextual determinants in implementation science, and the two non-contextual categories (intervention characteristics and characteristics of individuals) from the Consolidated Framework of Implementation Research (CFIR) by Damschroder, et al. [17]. In the following the theories and how they complement each other are presented; additionally, the combined theoretical framework is visualised in Figure 1.

Complex adaptive systems are unpredictable [25]. Plsek and Greenhalgh [25] describe characteristics of complex adaptive systems, which here are translated into the context of the Greenlandic healthcare system, in which the parenting programme MANU is implemented. The Greenlandic healthcare system is embedded and co-evolves within other systems, and so do the individuals within the system. This leads to unexpected actions when change appears. The continuously emerging change from the interactions among health professionals and systems makes the implementation process in a complex adaptive system unpredictable, requiring to abandon linear models and to respond flexibly to emerging opportunities [25]. The complex system perspective provides the underlying understanding of the healthcare system’s unpredictability, which is depicted through the dotted lines and overlap of circles in the visualisation of the theoretical framework, see Figure 1. The non-linearity of the healthcare system is captured by the contextual levels reviewed and described by Nilsen and Bernhardsson [26].

In a scoping review, Nilsen and Bernhardsson [26] grouped contextual determinants influencing implementation of 17 frameworks into 12 contextual dimensions of determinants. Half of these dimensions were divided into micro, meso and macro level, while the other half were considered to affect multiple levels. In this study, the wider environment at macrolevel is the Greenlandic community at large, where exogenous influences (e.g. policies) can determine implementation at meso level, meaning in the healthcare system. In the healthcare system, there are four organisational dimensions of determinants, namely organisational culture and climate, organisational readiness to change, organisational support, and organisational structures. At microlevel are the intervention recipients, who in this study are the expecting parents. On all levels, the determinants regarding leadership, feedback, financial resources, time availability, social relations and support, and physical environment can influence the implementation of MANU.

![Figure 1. Theoretical framework based of Plsek and Greenhalgh [25], Nilsen and Bernhardsson [26], Damschroder et al. [17].](image-url)
The Consolidated Framework for Implementation Research (CFIR) by Damschroder, et al. [17] provides an overview of determinants influencing implementation outcomes, where the three contextual categories process, inner setting and outer setting are already included in Nilsen and Bernhardsson [26] contextual dimensions. For this study’s objective to fully understand MANU as an intervention in its context and how health professionals initially received MANU, we included the two non-contextual categories from the CFIR, namely intervention characteristics and characteristics of individuals. MANU being the intervention in focus and primarily implemented within the healthcare system is presented within the meso level in Figure 1. Determinants in the category intervention characteristics includes perceptions of the intervention’s evidence strength and design quality, its relative advantage, adaptability and complexity [17]. The individuals in this study are the healthcare professionals implementing MANU, their characteristics influencing implementation include self-efficacy, and knowledge and beliefs about the intervention [17].

**Study design**

An in-depth implementation study with qualitative methods was conducted. The use of qualitative methods in implementation research is limited, though increasing [27,28]. By applying and combining qualitative methods in form of document analysis, interviews, focus group discussion, and observations [29–31], this study provides insight into how the determinants presented in this study’s combined theoretical framework influence the implementation of MANU in the healthcare system. The different methods applied are described below. Table 1 provides an overview and timeline of data collection and methods. Stakeholders from both the health and social sector, from management to practitioner positions, and with both Greenlandic and/or Danish background were purposively selected because of their professional positions. They participated in the study in one or multiple ways, for example being interviewed, participating in the focus group discussion, and making relevant documents accessible. The specific positions of stakeholders will not be mentioned in the separate sections, since identification of individuals is fairly easy in Greenland’s small population. Data collection was an iterative process and was collected over almost two years from 2017 to 2018. All data collection was conducted in Danish, if not stated otherwise below. The Greenlandic Scientific Ethical Committee (Danish: Det Videnskabsetiske Komitee) approved the project.

**Document analysis**

Documents were collected throughout data collection, and the majority of the documents were made available by the MANU programme coordinator. About 30 documents were collected and consist of: i) internal or public government documents, such as evaluations and §37 questions,1 from before the initiation of MANU; ii) protocols, working documents and email correspondences from when MANU was developed; and iii) the MANU parent book and provider manual. A qualitative content analysis of the documents was used with a focus on extracting information regarding the contextual factors conceptualising the parenting programme MANU, for example, when and in reaction to which political decisions a related §37 question was posed.

**Open-ended interviews**

About 30 formal conversations in form of meetings and open-ended interviews with 14 different stakeholders were held. The 14 stakeholders were the MANU-coordinator, Danish consulting firm involved in the development of MANU, central management from ministries and national boards of the health and social sector, experienced midwives and public health nurses, and stakeholders with experience of implementing similar health promotional interventions in Greenland. These stakeholders were recruited based on their different professional positions and contextual positions within the healthcare system (meso level) or community at large (macro level). The latter, for example, being

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1A §37 question can be posed by politicians in the Greenlandic Parliament (Inatsisartut) to the Government of Greenland, who is obliged to respond.

### Table 1. Overview and timeline of the study’s data collection and methods.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Time of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document analysis</td>
<td>February 2017 – December 2018</td>
</tr>
<tr>
<td>About 30 documents</td>
<td></td>
</tr>
<tr>
<td>14 stakeholders</td>
<td></td>
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<tr>
<td>Open interviews</td>
<td>October 2018</td>
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<tr>
<td>14 stakeholders</td>
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<tr>
<td>Focus group discussion</td>
<td>November 2018</td>
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<tr>
<td>with stakeholders</td>
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<tr>
<td>Observations at MANU</td>
<td></td>
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<tr>
<td>trainings</td>
<td></td>
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<tr>
<td>1 training in Ilulissat</td>
<td></td>
</tr>
<tr>
<td>with 41 professionals</td>
<td></td>
</tr>
<tr>
<td>1 training in Nuuk</td>
<td></td>
</tr>
<tr>
<td>with 29 professionals</td>
<td></td>
</tr>
<tr>
<td>Semi-structured interviews</td>
<td>November 2018</td>
</tr>
<tr>
<td>8 health professionals</td>
<td></td>
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<tr>
<td>Observations of MANU sessions</td>
<td>December 2018</td>
</tr>
<tr>
<td>4 sessions</td>
<td></td>
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</tbody>
</table>
a stakeholder outside the healthcare system who is not directly involved in the implementation of MANU; however, they coordinate or are developing programmes that coexist with MANU. Most meetings were held individually and only few in groups of two or up to five persons, and the majority were held face-to-face and few over telephone. These conversations and interviews were open-ended with only this study’s objective being the general agenda. Stakeholders were able to direct the conversation into topics related to MANU that they found of most interest. Notes were taken during and after the meetings.

**Focus group discussion**

In October 2018, a focus group discussion (FGD) lasting two hours was held, where six of nine invited stakeholders attended. The three stakeholders, who were unable to participate in the FGD, were later individually interviewed on the topics discussed. The group of stakeholders was heterogeneous in terms of employment in the health or social sector and holding a management and/or practitioner position. In the FGD, participants were first informed about the study’s aim and design, then two discussions were facilitated. First, participants were asked to share their perception of MANU’s concept and aim. Their reflections were then summarised by the facilitator and elaborated with a short presentation of the programme’s intention as stated in MANU. In the second discussion, participants were asked to note on individual post-its barriers and facilitators they experience or expect to see in the implementation of MANU. Afterwards, participants shared their notes with the group and collaboratively grouped the identified factors in the middle of the table for everyone to see. The discussions were facilitated and documented by two researchers. The notes taken during the FGD were later combined.

**Observations of MANU trainings and sessions**

Two MANU training programmes of professionals in Ilulissat and Nuuk, respectively, were observed. At the training in Ilulissat, 41 professionals from the health and social sector participated. Half of the attending professionals were from Avannaq region, while the remaining were from bigger and smaller communities from the regions Qeqertalik, Qeqqata and Sermersooq (Table 5 in results provides an overview of the regions). In Nuuk, 29 professionals participated from mainly Nuuk and communities within the region (Sermersooq). The trainings were organised and facilitated by the MANU team and the Danish consulting firm Center for Forældreskab (Centre for Parenthood), who was brought in to assist with the development of MANU. Each training lasted three days. The facilitators spoke Danish, while a professional interpreter translated between Greenlandic and Danish simultaneously.

The focus of the observations was on implementation determinants by noting how MANU was presented and communicated to professionals, and how facilitators and professionals interacted, for example, were professionals engaging in the training exercises, or what type of questions did they pose to the facilitators during the training. The primary researcher presented herself and the aim of the study to the participants at the beginning of the training. Notes of the observations were taken during trainings and transcribed by the end of the day.

Four MANU sessions for parents were observed in Nuuk in December 2018. The sessions lasted between one to two hours. Two Danish-speaking sessions facilitated by a midwife, and one Danish-speaking and one Greenlandic-speaking session facilitated by public health nurses were observed. These sessions were selected by convenience. Observations in the MANU sessions were focused on experiencing how a session operated in practice, and how parents interact with the facilitator and with each other. The primary researcher and the purpose of the study was first introduced by the facilitator, then parents were asked if they accepted the researcher being present. In all sessions, parents consented.

**Semi-structured interviews with health professionals**

During the MANU training in Ilulissat eight attending health professionals were individually interviewed. The health professionals were midwives, public health nurses or health assistants from six different communities. They were recruited out of convenience based on being health professionals attending this training [32]. The interviews were semi-structured and lasted between 10 and 20 minutes. The health professionals were asked: i) why did you choose to attend the training, ii) what were your expectations for the training, iii) how do you perceive the training and the parenting programme MANU, iv) what are your expectations for when you return to your work place, how will you approach this new task. Notes were taken during the interviews and transcribed afterwards.

**Data analysis**

A thematic analysis of the transcriptions and fieldnotes was performed in an iterative process, where primarily
the first author (CI) performed analysis in close collaboration with the last author (CVLL). Based on the study’s objective, a deductive analysis approach using the presented combined theoretical framework was applied. Data was first imported and initially coded in the qualitative data analysis software NVivo12 using the determinants of the theoretical framework as coding categories. Then the determinants of the framework were set up in a table in Microsoft Word, and the coded data in NVivo12 was summarised and transferred into this table to get a concise overview of the study’s findings. The process was iterative in the way that when reporting data the transcripts, coded data in NVivo12 and the summarised table were used. For the final step of the analysis the same focus group participants as in the data collection attended another meeting in January 2021, where the analysed results were presented. After the presentation the focus group participants were invited to discuss lessons-learned based on the results. During this focus group discussion, the primary researcher (CI) summarised their conclusions and also utilised this forum to validate the reporting of the results. The lessons-learned pointed out by the focus group participants are included in the discussion of this article. The quotes presented in this paper are based on the notes taken during interviews and were translated from Danish to English.

**Results**

This study aims to identify determinants influencing the implementation of the MANU parenting programme in Greenland from a national perspective. Firstly, which context was MANU conceptualised in and how was it developed? Secondly, how was MANU implemented and initially received in the healthcare system? The study’s findings are presented following the study’s conceptual framework, and largely also follow the research questions, for instance, the first three sections contain results mainly answering the first research question. After each section a table provides an overview of the presented findings.

**MANU’s evolution in the Greenlandic community at large and the healthcare system**

Reviewing the contextual determinants at macro (the Greenlandic community at large) and meso (healthcare system) level prior to MANU’s development provides insight into how it evolved. This information was gathered through the open interviews held with stakeholders and document analysis validating and expanding the information from interviews.

In 2009, the Greenlandic KTB programme, predecessor to the parenting programme MANU, was implemented. In 2012, KTB was evaluated. The evaluation pointed at poor organisational support to midwives, who were to provide KTB, leading to lack of knowledge about and belief in the intervention. Another barrier in KTB’s implementation then was the inadequate adaptability of the intervention to the local context. Besides KTB’s internal evaluation report stating these challenges, it was also mentioned in stakeholder interviews. Following this evaluation, KTB’s implementation was not further supported by the involved ministries, Ministry of Health and Ministry of Social Affairs. This was described in §37 questions and in interviews with the MANU coordinator. However, the Board of Health and Prevention (Danish: Styrelsen for Sundhed og Forebyggelse), which nationally manages the healthcare system, initiated in 2014 a working group to revise KTB but without available funds at the time. After unsuccessful applications for funding, a §37 question from a politician in parliament (Greenlandic: Inatsisartut) brought the absence of a parenting programme to the political agenda, leading to the 2016 Finance Act allocating funds to revising KTB, later MANU. By the wider environment’s commitment at macro level and the national management’s support at healthcare system (meso) level, the development of MANU had facilitating preconditions. An overview of the presented findings is provided in table 2.

<table>
<thead>
<tr>
<th>Contextual levels</th>
<th>Determinants</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Greenlandic community (macro level)</td>
<td>Wider environment</td>
<td>Predecessor KTB’s evaluation pointed at barriers in implementation related to organisational support and lack of KTB’s adaptability. Upon evaluation the Ministry of Health and Ministry of Social Affairs withdrew their involvement. Following a §37 question from parliament in 2015, the revision of KTB was budgeted for in the 2016 Financial Act.</td>
</tr>
<tr>
<td>Financial resources</td>
<td>Following a §37 question from parliament in 2015, the revision of KTB was budgeted for in the 2016 Financial Act.</td>
<td></td>
</tr>
<tr>
<td>The healthcare system (meso level)</td>
<td>Leadership</td>
<td>Central management initiates a working group in 2014 to revise KTB, later MANU.</td>
</tr>
</tbody>
</table>
**Development of MANU**

MANU was developed in 2016 within the healthcare organisation, where the Danish three-person consulting firm Centre for Parenthood [33] was brought in to contribute with evidence and expertise on parenting programmes. Thus, the working group managing the development of MANU, consisted of the consulting firm and an experienced midwife from the healthcare system in Greenland. Findings regarding the development of MANU are primarily based on open interviews with stakeholders, since documentation of this process was limited or not accessible. Perspectives of stakeholders are described below.

To explore relevant topics to include in MANU, the working group conducted two interviews with parents. One interview was held with a couple who participated in KTB, and another interview was held with a small group consisting of six pregnant women and one expecting man. A reference group and a steering group were created and involved in the development process. The reference group consisted of practitioners (two midwives, one public health nurse, and an educational psychologist) who were involved in discussions on the content and design from the initial to final stage of the programme development. The steering group included three nurses from the management level (national, public health nurses, and midwives) and this group granted the final approval of MANU materials. The purpose of involving both groups was to ensure that the intervention would fit the Greenlandic context, as stated by the working group in an interview. Further, an underlying intent, but not specifically stated as such, was to shape change agents among practitioners and managers to lead the implementation of MANU, and finally to contribute to organisational readiness to change through early involvement of stakeholders. An overview of the presented findings is provided in table 3.

### MANU’s intervention characteristics

As stated in MANU’s manual, MANU aims to provide parents through pedagogical methods with the ability to i) develop their own parenting style from early on, ii) prevent that parents who had adverse childhood experiences will repeat this towards their own child, iii) network with other parents, and iv) equal involvement of mothers and fathers. These goals have also repeatedly been mentioned in open interviews with the working group and during trainings of professionals. In the focus group discussion with stakeholders and semi-structured interviews with professionals at MANU trainings, these goals were also reflected in participants’ answers on how they perceive MANU’s concept and what strengths they see in MANU.

In an interview during the MANU trainings, a midwife described the advantages of MANU compared to exclusively providing consultations:

“MANU is much more thorough than usual birth preparation, it is not just about birth but also about parenting. You can make a bigger difference with MANU.” (midwife A)

While generally all participants in the study's interviews and focus group discussion saw an advantage in having a parenting programme as MANU, many also pointed out limitations or challenges with MANU’s content, language and scope. The limited amount of practical information in MANU was repeatedly pointed out in the open interviews. Professionals requested MANU to include more instructional information on labour and breastfeeding. Most participants in the study complemented the design and layout of MANU, for example, for using Greenlandic features. Furthermore, a few professionals in the semi-structured interviews mentioned that MANU being provided in both languages is a strength and found the material easy to read. However, one public health nurse specifically mentioned the use of language in MANU to be a barrier:

“You have to be good in reading to be able to read the MANU book, and many in [big community] are not used to reading. MANU is, in our opinion, made above middle-class level. One must be educated to be able to reflect and talk about heavy concepts such as conflict.” (public health nurse A)

Most often MANU’s scope in terms of number of sessions and duration was discussed to be a barrier for implementation among stakeholders in the open interviews and focus group discussion. In some cases,
professionals decided to adapt the scope of the programme by shortening it. This led to some places summarising MANU’s nine sessions to four or shortening the duration of sessions from 2.5 hours to one hour. However, the working group disapproved of this form of adaptation. The MANU manual highlights the importance of fidelity for implementation outcomes, while recognising adaptations in the form of individual instead of group sessions being necessary when working with parents in vulnerable positions or in smaller communities.

The working group expressed in interviews how they put much effort into making a user-friendly manual for professionals, so that any professional, who has received MANU training or not, could hold sessions for parents. This was perceived as a crucial component for implementation according to the working group, which based on KTB’s evaluation results and on Greenland’s high-turnover and lack of human resources. Professionals, who have held MANU sessions, explained in the open interviews how the MANU manual is helpful and easy to use. An overview of the presented findings is provided in table 4.

**The healthcare system – central coordination and national trainings**

At meso level, the healthcare system’s organisational structures and support and to what extend these are considered in the implementation process are determinants for the implementation [17,26]. Repeated interviews with stakeholders and observations of the national implementation over a two-year period provided insight into the structural characteristics of the organisation. Leadership in the implementation process can be formal, such as national and regional management, and informal through change agents.

The midwife of the working group was appointed coordinator, who established a MANU team with a public health nurse and an educator in child development to assist with the national coordination. The Centre for Parenthood continues to be an integral part of the implementation by facilitating the trainings to professionals and developing subsequent MANU material the following two years. This included: MANU 1–2 years, a book for public health nurses and parents; MANU Hashish & Alcohol, booklets for consultations with parents with addictions; MANU community meetings, a topic guide for discussing the community environment for children; MANU 2–3 years, material for public health nurses, educators in nurseries and parents; and a MANU homepage. According to the working group the different MANU materials were developed trying to supply the prevailing demand for Greenlandic material among professionals in healthcare and municipalities, which the MANU team experienced.

The working group stated that providing training to professionals is of high importance for implementation, since introductions to KTB’s materials were stated inadequate in its evaluation. The training consists of three days and is hosted by the MANU team and facilitated by the Centre for Parenthood. In the training, professionals are first introduced to MANU 0–1 years and then to the remaining MANU materials available at the time. Since other MANU materials include professionals from municipalities, they participated in the trainings as well. Over the course of two years the majority of MANU relevant professionals from the healthcare system attended in one of the five organised trainings. More trainings within these two years were anticipated by the MANU team, to reach out to remote communities.

When MANU was finalised and production completed by the end of 2016, materials were nationally distributed to Greenland’s five regional hospitals. Greenland’s healthcare is decentralised to its five regions, which is overseen by national management but regionally managed. 60% of the population live in the regional capitals where the regional hospital is placed. Each regional hospital, where midwives and public health nurses work from, manages smaller health centres and nursing stations within its region. Since not all professionals could be trained at once, professionals, who have received training as well
as those who only have received materials, began providing MANU sessions to parents in 2017.

**Table 5** provides an overview of the status of trained professionals and by the MANU coordinator estimated status of how MANU is operating in Greenland’s 16 big communities. Small communities are not included. This table was developed in collaboration with the MANU coordinator in October 2018, prior to the two trainings in November 2018. There was variation between the big communities on how many professionals were trained and how MANU is provided. In 12 of the 16 big communities at least one or more professionals from mainly the healthcare sector, but also municipality personnel, have received MANU training. The MANU coordinator considers MANU to be operating in seven of the 16 big communities, meaning sessions are held as planned. In two of the big communities the coordinator found MANU not to be operating. The MANU coordinator suspected low motivation among the professionals to be the biggest barrier in these places. In almost half of the big communities MANU was described to be operating with adaptations, most often this meant that not all nine sessions were provided or professionals struggling with recruiting parents.

MANU is hardly provided in small communities, since professionals are only able to visit small communities one or three times a year conditioned to for example the number of people living there [34]. However, in some small communities, sessions are provided in a summarised and on individual basis when possible. Focus group participants and some interviewed professionals identified this as a challenge for making MANU truly universally and nationally accessible. In response to this, the MANU coordinator aspires that small communities’ existing telemedical devices would be used for providing remote sessions. An overview of the presented findings is provided in **table 6**.

**Financial resources and organisational readiness to change**

Professionals had to travel in order to attend the trainings, which took place in Nuuk, Aasiaat and Illulissat. Their travel expenses were mainly covered by MANU. From 2016 and onward, MANUs implementation has been financed through the Financial Act.

### Table 5. Overview of MANU’s implementation, status October 2018.

<table>
<thead>
<tr>
<th>Region</th>
<th>Big communities</th>
<th>Professional</th>
<th>MANU trained?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avannaas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>154 live births in 2017</td>
<td>Qaanaaq</td>
<td>1 Health assistant</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Upernavik</td>
<td>1 Health assistant</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Uummannaq</td>
<td>1 Health assistant</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Ilulissat (regional capital)</td>
<td>2 Midwives</td>
<td>Yes all</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Public health nurses</td>
<td></td>
</tr>
<tr>
<td>Disko</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99 live births in 2017</td>
<td>Aasiaat (regional capital)</td>
<td>2 Midwives</td>
<td>Yes all</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Public health nurses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Health assistant Municipality personnel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Qeqertarsuaq</td>
<td>1 Public health nurse</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Municipality personnel</td>
<td></td>
</tr>
<tr>
<td>Qeqqa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>140 live births in 2017</td>
<td>Qasigiannguit (regional capital)</td>
<td>1 Health assistant</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Sisimiut</td>
<td>1 Midwife</td>
<td>Yes all</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Public health nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Health assistants Municipality personnel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maniitsq</td>
<td>1 Health assistant</td>
<td>Yes all</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Public health nurses</td>
<td></td>
</tr>
<tr>
<td>Sermersooq</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>347 live births in 2017</td>
<td>Nuuk (regional capital)</td>
<td>13 Midwives</td>
<td>Half of each profession</td>
</tr>
<tr>
<td></td>
<td>Paamiut</td>
<td>7 Public Health Nurses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Health assistant Municipality personnel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tasiilaq</td>
<td>1 Midwife</td>
<td>Yes all</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Public health nurse available personnel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ittooqtoormiit</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Kujataa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>113 live births in 2017</td>
<td>Qaortoq (regional capital)</td>
<td>2 Midwives</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Narsaq</td>
<td>1 Public health nurse</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Nanortalik</td>
<td>1 Health assistant Municipality personnel</td>
<td>No</td>
</tr>
</tbody>
</table>

### Table 6. The healthcare system – central coordination and national trainings.

<table>
<thead>
<tr>
<th>Contextual levels</th>
<th>Determinants</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>The healthcare system (meso level)</td>
<td>Social relations &amp; support</td>
<td>Collaboration across sectors and regions established at trainings is expected to provide support.</td>
</tr>
<tr>
<td>Leadership</td>
<td>MANU team coordinates MANU nationally.</td>
<td></td>
</tr>
<tr>
<td>Organizational determinants</td>
<td>Organizational readiness to change</td>
<td>In some places, professionals started giving sessions as soon as they received the material or training in 2017.</td>
</tr>
<tr>
<td>Organizational support</td>
<td>Materials were provided to all regions. Five trainings within two years were held, reaching almost all relevant health professionals. The MANU team coordinates nationally within the decentralised system.</td>
<td></td>
</tr>
<tr>
<td>Organizational structures</td>
<td>National management oversees the five regions, which each are regionally managed. MANU is provided from the regional hospitals to healthcare centres and nursing stations.</td>
<td></td>
</tr>
</tbody>
</table>
Focus group participants were concerned that this training format will not be financially sustainable due to the high turnover of professionals. To overcome this barrier the working group is planning to develop an online training programme.

By involving managers and practitioners in the development process, the healthcare system is to some degree prepared for change, namely for implementing a new programme. However, the MANU coordinator explains how some regions or communities expressed to not seeing it feasible to implement MANU. This related to barriers like high workload, lack of human resources, restricted support from local managers, or managers requiring MANU’s scope to be shortened. These were also barriers that interviewed professionals had experienced or expect to experience. Some also mentioned the importance of having management or a change agent leading implementation.

“I wish my managers would also attend a MANU training, so they understand why I need to spend more work hours on MANU. I feel we otherwise get resistance from them.” (public health nurse B)

An overview of the presented findings is provided in table 7.

### Professionals’ characteristics

Professionals’ perception of MANU and their individual belief in their own capabilities (self-efficacy) to implement MANU influence implementation, but the individual is also influenced by interacting with peers and the organisation [17]. Change agents enable implementation, but, as the MANU coordinator pointed out in an interview, support from peers and local management remains important. The MANU team described how they both focus on supporting motivated professionals, who are lone change agents in their local organisation, and assist places with low self-efficacy and belief in the intervention. Their support includes consultations over the telephone, providing material, offering training, involving national management, placing incentives, or advocating for the financing of more human resources.

The working group described how the aim of the training is to motivate professionals, strengthen their self-efficacy, and to provide a forum for networking across sectors and regions. In fact, at the observed trainings professionals expressed how the training gave them a good understanding of MANU’s concept and that they were excited and motivated to implement MANU in their own community. Networking visibly occurred at the observed trainings and was also confirmed in the conducted interviews. The collaboration across sectors and regions was highlighted by the MANU team, since this could prevent MANU from depending on individuals. An overview of the presented findings is provided in table 8.

### Parents, the intervention recipients

Characteristics of parents, who are recipients of the MANU programme, have an equal important influence on implementation. The barriers and facilitators to meeting their needs in regard to the intervention must be known and prioritised at meso level [17]. When developing MANU, parents’ needs were considered based on international evidence on the importance of the first thousand days and on studies conducted in Greenland showing evidence for many children growing up in vulnerable homes. A small group of parents were interviewed in the initial phase of the development of MANU, but were not further involved in the development process. The observations

### Table 7. Financial resources and organisational readiness to change.

<table>
<thead>
<tr>
<th>Contextual levels</th>
<th>Determinants</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The healthcare system</strong> (meso level)</td>
<td>Financial resources</td>
<td>The following three years funds in the Financial Act remain allocated to the development and implementation of MANU. High expenses for providing trainings is perceived as a barrier, though an online solution is underway.</td>
</tr>
<tr>
<td><strong>Intervention characteristics</strong></td>
<td>Adaptable</td>
<td>Adaptations on content and scope have been made locally.</td>
</tr>
<tr>
<td>Organizational determinants</td>
<td>Barriers with implementation related to high workload, lack of human resources, restricted support from local managers, or managers requiring MANU’s scope to be shortened.</td>
<td></td>
</tr>
<tr>
<td>Organizational structures</td>
<td>High turnover of professionals leads to continuous need for providing training to new employees.</td>
<td></td>
</tr>
</tbody>
</table>

### Table 8. Professionals’ characteristics.

<table>
<thead>
<tr>
<th>Contextual levels</th>
<th>Determinants</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The healthcare system</strong> (meso level)</td>
<td>Social relations &amp; support</td>
<td>Collaboration across sectors and regions established at trainings is expected to provide support.</td>
</tr>
<tr>
<td>Characteristics of individuals</td>
<td>Knowledge &amp; Beliefs about the Intervention Self-efficacy</td>
<td>Training provided good knowledge and motivation for implementing MANU. Training intends to provide professionals with self-efficacy. Still, self-efficacy varies among interviewed professionals.</td>
</tr>
</tbody>
</table>
from the four MANU sessions showed that the majority of the parents attending these sessions were interacting with the professional, other parents and MANU material during the session; possibly indicating interest in MANU. However, in all four sessions only half or less of the enrolled parents showed up, their reasons for not attending that particular session is unknown.

In the observed trainings, professionals discussed among each other potential barriers for implementing MANU, this included reaching out to parents, especially fathers, and creating safe spaces for parents to share their thoughts. Focus group participants also discussed the challenge of recruiting parents, elaborating on the fact that sessions are provided within normal working hours thereby questioning fathers’ ability to attend sessions. Interviewed professionals, who had already begun to provide MANU sessions, observed many parents not interested in attending or not able to attend all nine sessions. The MANU coordinator explained in an interview how professionals need to be tenacious and adapt their working hours in order to overcome this barrier. A public health nurse pointed out how implementation at microlevel takes time:

“It takes time before MANU is a ‘thing’ so that everyone who is pregnant will naturally attend.” (public health nurse A)

An overview of the presented findings is provided in Table 9.

<table>
<thead>
<tr>
<th>Contextual levels</th>
<th>Determinants</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>The healthcare system (meso level)</td>
<td>Intervention characteristics</td>
<td>Professionals expressed challenges with MANU’s scope, content and language.</td>
</tr>
<tr>
<td>Parents (micro level)</td>
<td>Parents’ needs &amp; resources</td>
<td>Anticipated and experienced challenges with recruiting parents.</td>
</tr>
</tbody>
</table>

### Discussion

This study collected data during the parenting programme MANU’s first two years of implementation with the intent to identify implementation determinants taking a national perspective. After summarising the identified determinants influencing MANU’s implementation, the following sections will respectively respond to the first and second objective of the study. The study objectives were to understand the context which MANU was conceptualised and developed in, followed by how programme implementation was carried out and initially received in the healthcare system.

The results were discussed in another meeting with the same focus group participants as in the data collection. The participants validated the analysis of the study’s results and engaged in discussions on lessons-learned. Despite the political interest and financial security enabling MANU’s development and implementation, a thorough assessment of the implementation capacity of the healthcare system prior to the political decision-making could possibly have prevented some of the challenges identified. With a decisive ambition to implement MANU nationally after having finalised programme materials, the MANU team has come a long way with the national rollout within the first two years. While the focus was on disseminating the material and training professionals, professionals’ ability to implement MANU remains conditional on local context challenging implementation. The latter leading to professionals adapting MANU’s scope, which disagreed with the MANU team’s ambition to implement programme fidelity. This disagreement also challenged implementation, identified as restraining determinants relating to the intervention’s adaptability, and organisational structure, support and readiness to change. Including relevant stakeholders in the development process through a reference and steering group enabled change agents in parts of the healthcare system supporting implementation, though the scarce involvement of parents’ perspective could be a restraining determinant for MANU to reach its intervention recipients.

### Conceptualisation and development of MANU

MANU was conceptualised based on a political desire to ensure children’s well-being by providing parents with the essential parenting skills, and a desire to create a programme for the Greenlandic context rather than adapting a Danish programme as, for example, in the case of the first universal parenting programme Prepared for Baby (KTB). The political ambition at the Greenlandic community at large is based upon the awareness that adverse childhood experiences are widespread, which has been monitored by the Greenland Population Health Survey [35]. With the growing interest in improving children’s life chances and parenting skills, since the 1990s in Europe, parenting has become a public health issue [36]. Furthermore, the Convention on the Rights of the Child declares parents’ essential role in children’s upbringing and the importance of states providing appropriate support to parents [37]. These political ambitions and ongoing development going from corrective to preventive initiatives over the past decades have provided a window of opportunity for the parenting programme MANU to be
financially secured in the Financial act. Together with an available working group to begin developing MANU immediately, favourable conditions for implementation in terms of financial resources and time were present. However, as Nilsen and Bernhardsson [26] point out, the necessary condition of available resources is only one of the two context dimensions for implementation. It needs to be combined with driving forces such as supportive leadership and readiness for change if implementation is to succeed [26].

When MANU was developed, a reference and steering group were involved to review and approve materials. Involving stakeholders in the development process can have encouraged organisational readiness for change and created change agents. The intention of involving stakeholders, as stated by the working group, was assuring a programme fitting the Greenlandic context. This intention is based on the prior Danish parenting programme KTB, which was translated to Greenlandic. In the past decades and still ongoing, Western, typically Danish, health intervention models are directly or with slight adaptations applied in Greenland and only few achieve local integration. Presumably a backlog of colonisation and the fact that Greenland has roughly adopted the Danish welfare-state model and healthcare system. This is a common phenomenon in the circumpolar region. Based on collective research and expertise, the scholars of the Fulbright Arctic Resilient Communities Group pointed out the importance of taking a strength-based approach by acknowledging and integrating Indigenous knowledge, and recommended applying community-based approaches in research and policy [38].

MANU was internally developed though with the driving forces being the external Danish consulting firm Centre for Parenthood, who provided material, international evidence and experience from previous developed parenting programmes in Denmark. Although the programme’s aim, layout, evidence and underlying theories are acknowledged as relevant for the Greenlandic context by interviewed professionals, they expressed challenges with the content, language and scope of the programme. The latter also emerging from conversations with the MANU coordinator, who saw adaptations to the programme’s scope in some communities, which was perceived unacceptable by the MANU working group due to the importance of fidelity for implementation and outcome. While political support at macrolevel enabled MANU; parents and families at microlevel were scarcely consulted regarding their opinion or needs for a parenting programme. Parent Exit Questionnaires are provided, when attending the last MANU session, however, challenges with disseminating and collecting questionnaires have persistently occurred. Parents could have been involved in and along the development and implementation of MANU, since their perspective can ensure a suitable programme and have helped finding suitable solutions for anticipated or experienced challenges in implementation.

A different approach to developing and implementing a comparable parenting programme was applied in Nunavut, Canada. In response to numerous requests from communities, the local Qaujigjartuitt Health Research Centre [39] conceptualised and developed a parenting programme in collaboration with organisations and communities. This finally led to a piloted, evaluated and revised evidence-based and culturally responsive parenting programme being made available for all Nunavut [39]. Another relevant example, showing an Indigenous focused approach to developing a parenting programme, is the First 1000 Days Australia programme, which is an evidence-based model conceived of and led by Indigenous people to promote resilience, leadership and innovation in Aboriginal and Torres Strait Islander families [40,41].

**Implementation and initial perceptions of MANU**

The findings show how the first years of MANU focused on developing MANU materials, national distribution and training professionals. Apart from this, the working group had not discussed further elements of programme implementation. The demand for Greenlandic material among practitioners as experience by the working group and the financial security and eagerness to meet this demand, seem to have led to the primary focus on producing and disseminating MANU material along with providing trainings to professionals. With the majority of the relevant health professionals having received trainings, in about half of the big communities the programme is implemented as intended and the other half operates with adaptations, according to the MANU coordinators observations.

Nilsen (2015) describes how “implementation is part of a diffusion-dissemination-implementation continuum; diffusion is the passive, untargeted and unplanned spread of new practices; dissemination is the active spread of new practices to the target audience using planned strategies; and implementation is the process of putting to use or integrating new practices within a setting” [24].Applying this to MANU’s first years of implementation: diffusion occurred when MANU materials were distributed and put to use while most professionals have not received training yet, and dissemination occurred when introducing MANU at trainings for professionals. Implementation by putting
MANU to use locally was indirectly expected of professionals. Implementation capacity, monitoring and evaluation, were not thought out prior to diffusion and dissemination. Based on the authors’ experience, this is not uncommon in Greenland. Typically programmes mainly receive resources for development and dissemination, while piloting, evaluating and revising initiatives are downgraded. Much practice-based experience exists but little has been systematically documented. Combined with the challenge of high turnover at local and central level, this practice-based experience gets lost. The reference and steering group could have been a relevant setting for discussing implementation capacity, which Durlak and DuPre [18] describe to be an important process for effectively handling complex phases and anticipated challenges of programme implementation.

The implementation process is critical to whether an intervention creates the expected change and whether the change can be sustained in the system in which it is implemented [17,21,22]. Evaluations of health promotion strategies in Greenland show poor implementation due to the lack of considering and understanding local context and local professionals’ experience with implementation, since communities are isolated from each other and resources vary [42,43].

Besides estimating implementation capacity, providing support during implementation is an important determinant [17]. Quoting Pawson and Tilley [44] “what works for whom in what circumstances and in what respects” [44], points out the importance of keeping in mind that these are individuals working in isolated communities, where work and cultural context as well as resources differ. The trainings functioned as a type of support for introducing material, meeting the MANU team and building potential support networks with other professionals. Findings did not indicate that the support provided after the trainings by the MANU team to professionals was systematic. While the MANU user-friendly manual might be facilitating local implementation, interviewed professionals anticipated barriers being high workload, limited human resources, difficulty recruiting parents and reaching small communities. Adaptations were observed in the status made in 2018, but fidelity to the programme was still urged by the MANU team. Fidelity in implementation science is discussed as important for implementation of interventions [45], since variations of adaptations to the programme’s scope and content across the country is expected to alter programme outcome and could challenge an effect evaluation. However, understanding the challenges of local implementation within their different unique context is of immense interest if we want to understand how barriers can be overcome to reach programme fidelity, or on the contrary if the programme should be revised to be flexible to local context.

Implications for practice and next steps in research

The implications for practice that were brought forward by the focus group participants in the second meeting can be summed up to the importance of considering implementation capacity from the very beginning of planning an intervention. As also described by Durlak and DuPre [18], assessment of the implementation capacity beforehand is important in order to be able to effectively handle complex elements and expected challenges in programme implementation. The lessons-learned were the importance of: providing the MANU team with the necessary competencies and resources for working with implementation processes; assessing the full amount of resources needed in the healthcare system for it to implement MANU; examining and clarifying which other initiatives MANU is to coexist with or to replace; involving municipalities from an earlier stage to support collaboration and self-efficacy across sectors for implementing MANU; maintaining the reference and steering group from the programme development to discuss and resolve challenges throughout implementation and for discussing potential programme revisions. Furthermore, the importance for the next steps in research to be studying local implementation strengths and challenges with MANU, as well as gaining insights to parent’s perspectives on parenthood and attending the parenting programme MANU. These are the study objectives of the consecutive studies currently being conducted by the author team.

Strengths and limitations

This study is comprehensive and has a strong validity by applying and combining data collection methods and collecting data over a two-year period. The long period of data collection made it possible in this study to observe changes in implementation and the system’s context, thereby reducing the chance of only having a “one moment” picture of the process. In order to analyse the comprehensive collection of data, it was conducive to combine three frameworks. A single implementation theory would have provided a too narrow focus, while the combination gave a better whole picture [24]. While perspectives from management to
practice level were included, some of the participants’ responses could have been biased, since questions regarding the development process, which was prior to data collection, were retrospective. Reporting on events and perspectives from the past are likely influenced by the present.

**Conclusion**

This study provides an understanding of the context in which the universal parenting programme MANU in Greenland was conceptualised and developed and describes how programme implementation was carried out and initially received in the healthcare system. Data were collected during MANU’s first two years of implementation with the intent to identify implementation determinants taking a national perspective.

MANU was conceptualised in a context where parenting skills were seen as a public health issue with a political interest to improve children’s well-being. However, families’ perspectives on what they need for transitioning to parenthood were not included in the development of the programme. The first years of MANU focused on disseminating material, training professionals, and developing more MANU related material. The MANU team worked intently to meet the conceived need for Greenlandic parenting material and ensure all relevant personnel has received training, local implementation was delegated to the individual professional. Programme fidelity was urged, but many local barriers were anticipated and experienced. Future research will gain insights to the local barriers to implementation and will explore parents’ perspectives and experiences with the aim to bring them to the forefront of the implementation process.

**Acknowledgments**

We would like to thank all participants for their time and openness in contributing to this project.

**Ethics approval and consent to participate**

The Greenlandic Scientific Ethical Committee (Danish: Det Videnskabelses Komitee) approved the project. Verbal informed consent for participation was given by study participants.

**Consent for publication**

Not applicable.

**Availability of data and materials**

Documents and reports used and analysed during the present study are available from the corresponding author on reasonable request. Qualitative data from interviews, the focus group discussion and observations is not available, since this would otherwise breach with participant confidentiality. Data and material are stored encrypted.

**Authors’ contributions**

Ci, CVLL, SK, TTT conceived and designed the study. Ci conducted all data collection with assistance in the focus group discussion by CVLL. RLK contributed with the collection of material for the document analysis and recollection of the events prior to the study’s data collection. Data analysis was conducted by Ci under the supervision of CVLL and feedback from RLK. Ci drafted the manuscript. Critical revision of manuscript was given by Ci, CVLL, RLK, SK, TTT. All authors reviewed and approved the manuscript.

**Disclosure statement**

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Parents’ perspectives on preparing for parenthood: a qualitative study on Greenland’s universal parenting programme MANU 0–1 year

Christine Ingemann1,2*, Else Jensen1, Ingelise Olesen1,2, Tine Tjørnhøj-Thomsen3, Siv Kvernmo4 and Christina Viskum Lytken Larsen1,2

Abstract

Background: The transition to parenthood has received increasing attention in research, partly due to evidence pointing out the crucial developmental period of a child’s first thousand days. Parenting programmes aim to prepare and support families in their transition and distress. For a programme to be implemented successfully it is important to consider parents’ needs and resources. Bringing parents’ perspectives and experiences to the forefront of the implementation of the Greenlandic parenting programme MANU 0–1 Year (MANU) is important for determining if the programme can meet its aim of contributing to thriving families. This study aims to investigate how parents’ notions and experiences of parenthood are reflected and challenged in MANU.

Method: Data were collected in three of Greenland’s five municipalities. Qualitative interviews were held with 38 mothers and 12 fathers either individually or as couples: a total of 40 interviews. Additionally, a Sharing Circle with three fathers was held. Interviews were in Greenlandic or Danish. A thematic, inductive analysis was applied.

Results: In their transition to parenthood, participants experienced a reprioritisation of their life and changes in their network. It is important to parents that their child experiences security and care, and participants describe this in contrast to their own childhood. Community is the most important value in child-rearing. Conversations and advice from family members and friends are mentioned as a means to prepare for birth and parenthood. Additionally, conversations with midwives and MANU sessions were also used for preparation. Parents appreciated learning from and listening to other parents in MANU sessions. However, accessing MANU depends on the individual parent’s interest and ability to attend sessions.

Conclusions: Parents’ notions and experiences of parenthood are addressed in the programme, but the use of MANU depends on the parents’ attendance and how it is organised and locally offered. The study suggests that MANU has the possibility to create a space for parents to reflect and prepare. However, for MANU to be universal as intended and to reach both mother and father the facilitation of sessions could be revisited.

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Keywords: User perspective, Parenting program, Parent education, Preparation, Implementation, Arctic, Circumpolar, Qualitative methods, Indigenous perspective, Thematic analysis

Background
In recent years, there has been increasing public and scholarly attention to the transition to parenthood. This is partly based on evidence showing that from the prenatal period until the age of two is a crucial development period for the child. This period is called 'the first thousand days' and is considered critical for shaping the foundation for the child's health and development [1]. Parents' choices in parenting and upbringing influence the health of their children throughout the child's development both physically and mentally [2]. Additionally, the transition to parenthood is known to be a major developmental period for families while learning to care for a newborn [3–5]. This period increases relationship stress and disharmony due to the new responsibilities and negative outcomes of unfulfilled expectations after childbirth [5, 6]. Besides parents needing emotional and psychological support during this transition [6], evidence also strongly recommends that families receive guidance for providing nurturing care and protection so that children achieve their developmental potential [7].

Parent education programmes targeting either specific at-risk sub-populations or those designed as universal programmes accessible to everyone are developed internationally [3, 8, 9]. An underlying hypothesis of many parenting programmes is that knowledge deficit among parents is a major cause of parental distress [10]. Furthermore, parents' knowledge and needs are barely explored prior to programme development. Universal programmes may be of value when parents can access the programme at a time and in a format that suits them [8, 10].

The universal Greenlandic parenting programme MANU 0–1 Year (MANU), which stands for Meeraq Angajoqqaat Nuammaarneg, meaning 'child's and parent's happiness', was developed to provide expectant and new parents with relevant information and reflections on how they want to be as parents through pedagogical exercises [11, 12]. MANU is based on developmental theories, international evidence on the first thousand days and the high number of vulnerable families in Greenland [11]. Ultimately, MANU is expected to secure a healthy foundation for children's development and to contribute to the prevention of adverse childhood experiences [12, 13].

Previous studies in Greenland show the importance of appropriately integrating cultural beliefs, values and local practices into Greenland's public health and healthcare system [14–16]. Cultural values and Indigenous knowledge are fundamental in parenting programmes in populations comparable to Greenland. These include the breastfeeding initiative built on traditional infant feeding practices in the Northwest Territories of Canada [17, 18], and Indigenous-led parenting programmes like the First 1000 Days Australia [19] and the Inunnguiniq parenting programme in Nunavut, Canada [20, 21].

MANU is offered as a universal programme, but it is uncertain how the programme meets the needs of Greenlandic parents in general. Since only few perspectives of parents were explored during the development process of MANU. Considering parents’ needs, expectations, attitudes and resources are important determinants in programme development and implementation [22–24]. Bringing parents’ perspectives and experiences to the forefront of MANU’s implementation process is valuable for understanding what hinders or supports programme implementation as well as if the programme has the potential to meet the ultimate outcome of healthy and thriving families [11, 22]. Therefore, this study aims to investigate how parents' notions and experiences of parenthood are reflected and challenged in MANU: first, by investigating parents’ experiences of their transition to parenthood and identifying their values in child-rearing; then, by comparing these experiences with MANU’s content and parents’ perspectives on attending MANU to identify opportunities to advance the programme to meet parents' needs.

Methods
This study applied qualitative methods to investigate parents’ perspectives on parenthood in relation to the parenting programme MANU. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were applied for reporting on study design, analysis and findings, which are domains 2 and 3 in the checklist [25]. The present study is part of a PhD project which applies a community-based participatory research (CBPR) approach. Based on N Wallerstein, B Duran, JG Oetzel and M Minkler [26] five stages in CBPR, a reference group consisting of stakeholders involved or related to MANU was established at the very beginning of the PhD project [11]. Furthermore, in the present study the reference group set the study's aim, decided on study sites, advised on interview questions, discussed use of a translator versus a Greenlandic interviewer, contributed to the analysis and engaged in recommendation development. Scholars have increasingly discussed the importance of applying approaches like CBPR in circumpolar health research
[27, 28]. In this way, the study and its results are placed back in the hands of the participants themselves, who own and need the knowledge.

Research setting and MANU

Kalaallit Nunaat is the Greenlandic name for Greenland and can be translated as ‘Land of the people’ or the ‘Land of the Kalaallit’ [29]. Most of the Greenlandic population, close to 90%, are ethnic Greenlanders (Kalaaleq/Inuit) – a recognised Indigenous population. Most Greenlanders speak the national language Kalaallisut (Greenlandic), while both Danish and Kalaallisut are taught in schools. Greenland is the largest island and least densely populated country in the world, with a total population of 56,421 and a fertility rate of 2.1 in 2021 [30]. Towns and settlements are isolated from each other, meaning they are only reachable by air or sea. About 60% of the inhabitants live in one of the five regional towns, and the remaining population lives in the other 11 towns and about 54 settlements. The regional hospitals are located in the five regional towns. Women can give birth in the national hospital in Nuuk (capital city), the regional hospitals in Sisimiut and Ilulissat or Tasiilaq’s health centre. Countrywide, there are marked socioeconomic and infrastructural differences between towns and settlements [31]. Greenland is a former Danish colony, which gained Home Rule in 1979 and Self Rule in 2009 but is still part of the Kingdom of Denmark. Greenland has roughly adopted the Danish welfare-state model and healthcare system. Since 1992, the healthcare system has been fully administered by the Greenlandic government.

Study sites

Three of the five municipalities in Greenland were selected for this study. Data were primarily collected in the regional towns of these municipalities, while a few smaller towns were included through phone interviews or if a participant was visiting the regional hospital due to childbirth. In 2020, the researchers spent two weeks on the first site and three weeks on the second site. On the third site, data collection was spread out over a longer time period due to the first (CI) and second (EJ) author living there.

The parenting programme MANU

Since the development of the parenting program MANU 0–1 Year in 2016, a range of other MANU programme items have been developed [11]. This study has focused on MANU’s first item ‘MANU 0–1 Year’, which aims to prepare expectant parents for parenthood. MANU 0–1 Year, henceforth MANU, provide parents with a book containing information and conversational exercises, and six antenatal and three postnatal 2.5-hour sessions provided by midwives, public health nurses (Danish: sundhedsplejerske), or health assistants as facilitators [11, 12]. The book and sessions coincide in terms of content. Parents are provided with information on the pregnancy progress, both physical and mental; healthy nutrition, including the harm of consuming alcohol and hashish; the development of the child’s brain; signs of birth and birthing phases; a newborn’s needs; and the importance of care for the child’s development. MANU addresses topics on bonding and sensitivity; having to travel to give birth; sex during and after pregnancy; practical preparations for the child’s arrival; sibling jealousy; a typical day with a newborn; family network; reflections on one’s own childhood; setting boundaries; and opportunities and challenges associated with receiving support and advice from elders. Connected to this information and the addressed topics, there are pedagogical exercises inviting parents to reflect on their own thoughts and share their thoughts with each other.

The first two years of MANU’s implementation focused on disseminating material and training professionals on a three-day introductory course [11]. In the programme’s early stage of implementation, local challenges with carrying out MANU were already anticipated or experienced by health professionals, and adaptations were made to the frequency of group sessions offered [11]. Furthermore, during the COVID-19 pandemic, MANU group sessions were not offered due to restrictions on group gatherings. No alternative versions of MANU were offered during lockdowns.

Data collection

Interview guide

The interview guide was developed by CI based on topics and questions relating to: i) child-rearing and parenthood in MANU [12]; ii) topics discussed with the reference group and with the author team based on their fields of experience and implementation science [22, 23]; and iii) an explorative pilot interview in Danish with a parent. The translation of the interview guide was an iterative process between EJ, IO and CI, in which understanding and wording of the questions were discussed, as well as the structure of the interview guide. After a second pilot and the first interviews were conducted, the last few alterations to the guide were made.

The interview guide was divided into two topics: i) family and parenthood and ii) MANU. An English version of the interview guide is provided in Additional file 1: Appendix 1. As an introduction, participants were asked their age, where they grew up and whether it was their and their partner’s first child. Questions in the first part of the interview were on pregnancy decision; life changes in connection to parenthood; values in child-rearing;
important family relations in child-rearing (using a blank circle diagram for illustration, see Additional file 2: Appendix 2); responsibility in child-rearing: reflections on parents’ own childhood experiences and connections to the older generation (e.g. grandparents); and who participants get advice from and on what. The second part on experiences with MANU was developed based on parents’ preferences, expectations, attitudes, knowledge, needs and resources, which can influence implementation [22]. Questions concerned if and how participants were invited to take part in MANU; how often they attended, and if not why; if their partner attended; if any topics were of specific interest to them; how they liked the set-up of the MANU sessions; if it met their expectations; and if they had any suggestions.

Recruitment of participants
The study set out aiming to interview six couples on each of the three sites: four couples who had attended the MANU parenting programme and two who had not. Furthermore, criteria for participation were that parents should either be pregnant or their youngest child should not be older than 1 year. In agreement with the local midwives and public health nurses, participants were recruited in the waiting room for midwife or public health nurse consultations, at the hospital ward, patient hotel, from participant lists of MANU sessions and at observed MANU sessions. Additionally, participants were recruited outside the health centre or on the street and through posts in relevant local Facebook groups and small posters in towns. Potential participants were primarily approached and invited by EJ in Greenlandic.

Semi-structured interviews
A semi-structured interview design was chosen, since the study is interested in parents’ perspectives on specific themes, namely parenthood, child-rearing and MANU [32]. Participants could choose to be interviewed in Greenlandic or Danish. The semi-structured interviews were conducted primarily in Greenlandic by EJ, while CI was present during all interviews to observe the conversation and be available for potential questions. Participants were interviewed either in CI’s home or office, or the participant’s home.

Sharing circle with fathers
Sharing Circles, an Indigenous form of communication [33], were used as a data collection method for the sharing of experiences [34]. In an attempt to include more male participants in the study, the authors tried to organise Sharing Circles on two sites, but this only succeeded at one site. At the first Sharing Circle only one out of five invited fathers came; he was individually interviewed. At the second Sharing Circle, three out of six invited fathers participated.

For the second Sharing Circle, a community room was provided by the municipality. The room was a broad airy space, where chairs were placed in a circle in the middle of the room. Refreshments were provided, and participants gathered and greeted each other. Then participants took a seat. CI stayed outside the circle for observation. EJ facilitated the Sharing Circle in Greenlandic. First, the study and the day’s topic were introduced, then EJ introduced the rules of the Sharing Circle. These included ethical considerations of confidentiality, that the person who is talking should not be interrupted and that everyone would be given the opportunity to share. First, participants were asked about their reaction when they found out they would become a father; then values that were important to them in child-rearing; who, besides them as parents, plays an important role in raising their child; who they ask for advice regarding their child or parenthood; and how they had prepared for parenthood and if they had missed anything.

Field notes
In order to keep track of the persons recruited, field notes were taken during data collection. Furthermore, during the Greenlandic interviews CI took participatory notes on the flow and atmosphere of the interview [35]. Consolidated field notes were taken after each interview; CI and EJ briefly reflected on their experience and their daily experiences of the data collection process [35]. These notes were used to recall and understand the context the interviews were held in.

Study participants
Qualitative interviews were held with 38 mothers and 12 fathers, either individually or as couples. The interviews had a duration of 25 to 50 minutes, and the Sharing Circle with three fathers took about 1 h. Table 1 provides an overview of the interviews with an indication of the language, Greenlandic (GL) or Danish (DK), couple or individual and if the participants are from a large or small community.

Fewer couple interviews were held than initially planned. A total of 30 people declined, cancelled or did not attend the scheduled interview. Men were often not interested in participating or could not find the time due to work. When recruiting, it was difficult to identify if parents had participated in MANU fully, to some degree or not at all. Table 2 provides an overview of participants’ age, their newborn’s age or if they were pregnant at the time of the interview, if they have older children, if they are partners with the mother or father of their newborn child and if they have attended any MANU sessions.
Parents who had attended MANU sessions could rarely remember the precise number or which one of the nine different MANU sessions they had attended, therefore it is not possible to provide a reliable number of sessions attended by study participants.

**Data analysis**

Interviews were audio-recorded after obtaining participants’ consent. Then, recordings of the Danish interviews were transcribed primarily by CI and also by a Danish student assistant. The Greenlandic interviews were primarily transcribed and translated by EJ and also by two Greenlandic student assistants.

A thematic, inductive analysis of the transcriptions and fieldnotes was performed [36]. All data were imported into the qualitative data analysis software NVivo12. First, randomly selected transcripts were thoroughly read by CI, EJ and IO. Then, general themes and impressions from these transcripts were discussed. As a next step, CI coded all transcripts in NVivo, based on the themes discussed in the first step. Thirdly, themes were summarised, and some themes were re-coded. Lastly, transcripts, themes and summaries were revisited for validation of the presented results.

**Table 1** Overview of interviews

<table>
<thead>
<tr>
<th>Site</th>
<th>Size of town</th>
<th>Couple interviews</th>
<th>Individual female interviews</th>
<th>Individual male interviews</th>
<th>Sharing Circle with fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Regional town</td>
<td>1 in GL</td>
<td>4 in GL</td>
<td>2 in GL</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>Small town</td>
<td>/</td>
<td>3 in GL</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>B</td>
<td>Regional town</td>
<td>3 in GL</td>
<td>8 in GL</td>
<td>/</td>
<td>1 in GL with 3</td>
</tr>
<tr>
<td></td>
<td>Small town</td>
<td>1 in GL</td>
<td>1 in GL</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>C</td>
<td>Regional town</td>
<td>4 in GL</td>
<td>3 in GL</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>Small town</td>
<td>/</td>
<td>2 in GL</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

GL indicating interview held in Greenlandic and DK in Danish

**Table 2** Overview of participant characteristics

<table>
<thead>
<tr>
<th>Site</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of participants</td>
<td>13</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>26–30: 1</td>
<td>26–30: 5</td>
<td>26–30: 8</td>
</tr>
<tr>
<td></td>
<td>&gt; 35: 1</td>
<td>&gt; 35: 1</td>
<td>&gt; 35: 3</td>
</tr>
<tr>
<td></td>
<td>Unknown: 1</td>
<td>Unknown: 3</td>
<td>Unknown: 1</td>
</tr>
<tr>
<td>Age of newborn or pregnant at point of interview</td>
<td>Pregnant: 2</td>
<td>Pregnant: 5</td>
<td>Pregnant: 7</td>
</tr>
<tr>
<td></td>
<td>1–6 months: 5</td>
<td>1–6 months: 9</td>
<td>1–6 months: 9</td>
</tr>
<tr>
<td></td>
<td>7–12 months: 5</td>
<td>7–12 months: 6</td>
<td>7–12 months: 2</td>
</tr>
<tr>
<td></td>
<td>13–15 months: 1</td>
<td>13–15 months: 1</td>
<td>13–15 months: 0</td>
</tr>
<tr>
<td></td>
<td>Unknown: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older children?</td>
<td>5 Yes</td>
<td>13 Yes</td>
<td>7 Yes</td>
</tr>
<tr>
<td></td>
<td>8 No</td>
<td>9 No</td>
<td>11 No</td>
</tr>
<tr>
<td>Together with the newborn’s father/mother?</td>
<td>12 Yes</td>
<td>22 Yes</td>
<td>14 Yes</td>
</tr>
<tr>
<td></td>
<td>1 No</td>
<td>0 No</td>
<td>3 No</td>
</tr>
<tr>
<td>Attended MANU sessions</td>
<td>9 Yes</td>
<td>13 Yes</td>
<td>17 Yes</td>
</tr>
<tr>
<td></td>
<td>4 No</td>
<td>9 No</td>
<td>1 No</td>
</tr>
</tbody>
</table>
The quotes presented in this paper were translated from Kalaallisut to Danish to English, or from Danish to English.

**Ethical considerations**
The study has been performed in accordance with the Declaration of Helsinki, and the Greenlandic Scientific Ethical Committee (Danish: Videnskabsetisk Udvalg) granted ethical approval of the project.

Each participant was provided with an informed consent form in either Danish or Greenlandic, and the content was explained. Participants signed the form to document their informed agreement and received a copy with the researcher’s contact details. For the de-personification of the data, codes for each participant and material were developed. An Excel spreadsheet was used as a tracking method to keep an overview of planned, held and cancelled interviews. The date, participant’s contact details, length of interview, method of recruitment, interviewer, transcriber and quality check of transcription were noted. All data are stored on an encrypted drive, in accordance with data management guidelines. All stakeholders and participants were invited to receive an e-mail newsletter on updates and results of the study.

The author team reflected on potential ethical concerns prior to interviewing couples and addressing parenthood, child-rearing and own childhood experiences. When interviewing couples, the relation between the two participants might influence or limit their responses, but it can also, on the contrary, enhance them. However, this was difficult to determine during the interviews, as the interviewer was with participants for such a short period of time. Furthermore, the addressed interview topics are sensitive in that they are connected to a person’s identity, opinion and own experiences. Additionally, parenthood and child-rearing are topics widely discussed in society about which the public had many opinions on what is right and wrong [32]. A few participants became emotional, for example, when asked about the changes they have experienced in their transition to parenthood. Nonetheless, at the end of the interview they were thankful for the opportunity to reflect on their experiences and to express their thoughts.

**Results**
The study’s results are organised into the following themes and sub-themes: (i) approaching parenthood, (ii) toqqissisimaneq – security and care, (iii) ataatsimoorneq – community, (iv) preparing for birth and parenthood, and (v) delivery of MANU. Some of the themes contain further sub-themes, which are presented in Fig. 1. The first four themes show how parents experience their transition to parenthood, prepare for it and how they understand child-rearing, while the fifth theme focuses specifically on parents’ experiences with attending the MANU programme.

**Approaching parenthood**
In parents’ approaches to parenthood, their first step was deciding to be pregnant. Then, in their transition to parenthood they experienced changes in their lives and wanted to provide for their unborn child.

---

**Fig. 1** Overview of themes and sub-themes
Pregnancy decision making
Participants had both similar as well as different starting points to parenthood. Many of the participants had at some point in their relationship with the co-parent discussed their desire to have children, as one participant expressed: “We didn’t specifically decide it, we just welcomed them (children), when they arrived (were conceived)” (Mother 1). However, for some participants the pregnancy was unexpected in terms of not knowing whether to keep or abort the pregnancy, and a few found out too late to even consider an abortion. For them, the support they received from their partner and parents, as well as the emotional bond they developed with the child contributed to their decision to keep the unborn child.

Transition to parenthood
Regardless of whether the pregnancy was expected or not, the transition to parenthood was a great upheaval for the participants. They described how becoming a parent is lifechanging. It reshaped their perspective on their surroundings, changed their priorities, affected their friendships, and shifted their focus from themselves to their child. One father expressed how he can no longer imagine being without his daughter:

“Now my happiness is no longer out in nature, in solitude. It is in my daughter. I won’t be able to go out into nature alone as before. To go out for a walk alone. It may never be like that again. If I’m going out into the nature today, it has to be together with my daughter.” (Father 2)

Many defined the transition to parenthood as leaving their youth and freedom behind, while receiving a lifelong responsibility; one participant described her experience: “You get a huge responsibility after the birth, which you have the rest of your life. That was perhaps the most overwhelming thing for me” (Mother 4). Many parents expressed they have had made lifestyle changes by limiting or refraining from alcohol consumption, or, for some, getting out of their alcohol or hashish addiction, when they found out they were to become parents. Stepping away from addiction and youth life gave both fathers and mothers confidence and the desire to become independent, find a job and get an education. As one emphasised: “Before I had children, I never thought of taking an education” (Mother 5). Leaving youth life behind meant giving up partying and visiting cafés, which decreased participants’ friendships, though the real and close friends remained. Similar to others, one mother explained how becoming a mother was everything she desired, but after having a child she was surprised by how tough it is mentally to put your child’s needs before your own.

Being able to provide
With the transition also came the desire to be able to economically provide for the child. Many participants expressed that they did not want their child to lack anything. For participants, the most important preparation was to buy the necessary practical things for the child’s arrival (e.g. clothes, pram). Furthermore, many discussed the importance of having or finding a job, finishing their education and moving out of their parents’ or their partner’s parents’ house. However, finding a place to live is a matter of joining long waiting lists for an affordable apartment, due to lack of housing in many communities in Greenland. One father described how him and his partner are waiting for a flat that is suitable for their newborn:

“It takes a long time. There are only flats available near [area]. It is not suitable to live there when you have a child. There is drinking and quarrels. It is the only apartment block they offer, but we do not want to live there.” (Father 3)

Despite appreciating their parents’ support, it is not perceived as ideal; as one mother puts it: “It is strange to imagine that we will become a family while still living with his parents.” (Mother 6).

Toqqissisimaneq – security and care
Toqqissisimaneq is Greenlandic (Danish: tryghed) and can be translated to security and care. This second theme mainly stems from the responses to the interview questions: ‘How do you want to see your child grow up? Which values do you see important in child-rearing?’ and ‘What do you want to do differently compared to your own childhood and why?’ When parents were asked to define toqqissisimaneq, several aspects were connected with the term. Most participants defined it as providing a secure environment that is free of alcohol, hashish and violence, but it also includes a calm home, stability, prioritising the child’s needs and being without worries. Participants want to achieve this by giving love, creating close (body) contact and ensuring the child feels cared for and is able to discuss difficult matters.

Participants shared how they went through adversities connected to alcohol, hashish and quarrels in their
childhood home. In the following quote, one father expressed how hard it is to experience this in one's childhood:

“It’s because it’s the worst thing you experience in your childhood. When parents get drunk, they change completely. It’s the worst experience you can have. [...] It is harsh, and you feel apprehensive.” (Father 2)

Based on these experiences and the desire to prevent adversities, participants have mostly banned alcohol from their home and saw it as important for their child to not experience alcohol in their upbringing. As one mother clearly pointed out: “I do not want to pass this on to a child.” (Mother 16).

Knowing how to care for one’s children and collaborating as parents is important, which participants reported in the light of having experienced the opposite in their childhood. Parents wanted to create a stable home with routines and boundaries, where their children learn the importance of going to school, being independent, gaining self-confidence and learning to be open and curious about life. In this respect, one mother described the importance of boundaries:

“I want to teach my child to set boundaries and that he knows where his own boundaries are. And he should learn to be responsible.” (Mother 9)

Good communication and respect were also important values, and parents wanted to show patience and explain decisions made. Furthermore, their child should be treated as an equal, feel heard and have a certain degree of influence on decision making. Respecting the child for who they are and supporting their interests was as important as teaching them to respect others, especially elders.

Ataatsimoorneq – community

The third theme atatsimoorneq arose from multiple responses to interview questions, where participants continuously mentioned and discussed the role of family and spending time together. Ataatsimoorneq is Greenlandic (Danish: fællesskab) and means community — sense of togetherness. Experiencing community or togetherness with extended family by learning about family ties, attending family gatherings and eating together on a regular or even daily basis when living in the same place stood out as an important value in child-rearing. Community is something participants had experienced themselves in their childhood, which they wanted their child to experience as well. As one mother expressed:

“Being together, for example eating together, community, and visiting each other. It is about having a good time together and laughing together.” (Mother 15)

Enjoying nature with family by going sailing, picking berries or going hunting is also valued by participants, but sailing and hunting can be an unaffordable expense. Even if extended family does not live in the same community, it is important for them to follow the child’s development through text messages or video calls.

Participants reported that grandparents had the closest relation to their child after themselves, even when the grandparents did not live in the same community. While parents agreed that it is primarily their responsibility to raise their child, some found that extended family (e.g. grandparents) can take part in it as well. Participants themselves remember the unconditional love and joy they received when spending time with their own grandparents in their childhood. This is something parents want their children to experience, as one mother described: “You feel great joy when you are with your grandparents. I would very much like to pass this on” (Mother 8).

Preparing for birth and parenthood

The fourth theme deals with parents’ perspectives on preparing for birth and parenthood. Participants reported that they prepared by (i) listening to others’ experiences and (ii) using public services. These two sub-themes included parents’ experiences with MANU and will be elaborated below.

Listening to others’ experiences

The most common way to prepare for birth and parenthood for participants was by talking to their own mother, sister, aunt or friend who had experienced childbirth and being a parent. One woman described how she prepared to give birth:

“My mother has been very important. For example, I can ask her about birth, also my grandmother. Those who have experienced giving birth. That is how I have prepared myself to give birth.” (Mother 7)

Family members and friends are also an important source for advice and guidance after birth, when doubts arise as to the well-being and raising of the child.

When participants who had attended MANU sessions described their experiences with MANU, many valued the possibility to learn from the other expectant parents in their group. This way they could also learn from others’ experiences and perspectives on the topics addressed in MANU. One mother expressed her positive experience:

“It was good to meet other expectant parents, also those who already have parenting experience. You
feel very welcome, and I did not feel any limitations on what I could share with the group.” (Mother 3)

Talking about thoughts and feelings as a couple regarding pregnancy, parenthood, their unborn child or relationship was for some participants a natural part of their relationship, while for others these conversations were rare or new. Men in particular described themselves and were described by women as quiet and having difficulty expressing themselves. From the interviews with men, it appears that they seldom sought advice and guidance in their network. However, they expressed a desire to talk to other fathers in similar situations about their experiences. In the following two quotes, two fathers expressed this need:

“I’ve missed talking to other fathers a lot for a while, being able to contact other fathers who have children at my own daughter’s age. Just to be able to share with each other. I have missed that a lot. But we men are not always open. This is a challenge. It is not possible to contact anyone. Some days I do not feel like I have anyone I can contact, even though I have a large family and my partner.” (Father 1)

“That’s also why I’ve said yes to participating in your study, so that I can get rid of my thoughts a bit. […] It would have helped a lot, if I had had the opportunity to talk about my thoughts as a father earlier on. In all areas it would have been very different for me. […] It is only recently, when I heard about you wanting to interview, that I came to think of how I haven’t had conversations at all. From the very first day she was born, it is now for the first time that I share my thoughts.” (Father 2)

In relation to this, they suggested that having a fathers’ group after birth, just like mothers meet in groups after birth, could be useful.

Public services
Preparational and supporting services and programmes from the healthcare system and municipality were described as important and useful by the study’s participants. Conversations with the midwife during consultation hours were central, and participants appreciated being able to contact health personnel at any time when needed during their pregnancy. One mother expressed how her relation to and confidence in her midwife was important during her pregnancy:

“The midwives have helped me a lot by talking with me about my anxiety. […] I felt understood […] But at one point during my pregnancy there was a high turnover in personnel, so I grew tired of having to explain everything from the beginning to the new staff.” (Mother 8)

After the birth, the home visits from public health nurses were appreciated, and participants welcomed the possibility to ask all kinds of questions they had regarding their newborn. Participants used the municipalities’ family centres to receive help, for example, regarding relationship conflicts, addiction or anxiety.

Parents, who had attended MANU sessions, were satisfied with the programme. As one mother described it: “MANU is a good thing, and I think all pregnant women should participate in it. With MANU one does not feel alone or confused” (Mother 9). One father reported how MANU helped them prepare for parenthood as a couple:

“It has helped us a lot in our preparation. Our conversations in MANU are different than at home. And the fact that the two of us can prepare together, that is something I have been very happy about.”

(Father 1)

Delivery of MANU
MANU was generally appreciated by participants, but many experienced challenges with accessing MANU. This fifth theme is divided into the following three subthemes: (i) accessing MANU, (ii) MANU’s format, and (iii) MANU’s content.

Accessing MANU
Almost all participants were offered the opportunity to attend MANU sessions. Most parents received MANU group sessions, while parents with an addiction problem received MANU in individual consultations. Few participants recalled having attended all nine sessions. Others only attended a few sessions due to work, illness or other personal hindrances, as one mother described:

“I would have participated if it wasn’t during working hours. And, while I was pregnant, I wanted to gather more hours at work in order to be eligible for more maternity leave support. I didn’t want to lose any hours at work.” (Mother 8)

Men in particular did not attend MANU due to it being during work hours, in addition to lacking interest in MANU, as one father explained: “I was a bit indifferent to attending MANU. I just thought that we can handle it ourselves. But now after having attended MANU, I think it helps me” (Father 4).

MANU sessions were not always offered as the programme suggested, due to restrictions in relation to the COVID-19 pandemic, illness among personnel or too few people signing up. Furthermore, participants from
MANU's format
As a result of many not attending MANU sessions due to hindrances, some participants described how this influenced group dynamics because they were too few or the parents attending changed with every session. In MANU group sessions, the facilitator (e.g. a midwife) used a slideshow to provide information, conversational exercises from the MANU book and invited parents to ask questions. Participants were generally content with this format, however, the facilitator’s motivation and skills to hold a session were noticed and deemed relevant to whether they got something out of it. This also influenced whether parents found a session of 2.5 hours too long or just right. Furthermore, one father expressed that he would have appreciated the sessions to be more physically active, since sitting down for 2.5 hours can be tiring, despite the information and topics discussed being interesting. Participants barely read the MANU book, except when using it during the sessions.

MANU's content
During pregnancy, female participants expressed being very occupied with preparing themselves for birth. This was also frequently mentioned topic and session attended when interviewing parents about their experiences with MANU. Other topics parents remember from the sessions they attended varied, but they valued receiving information about how a newborn sleeps and eats, how to learn to distinguish its cries and what parents can do. Furthermore, they described having reflected on their own childhood and how they would like to be as a parent, and they also became aware of who was in their network. Having a space to have these conversations or just having these topics addressed was appreciated. The following two quotes describe the positive experiences with the exercises in the MANU sessions: “All the exercises were so good. They help us to know each other better as a couple” (Mother 10) and “I feel the exercises trigger thoughts in my head” (Mother 11). Some participants would have liked to have received more guidance on how to nurture their relationship with their partner after birth. Many expected to receive more hands-on preparation in the MANU sessions, for example, on how to bathe or hold a baby. A few mothers mention that their male partner found MANU too theoretical and too much about feelings.

Many participants also sought information from books, the internet, Facebook groups (local groups for e.g. expectant mothers), smartphone applications (e.g. foetus development) and podcasts, such as the Greenlandic podcast on birth experiences ‘Ernineq’ (birth).

Discussion
This study aimed to investigate how parents’ notions and experiences of parenthood are reflected and challenged in MANU. Participants described in qualitative interviews and a Sharing Circle how they experienced a reprioritisation of their life in the transition to parenthood, for example, by having to set aside their own needs and rearranging their network. It was important to parents that their child experiences security and care, and some participants described this in relation to their own childhood. Through good co-parenting and setting boundaries, parents wished to raise their children to be respectful, confident and independent. After parents, grandparents were the most important familial relation to the child. In connection to this, community and togetherness stood out as the most important value in child-rearing. Conversations, advice and guidance from family members and friends were most often mentioned as a means to prepare for birth and parenthood. Additionally, conversations with midwives and MANU sessions were also used in preparation. Besides the relevant information and topics addressed in MANU, parents appreciated when they could learn from and listen to other parents. However, accessing MANU depended on the individual parent’s interest and abilities (e.g. in relation to work or personal hindrances) to attend sessions and read the MANU book.

A balance between awaiting and preparing
A period of unpredictability follows pregnancy and the transitioning to parenthood. Many participants described how the decision to become pregnant was unplanned, and only when they found out did they make the decision to keep the child, based on their current situation and their desire to have a child. MM Schlüter [37] discusses motherhood and unpredictability in an anthropological study conducted in Nuuk, Greenland. She identifies mothers’ approaches to the unpredicted events that come with pregnancy and parenthood as a Greenlandic narrative, in which the focus is on meeting life’s challenges with calmness and a sense of awaiting [37]. Accepting one’s situation as it comes and awaiting the unpredictable changes are common in an Arctic context, where Inuit people live close to nature. Greenlanders are often described as not planning far ahead or predicting different outcomes of a situation [37, 38], which stands in contrast to the external influence of urbanisation by which Greenlanders find themselves both resting in unpredictability while also adopting Western ways of having
expectations and predicting outcomes. As an Inuit elder from Canada pointed out, this does not mean “that Inuit never planned for the future. [...] We are here today because our ancestors made sure that we could survive. They did not live one day at a time. They made us into human beings right from birth.” [39].

In recent anthropological studies in Greenland, the desire to plan ahead, to control or predict outcomes was described by women and elders as being a very Danish trait [40, 41]. Educational sessions that inform and prepare for parenthood could be perceived as a more Western approach. Nevertheless, having access to public services is important to participants and the possibility to attend MANU is appreciated. But talking to family members and friends with experience was most prominently described to be a common way to prepare for birth and parenthood. This approach is similar to statements in a qualitative study on child-rearing in Greenland from 1989 by L. Zollner [42], in which parents described not looking up information but rather following their instincts and traditions.

**Family involvement in parenthood and child-rearing**

Ataatsimoorneq (community) as a value and providing toqqissisimaneq (security and care) are important aspects in child-rearing for the participants. Ataatsimoorneq and toqqissisimaneq are addressed in MANU within informational text or conversational exercises.

Toqqissisimaneq was defined as providing a secure home that is free of alcohol, hashish and violence and a home that is calm, stable, worry-free and has the child’s needs as a priority. Ensuring a secure and caring childhood is not an unusual desire in child-rearing. However, considering Greenland’s social challenges related to high misuse of alcohol and hashish resulting in adverse childhood experiences [43], it is striking that many participants name toqqissisimaneq and define it in this way. Some participants describe it in contrast to their own childhood experiences, while it is also important to know that these social challenges are a persistent focus within and about Greenland.

Cherishing ataatsimoorneq by dining together weekly with extended family members and that grandparents receive a significant role in child-rearing are Greenlandic traits also found in previous studies. Having a tight-knit network is common in Greenland. G. Tröndheim [44] studied Greenlandic kinship and found that modern Greenlandic families still value and nurture familial relations and community, despite adopting more Western ways of individuality. Furthermore, a recent study in a smaller Greenlandic community found that familial and community connections play an important role in pregnancy decision making [15].

Ensuring a secure and caring environment while also cherishing community and family involvement can be challenging for new parents. In the transition to parenthood, parents re-identify themselves and find themselves in an ambivalence of how to detach themselves from their family, especially their own parents, while also seeking their support. Additionally, breaking free from one’s own adverse childhood experiences is challenging [45]. This can, for example, relate to participants weighing their dissatisfaction with the environment they were raised in while recognising how valuable the child-grandparent relation is to both the child and themselves. Finding one’s way as a parent, reflecting on one’s own childhood, identifying the valuable relations in one’s network, and experiencing ambivalence in one’s relations to one’s own parents are topics addressed in the MANU book. They are addressed as an overall topic within an informational text and a conversational exercise, but how much these topics are discussed in detail depends on the facilitator of the session and the individual parent.

Other values in child-rearing which participants mention are caring, respecting their child and setting boundaries to raise independent and confident children with respect and love for their fellow human beings. In Sami culture, for example, raising an independent human being who contributes to the community is also a core value in child-rearing [46]. In Arctic regions, like Sápmi (Norway) and in Nunavut (Canada), the raising of a capable human being is deeply connected to their ways of knowing and the involvement of elders (grandparents). Therefore elders, language and culture play a central role in the Indigenous-led parenting programmes in Sápmi (Norway) and Nunavut (Canada) [17, 19, 21, 47, 48]. The similarities of cultural values among Indigenous populations in the circumpolar region [15] suggest opportunities for learning from each other’s parenting programmes and point out the need for investigating family involvement in child-rearing in Greenland more closely.

**Opportunities for MANU**

In the interviews, parents were able to provide suggestions and evaluate MANU’s material, delivery and accessibility. For a universal programme to be of value to parents, it should be accessible in a format and at a time that suits them [10]. This study’s findings provide implications for: i) revising the MANU book’s format, ii) the opportunity to highlight how MANU creates a space for expectant and new parents to reflect, iii) reviewing how MANU sessions can be offered more conveniently to parents and iv) examining ways to engage and integrate men.

The MANU book was barely used outside the sessions even though participants found it to be a useful resource. In addition, many described using other
informational resources such as smartphone applications, the internet and books on pregnancy, birth and parenthood. When considering revising the MANU book, it could be relevant to also draw inspiration from the Inunnguiniq parenting programme’s brochure [49] and the booklets on family connections, fatherhood, child-rearing and parenthood developed by the National Collaborating Centre for Indigenous Health and the Aqqiumavik Society [48]. Additionally, briefer and more convenient access to preparational information could also be delivered through smartphone applications and phone messages, while taking into consideration that not everyone has a private (smart) phone, and internet access is limited in some regions in Greenland.

Listening to the thoughts and experiences of other participating parents in the MANU sessions was highly appreciated by interviewees. While the topics addressed were generally useful and relevant, participants suggested including more practical knowledge, for example, learning how to bathe or hold a newborn. Including such elements in the sessions would also address the participants’ feedback on the importance of experiencing an active session. Relevant components for this could be found in the Inunnguiniq parenting programme in Nunavut (Canada), where land components are included [21]. It would also be relevant to explore Indigenous methods for communicating information and facilitating discussions. This could be through storytelling and Sharing Circles.

In the interviews, parents discussed whether MANU sessions should be offered at a different time than during work hours in order to increase attendance of men in particular. Participants had no clear opinion or idea of when it would be better for them to attend, since those who already have children, would have to find childcare for when the sessions are taking place after work hours. In comparison, the Inunnguiniq parenting programme provides childcare as a part of the programme for parents to be able to attend the sessions [21]. However, this requires and depends on local resources and the organisation of MANU sessions.

Not being able to attend sessions due to work is not the only reason mentioned for men not participating. Participants described how men in general have more difficulties with expressing their thoughts and reflections, while this is a focal point of the MANU programme. Additionally, male participants expressed a need to talk to men in the same situation and found an organised fathers’ group to be potentially useful. MANU could consider providing fathers’ groups or divide parents into groups in sessions to meet this need. Integrating a land-based component could potentially motivate more men to participate and possibly stimulate them to converse.

Even though most participants had not attended all MANU sessions, the opportunity to do so was appreciated. Based on participants’ experiences, the sessions can be described as a space away from daily tasks – a space where expectant parents take the time as a couple to reflect and discuss. This is a valuable opportunity to reach out to parents and support them, making it even more important that local facilitators have the necessary resources to create such a space through MANU.

Strengths and limitations
The broad number of participants from three different regions in Greenland and from both regional towns and smaller towns enabled a broad representation of parents, which supports internal generalisability [50]. Potential differences in participants’ perceptions based on location were not reported due to the small sample size and because adherence to the implementation of MANU varies between localities. Furthermore, participants’ reflections indicated that they had grown up with either different or similar resources. Finally, the authors have sought to present all perspectives equally to further strengthen internal generalisability of this paper [50]. Reaching such a high number of participants is, we suggest, due to collaborating with a Greenlandic interviewer (EJ), who engaged in recruitment, development of the interview guide and data collection. Collaborating with a Greenlandic interviewer also strengthened the validity of the study in two ways: First, the close collaboration and quality checks in translation and methods; secondly, by giving participants the opportunity to speak in their preferred language without interruptions, thereby ensuring more detailed responses.

The data collection was conducted during the first year of the COVID-19 pandemic. During that period, MANU sessions could not be offered as the programme intended, due to implemented restrictions to prevent infection. This has possibly influenced participants’ participation in and awareness of MANU. At the third study site, all participants had attended MANU, and more women than men had participated in this study. This could be a limitation regarding the degree of nuance in the presented findings.

Conclusion
Based on the parents’ perspectives presented in this study, we conclude that parents’ notions and experiences of parenthood are generally addressed in the parenting programme MANU, but the experience and attendance of MANU depends on how it is organised and offered locally. The conversational exercises in MANU challenged parents’ notions of parenthood, but only in the sessions that parents attended, since barely anyone used
the MANU book outside sessions. MANU has the possibility to create a space for parents to reflect and prepare. However, for MANU to be universal as intended and to reach both parents, the facilitation of sessions could be revisited, for example, with inspiration from other Arctic parenting programmes or making information accessible on multiple platforms to meet parents’ different ways of learning and accessing information. Next steps from this study are first to examine more deeply parents’ perspectives on the roles of their extended family in child-rearing and second identify the local opportunities and challenges of implementing MANU.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interest.

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Abbreviations
CBPR: Community-based participatory research; MANU: Meeraq Angajoqqaat Nuannaarneq – the Greenlandic parenting programme.

Supplementary Information
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Authors’ contributions
CI, CVLL, SK, TTT conceived and designed the study. CI and EJ conducted all data collection. Data analysis was conducted by CI with assistance from EJ and IO, and under the supervision of CVLL. CI drafted the manuscript. Critical revision of the manuscript was given by CI, IO, CVLL, SK, and TTT. All authors reviewed and approved the manuscript.

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Availability of data and materials
The datasets analysed during the current study are not publicly available due to the difficulty to de-identify qualitative data in a small population like Greenland, but data are available from the corresponding author on reasonable request.

Declarations
Ethics approval and consent to participate
The study has been performed in accordance with the Declaration of Helsinki and the Greenlandic Scientific Ethical Committee (Danish: Videnskabsetisk Udvalg) granted ethical approval of the project. Each participant was provided with an informed consent form in either Danish or Greenlandic, and the consent was explained. Participants signed the form to document their informed agreement and received a copy with contact details.

Additional file 1.
Additional file 2.
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Paper III
Parents’ perspectives on the role of kin in child-rearing: a qualitative study on Greenland’s universal parenting program

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Paper IV
Professionals’ Experiences with Local Implementation of the Greenlandic Parenting Programme MANU 0–1 Year

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Greenlandic maternal and child health initiatives

Indsatser, strategier og programmer på Mor-Barn området
(+ evalueringer og undersøgelser)

- Hjørterummet i Nuuk
- Tidlig indsats
- Midvægs-evaluering
- Status-rapport
- Status-rapport
- Status-rapport
- Status-rapport
- Status-rapport
- Status-rapport
- Status-rapport
- Status-rapport
- Manu

- Dukkeprojektet
- Evaluering
- Illumi
- Ilmi
- Småbørnskonsulent uddannelsen

- Screening for herelse, følelse, grønlandica genet i klinikken
- Screening for fødselsdepression

- Børnvaccinationer programmet
- Inuuneritta 2007-2012
- Midvægs-evaluering
- Inuuneritta II 2013-2019
- Midvægs-evaluering

- Caries strategien
- SILA - temaer om gravide og børn
- Born & Unge Strategien

- Nye perinatale retningslinje 2002
- Born og Unge Strategien

- IVACQ - Child cohort

Ruth's phd. 'Faces of Childbirth' 2003-2011
Policy brief based on Paper I in KAL and DK
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Allattut: Christine Ingemann (chin@sdu.dk) aamma Christina VL Larsen

Aallaqqaasiut

Nalunaarusiami uani siunertarineqarpoq MANU-p atuutilersinneqamera pillugu ph.d.-ngomiutigalugu suliami erniniusssat siulliit naatsumik saqquummiunneqarnissaat. Nalunaarusiaq danskisut aamma kalaallisut allanneqarpoq, ilisimatuussutsikkut allaaserisat talliuttumi taaneqartut tunngaviligalugit:


Aallarniutitut misissuineq ph.d.-ngorniutigalugu suliap, najukkani atuutilersitinermik aamma angajoqqaat angajoqqaajunermut isiginninnerannik, kiisalu MANU-mut peqataanerisa sammineqamerannik imaqartup, ineriartitneqarnarneraan tunngaviliisuuvoq.

Misissuinermut tunuliaqutaq


Periuseq


Tabeli 1. Paasisuttissanik katersuinermi nalunaarsuut aamma piffissaq atorneqartoq, aamma periutsit atorneqartut.

<table>
<thead>
<tr>
<th>Periutsit</th>
<th>Paasisuttissanik katersuinermi piffissaq</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paasisuttissanik misissuqqissaaarme</td>
<td>Nassuiaatit 30-t missaanniittut februari 2017 – decembari 2018</td>
</tr>
<tr>
<td>Ammasumik apersuinerit</td>
<td>Inuit pingaarutilimmik inissisimasut 14-it</td>
</tr>
<tr>
<td>Suleqatigissitaq peqatigalugu</td>
<td>Inuit pingaarutilimmik inissisimasut 14-it</td>
</tr>
<tr>
<td>Siiunertifanniskanik ogaluserinninneq</td>
<td>Inuit pingaarutilimmik inissisimasut 14-it</td>
</tr>
<tr>
<td>MANU-mik pikkorissartitsinernut malinnaaneq</td>
<td>Illulissai pikkorissameq ataaseq, sulisut 41-t</td>
</tr>
<tr>
<td>Najoqqutalerluni apersuinerit</td>
<td>Peqqinnissakut sulissinermik ilisimasallit arfineq-pingasut</td>
</tr>
<tr>
<td>MANU-mik ilinniartitsinernut malinnaaneq</td>
<td>Ilinniartitsinerit sisamat</td>
</tr>
<tr>
<td>Najoqqutat pingasut ataatsimoortilugit tunngavigineqarput (Damschroder allallu, 2009; Nilsen &amp; Bernhardsson, 2019; Plosek &amp; Greenhalgh, 2001), paasisuttissat katersorneqartut aqqissuunnissaannut aamma misisssoqqissaarnissaat tunngasunut atorneqarlutik. Najoqqutat tunngavigineqartut nassuaataat itinerusoq allaaserisami, nalunaarsiamut matumunanga tunngavigilugut, takuneqarsinnaavoq.</td>
<td></td>
</tr>
</tbody>
</table>

Inerniliussat

Tulliuttuni misissuinermi paasisat pingaarnernaat saqqummiuonneggassapput. Immikoortut tamarmik ineriartitsinernermut- aamma atuutilersitsinernum suliaaqarnermut tunngasunut immikkuualututunut assiqiinngitsunut tunngassuteqarpum. Immikkuualuttut assiqiinngitsut, misissuinermi pingaarnertut sammineqartut, takutissiaq 1-imi takuneqarsinnaapput.
1. MANU-p peqqinnissaqarfimmi inuiaqatigiinnilu aallartinnera


2. MANU-p ineriartortinneqarnare
MANU danskit siunnersuisarfluutaat Center for Forældreskab (siusinnerusukkut taaguuteqartoq God Barndom), angajoqqaangortuqatungut piareersarnermut neqeroorutunut uppemarsaasinnerrnik piareersunik aamma nammqarnut ilisimasaminnik tapertaasimasut, suleqatigilugit peqqinnissaqarfimmit 2016-imilu ineriartortinneqarpq. Taamaalilluni aqutsisutut suleqatiqissitaaq Center for Forældreskabimmit aamma Kalaallit Nunaanni Peqqinnissaqarfimmi emisussiorntumit misiliqtaqarluurtumpin inuttaqarpq (kimgna: MANU-mik ataqattiqissaruloq). MANU-p ineriartortinneqarnare tapersersorniarlugu suleqatiqissitamik aamma

3. MANU-p uppernarsaaserneqarnera aamam neqeroorutip annertussia


MANU-mut aortussaniit aamma imarisai

- Sulissaaqarfiimi sulillit ulituni pingasuni pikkorsartinnsassapput;
- Sulissaaqarfiimi sulillit ilinniartitsinnassamut ilitsersuummik, angajoqqaanngortussanut siunnerfimmik titartakkai videofilmik paasiatsuissetissutunik pingasuni aamma PowerPoinmmik takutlassatinan tuneqnasassapput;
- Angajoqqaat atuakkamik paasisulassanik aamma ogaloqatiginnissamut sungiussaatim inalmimmik tuneqnasassapput;
- Aortussat tamamnik kalaallitoortut daniisidooortul tunniuneeqassapput;
- MANU ilinniartitsinernik qulingiluanik nat. ak. 2.5-ikkaartunik imaqarpoq – arfinillit erninnissaq sioqqullugu, aamma pingasut emeeraerempun kingorna;
- Emusissiirtoot, peqqissaasut meeralerisut aamma peqqissunissamut ilortit MANU-mik ilinniartitsinnaapput;
- Neqeroorut ‘First 1,000 Days’ (Ullut siullit 1.000-it) pilugut ilisimuusuuqskut uppernarsaaasermimmik tunngaveqarpoq; MANU angajoqqaanermi pinnnaasasassat pilugut najoqjutit pingasuni tunngaveqarpoq; ii) eqqarsartaaseq aalasaavagulugu namminneq allallu qaanoq Iluuniussanik naammassinsinaaq (Shai & Belsky, 2011), ii) atuqveqarpoq (Bretherton, 1992), aamma iii) nammineq misigissutsinik paasinnillunilu, naleeqquartunilu aqutsisinniinaaq (Rutherford allallu, 2015).

Sulissaaqarfiimi sulillit apersemqartut amerlasut MANU-tut ittumik neqerooruteqarnerup iluaqtaanik takunnittut, aamma aarnaqqaput MANU-p imarisaitut, oqatsinut aamma annertussusianut tunngatilluluguluaqartunilu unammiligassaqermaneranik tikkuaasuut. Angajoqqaanut aortussaniit paasissutissanik


4. Sulissaqaraffimmi sulialnunut illiniartitsitsinnassamik siunnerfilimmik qitiusumik ataqatigissasairneq

Ernisuissiortoq suleqtigissitiititoq MANU-mik ataqatigissaarsissussatut toqgameqarpoq, aamma MANU-mik suleqtigiiinni aallartzillsiiluni, peqissisaasumik meeralerisumik aamma meeqatt ineriartomerannia pædagog-imik inutitilimmik, nuna tamakkerlugu ataqatigissarnernutik iiukuuttunik. Center for Forældreskab atuutilersitsinerup ingerlanneqarnnerani sul peqataatinqarpoq, neqeroorutip aallartinerqameranit ukiit siulllit marluk lingerlanerannia MANU-mik pikkorissartitsinerminik aamma MANU-mut atortussat sulli ineriartorteqqinnersiisiaanni suliaqarluni, MANU-mik suleqtigiiit peqatigalugul. Suleqtigissitaq naapertorlugu MANU-mut atortussat assiigisingitsut tulliutut ineriartortinerqarpoq, atortussat kalaalisoortut peqquinissaraffimmi aamma kommunini sulisut akornannit nukinginnartumik piuaneqarmater naammassiniarlugu.


### Tabeli 2. MANU-p atuutilersinneqamernatul nalunaarsuut, oktobari 2018-imilliiffik.

<table>
<thead>
<tr>
<th>Nunap immikkoortua</th>
<th>Illoqarfiit</th>
<th>Suliassaqarfirmik ilinniagallit</th>
<th>MANU-pikkorissarneq?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avannaq</strong></td>
<td>Qaanaaq</td>
<td>Peqqinnissamut iktori ataaqeq</td>
<td>Naamik</td>
</tr>
<tr>
<td>Ernisut 2017-imi</td>
<td>Upernavik</td>
<td>Peqqinnissamut iktori ataaqeq</td>
<td>Aap</td>
</tr>
<tr>
<td>154-it</td>
<td>Uummannaq</td>
<td>Peqqinnissamut iktori ataaqeq</td>
<td>Naamik</td>
</tr>
<tr>
<td><strong>Ilulissat</strong></td>
<td>Ermisiiortut marluk</td>
<td>Peqqissaaasut meeralerisut pingasut</td>
<td>Aap, tamamik</td>
</tr>
<tr>
<td>(qituusoirqafik)</td>
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<tr>
<td><strong>Aasiaat</strong></td>
<td>Ermisiiortut marluk</td>
<td>Peqqissaaasut meeralerisut marluk</td>
<td>Aap, tamamik</td>
</tr>
<tr>
<td>(qituusoirqafik)</td>
<td>Peqqinnissamut iktori ataaqeq</td>
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<tr>
<td></td>
<td>Suliassaqarfirmik suliallit kommunimeersut</td>
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<tr>
<td><strong>Qeqertasuuq</strong></td>
<td>Qeqertasuuq</td>
<td>Peqqissaaasq meeralerisq ataaqeq</td>
<td>Naamik</td>
</tr>
<tr>
<td>Tunua</td>
<td>Qasiqiannnguit</td>
<td>Peqqinnissamut iktori ataaqeq</td>
<td>Aap</td>
</tr>
<tr>
<td>Ernisut 2017-imi</td>
<td>Sisimiut</td>
<td>Ermisioortoq ataaqeq</td>
<td>Aap, tamamik</td>
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<tr>
<td>140-t</td>
<td>(qituusoirqafir)</td>
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<td></td>
<td>Peqqissaaasq meeralerisq ataaqeq</td>
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<td>Suliassaqarfirmik suliallit kommunimeersut</td>
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<td>Peqqinnissamut iktori ataaqeq</td>
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<td></td>
<td>Peqqissaaasq meeralerisut marluk</td>
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<tr>
<td><strong>Maniitsoq</strong></td>
<td>Ermisioortu 13-it</td>
<td>Suliassaqarfinni tamani sulisut affaat</td>
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<tr>
<td>(qituusoirqafik)</td>
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<td><strong>Paamiut</strong></td>
<td>Peqqinnissamut iktori ataaqeq</td>
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<td>Sermersooq</td>
<td>Suliassaqarfirmik suliallit kommunimeersut</td>
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<tr>
<td>Ernisut 2017-imi</td>
<td>Peqqissaaasq meeralerisq ataaqeq</td>
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<tr>
<td>347-t</td>
<td><strong>Tasilaq</strong></td>
<td>Ermisioortoq ataaqeq</td>
<td>Aap, tamamik</td>
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<tr>
<td>(qituusoirqafik)</td>
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<tr>
<td></td>
<td>Peqqissaaasq meeralerisq ataaqeq</td>
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<tr>
<td><strong>Ittooqortoomiit</strong></td>
<td>Sulisut attavigineqarsinnanagillat</td>
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<td><strong>Qaqortoq</strong></td>
<td>Ermisioortuq marluk</td>
<td>Suliassaqarfinni tamani sulisut affaat</td>
<td></td>
</tr>
<tr>
<td>Qajartaa</td>
<td>(qituusoirqafik)</td>
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<tr>
<td>Ernisut 2017-imi</td>
<td>Peqqissaaasq meeralerisq ataaqeq</td>
<td></td>
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</tr>
<tr>
<td>113-it</td>
<td><strong>Narsaq</strong></td>
<td>Ermisioortuq marluk</td>
<td>Aap</td>
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<tr>
<td></td>
<td>Peqqinnissamut iktori ataaqeq</td>
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<td>Naamik</td>
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<tr>
<td></td>
<td>Narsaq</td>
<td>Sulisut attavigineqarsinnanagillat</td>
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<tr>
<td></td>
<td>Nanortalik</td>
<td>Sulisut attavigineqarsinnanagillat</td>
<td></td>
</tr>
</tbody>
</table>

5. Suliassaqarfirmi suliallit atuutilersisinnissaannut najukkami atukkat apequttaapput

Suliassaqarfirmi suliallnut atortussat ilisartinninamerisat, aamma neqeroorummiq soqutiginnlersinniamerisa saniatigut suleqatigiissitap kisaaatigaa suliassaqarfirmi suliallit akunnerminni attaveqaqatigiiliissasut, taamaalliltikut MANU-mut tunngasunik ikoqatigiissinnaassallutik. Suliassaqarfirmi suliallit apersorneqrut uppermarsarpaat, pikkorissartisineq MANU pillugu akunnerminni attaveqaqatigiilemmissaminnnut periarfissaasoq pitsaasoq. Suliassamik inegerlatesiit aamma nunap ilaani sumiiffiit akunnerminni suleqatiginnat pingaarutilillettut MANU-mi suleqatiinnt isigineqarpoq, MANU in unnuk atasiakkaaginnarnik isumalluteqalernissaa ata pingitsoortinnissaa qulakkeerniarlugu.

Suliassaqarfirmi suliallit akornanni allannquinissamut piaerreismeexq atuutilersitsinernemut ikiuutaavoq, kisiannilti soorul MANU-mik ataqatigiissaraiqup apersorneqarnerminni erseqqissaatigiigaa, suleqatinit aamma najukkami aqutsisunit tapersersorneqarnissaa aamma taama pingaaruteqartigivoq. MANU-mik suleqatiqiigt nassuuppaat, suliassaqarfirmi sulust tunnisiumalluurlutik kisimiilliutlik illoqarfirmimmi MANU-mik suliaqartut, aamma sumiiffinni allannquinissamut piaerreisersinanerup aamma MANU-mik upperinninnerup appasininnerpaafini.
qanoq tapersersuiniarsaritiginerlutik. Tapersersuineq tamanna oqarasuaatikut oqaloqtiginittarmernik, atortussanik tunniussamernik, pikkorissarnissamik neqerooruteqartarnernik, Peqqinnissaqarfimmi aqutsisunik akuutlitserinnik, kajumissatinik atuinernik, imaluunniit sulisut amerlanerulersinnissaasa aningaasalersomissaanmunat nassaarniarnermunat tapersersuinernik ilaqarpoq.


Ataqatigiissitsineq


Inerniliussatut saqquimmuneqarqat Ph.d.-ngorniuqgalluq suliaami suteqatigisitut teqgieqalugu eqqartorneqarpq, aamna taakku tunngavigalugut misilittakkat oqaluuserineqareeneresigut 尔斯ersinneqarpq, ilisimasat taakku siunissami MANU-p atuutilersinneqarnunni ingerlateqquinersinnerni, aammna sulianassan assingusunut atorneqarnissaa siunertaralugut. Oqaluuserinnnerit eqiqkameqarsinnaapput, neqeroorutip qanoq ineriartinrneqarnissaanat aamna atuutilersinneqarnissaanut kissaatigineqartumut aqeqissuaanerun aamna atuutilersitsinermi nukissat aalaaqqaterpiannuq niliiliffigineqarsinmanisaaapa pingaaruteqassusiansik. Tikkuussisut suteqatigiissitamit oqaluuserineqarsimasut tassaapput:

Najoqcutat


26.03.2021

MANU-programmets fødsel og første to leveår set ud fra de fagprofessionelles perspektiv

Af: Christine Ingemann (chin@sdu.dk) & Christina VL Larsen

Indledning

Dette notat har til formål at give et kort overblik over de første resultater fra ph.d.-projektet om implementeringen af MANU. Notatet er skrevet på dansk og grønlandsk på baggrund af følgende videnskabelige artikel:


Den indledende undersøgelse har dannet grundlag for udviklingen af ph.d.-projektet, som har fokus på den lokale implementering af og forældres perspektiv på forældreskab og deltagelse i MANU.

Baggrund for undersøgelsen

Indenfor interventionsforskning beskrives det ofte, at interventioner ikke har den forventede effekt på grund af udfordringer i implementeringsprocessen (Damschroder et al., 2009; Durlak & DuPre, 2008; Fixsen et al., 2005; May et al., 2016). Implementeringsprocessen er afgørende for, hvorvidt en intervention skaber den tilsigtede ændring eller ej (Durlak & DuPre, 2008; Haines et al., 2004; May, 2013). I en artikelserie udgivet i 2017 om sundhedsfremme målrettet barnets tidlige udvikling, beskrives det, hvordan implementeringen af forældreprogrammer ofte er fragmenteret og mangler koordination (Black et al., 2017; Britto et al., 2017; Richter et al., 2017). Richter et al. (2017) konkluderer, at selv når det lykkes at koordinere indsatser på et overordnet niveau, så mangler koordineringen og implementeringen på det lokale niveau (Richter et al., 2017).

Derfor handler denne undersøgelse om netop implementering af MANU. Mere konkret har vi undersøgt, hvilke faktorer, der har muliggjort eller udfordret implementeringen af forældreprogrammet MANU 0-1 år i programmets første 2 år fra 2016-18. Projektet er initieret og udviklet i tæt samarbejde med en referencegruppe, som består af centrale sundhedsfaglige nøglepersoner fra både ledelses- og praksisniveau.

Metode

Tabel 1. Oversigt og tidslinje for dataindsamling og anvendte metoder.

<table>
<thead>
<tr>
<th>Metoder</th>
<th>Tidspunkt for dataindsamling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dokument analyse</td>
<td>Februar 2017 – December 2018</td>
</tr>
<tr>
<td>Åbne interviews</td>
<td></td>
</tr>
<tr>
<td>Fokus gruppe diskussion med referencegruppe</td>
<td>Oktober 2018</td>
</tr>
<tr>
<td>Observering af MANU-kurser</td>
<td>November 2018</td>
</tr>
<tr>
<td>Semi-strukturerede interviews</td>
<td>November 2018</td>
</tr>
<tr>
<td>Observationer af MANU-undervisning</td>
<td>December 2018</td>
</tr>
</tbody>
</table>

Tre teoretiske perspektiver blev kombineret i en samlet teoretisk ramme (Damschroder et al., 2009; Nilsen & Bernhardsson, 2019; Plsek & Greenhalgh, 2001), som blev anvendt til at strukturere og analysere de indsamlede informationer. En mere omfattende beskrivelse af den teoretiske ramme findes i artiklen, som ligger til grunde for dette notat.

Resultater


Figur 1. Overblik over de forskellige elementer af udvikling og implementering identificeret i undersøgelsen.
1. MANUs fødsel i sundhedsvæsenet og i samfundet

Det første universelle forberedende program for gravide i Grønland var Klar til Barn (KTB). Klar til Barn tog udgangspunkt i den danske Social- og Servicestyrelses kursuskoncept Klar til Barn. KTB blev implementeret i 2009 og evalueret i 2012. Evalueringen havde til formål at gøre status på om alle gravide familier fik undervisning og om undervisningen dækkede behovet for at styrke forældrenes kompetencer. Evalueringen pegede på følgende udfordringer i implementeringen af KTB: 1) at introducere materiale/konceptet til det undervisende fagpersonale, 2) rekruttering af forældre, 3) tilpasning af materialet til de forskellige kontekster og forældres behov, 4) at afholde gruppeundervisning til både ressourcestærke og mindre ressourcestærke forældre samtidig, og 5) at kunne afholde alt undervisning af det fulde program.

Udfordringerne nævnt i KTBs evaluering fra 2012 blev også nævnt og uddybet i samtaler med de forskellige nøglepersoner involveret i MANUs udvikling. KTBs evaluering resulterede i at både Departementet for Sundhed og Departementet for Sociale Anliggender ikke længere støttede KTBs videre udvikling, som fremgår af §37 spørgsmål og samtaler med MANU-koordinatoren. På trods af dette nedsatte Sundhedsledelsen i 2014 en arbejdsgruppe til at videreudvikle KTB, men uden finansiel støtte. Et §37 spørgsmål bragte manglen af et forældreforberedelsesprogram på den politiske dagsorden og førte til, at der blev afsat penge i finansloven til KTB.

2. Udviklingen af MANU


3. Evidensen bag MANU og programmets omfang


MANU 0-1 tilbyder undervisning til alle kommende forældre i perioden, fra moderen opdager hun er gravid, til barnet bliver 9 måneder; i alt 9 undervisningsgange (God Barndom, 2016; Ingemann et al., 2019). Som anført i MANUs manual har programmets formål i) at give forældre mulighed for at udvikle deres egen forældrestil, ii) forhindre, at forældre, der er opvokset i et utrygt hjem, gentager dette over for deres eget barn, iii) at forældre får adgang til et netværk af forældre, og iv) at begge forældre deltager på lige fod dvs. at faderen er involveret lige så meget som moderen. Boks 1 giver et overblik over programmets omfang.
Mens mange af de interviewede fagpersoner så en fordel i at have et program som MANU, var der også nogle som pegede på mulige begrænsninger og udfordringer ift. MANUs indhold, sprog og omfang. Der blev nævnt behov for mere praktiske informationer i materialet for forældre (fx amning). MANUs layout og det at begge sprog er tilgængelig samtidig blev udpeget som en styrke. Nogen syntes at materialet var nemt at læse, mens andre nævnte at de var bekymrede for, om indholdets niveau var for højt for nogle befolkningsgrupper. MANUs omfang blev også diskuteret og nogen steder i landet havde man samlet de ni undervisningsgange til fire undervisningsgange, eller afholdt undervisningen på en time frem for 2,5 timer.

Muligheden for at afkorte MANUs omfang blev afvist af arbejdsgruppen, da man forventede at afvigelser fra manualen ville have indflydelse på programmets succes. Dette er også beskrevet i MANU-manualen hvor det dog er tilføjet, at afvigelser fra gruppe til individuel undervisning og tilpasning til forældres behov er acceptabelt. MANU-manualen har været et afgørende element i udviklingen og implementeringen af programmet ifølge arbejdsgruppen, da manualen muliggør at en hver fagperson kan afholde undervisningen, hvad enten man har været på kursus eller ej. Nogle fagpersoner, som deltog i herværende undersøgelse, gav udtryk for at manualen var anvendelig og nem at bruge.

4. En central koordinering med fokus på uddannelse af fagpersoner

Jordemoderen i arbejdsgruppen blev udnævnt til koordinator for MANU og oprettede et MANU-team bestående af en sundhedsplejerske og en pædagog i børneudvikling, som assisterede med den nationale koordinering. Center for Forældreskab var fortsat en integreret del af implementeringen ved at afholde MANU-kurser og udvikle yderligere MANU-materiale sammen med MANU-teamet i løbet af programmets første to leveår. Ifølge arbejdsgruppen blev de forskellige efterfølgende MANU-materialer udviklet for at imødekomme den presserende undersøgelse, gav udtryk for at manualen var anvendelig og nem at bruge.

Implementeringen af MANU har siden 2016 været finansieret gennem finansloven. Rejusedgifterne for fagpersoner, som deltog i MANU-kurser, blev i de første to år primært finansieret igennem MANU. Deltagere fra interviews og fokusgruppediskussionen diskuterede sårbarheden overfor kursusmodellen, hvor fagpersoner skal rejse til en by for at deltage i et tredages kursus. Den store personaleudskiftning vil kræve gentagne uddannelse af nye medarbejdere, som skal overtage MANU, og dermed gentagne omkostninger i forhold til afholdelse af kurser og fravær af medarbejdere på arbejdspladsen under kursusopholdet. Herpå responderede arbejdsgruppen med en igangværende planlægning af et online kursusprogram.
Tabel 2. Oversigt over MANUs implementering, status oktober 2018.

<table>
<thead>
<tr>
<th>Region</th>
<th>Byer</th>
<th>Fagpersoner</th>
<th>MANU-kursus?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avanna</td>
<td>Qaanaaq</td>
<td>1 Sundhedsassistent</td>
<td>Nej</td>
</tr>
<tr>
<td>154 fødsler i 2017</td>
<td>Upernavik</td>
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<td>Ja</td>
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<td>Nej</td>
</tr>
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<td>Ilulissat (regions by)</td>
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<td>Aasiaat (regions by)</td>
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</tr>
<tr>
<td></td>
<td>2 Sundhedsplejersker</td>
<td></td>
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<td></td>
<td>1 Sundhedsassistent</td>
<td>Kommunale fagpersoner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Qeqertarsuaq</td>
<td>1 Sundhedsplejerske</td>
<td>Nej</td>
</tr>
<tr>
<td></td>
<td>Qasigiannguit</td>
<td>1 Sundhedsassistent</td>
<td>Ja</td>
</tr>
<tr>
<td>Qeqqa</td>
<td>Sisimiut (regions by)</td>
<td>1 Jordemoder</td>
<td>Ja alle</td>
</tr>
<tr>
<td>140 fødsler i 2017</td>
<td>3 Sundhedsplejerske</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Maniitsoq</td>
<td>1 Sundhedsassistent</td>
<td>Ja alle</td>
</tr>
<tr>
<td></td>
<td>2 Sundhedsplejerske</td>
<td>Kommunale fagpersoner</td>
<td></td>
</tr>
<tr>
<td>Sermersooq</td>
<td>Nuuk (regions by)</td>
<td>13 Jordemødre</td>
<td>Halvdelen af hver personalegruppe</td>
</tr>
<tr>
<td>347 fødsler i 2017</td>
<td>Paamiut</td>
<td>7 Sundhedsplejersker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tasiilaq</td>
<td>1 Jordemoder</td>
<td>Ja alle</td>
</tr>
<tr>
<td></td>
<td>1 Sundhedsplejerske</td>
<td>Kommunale fagpersoner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ittoqtoortoomit</td>
<td>Ikke tilgængeligt personale</td>
<td></td>
</tr>
<tr>
<td>Kujataa</td>
<td>Qaqortoq (regions by)</td>
<td>2 Jordemødre</td>
<td>Ja</td>
</tr>
<tr>
<td>113 fødsler i 2017</td>
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<td></td>
<td>Narsaq</td>
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<td>Ja</td>
</tr>
<tr>
<td></td>
<td>Nanortalik</td>
<td>Kommunale fagpersoner</td>
<td>Nej</td>
</tr>
</tbody>
</table>

5. Fagpersoners mulighed for implementering er betinget af lokale forhold

Udover at introducere fagpersoner til materialet og vække deres interesse for programmet, ønskede arbejdsgruppen også at fagpersonerne vil få et netværk på tværs som de kunne samarbejde med omkring MANU. Interviewede fagpersoner bekræftede, at de oplevede kurset som en god mulighed for at etablere tværgående netværk omkring MANU. Samarbejdet på tværs af sektorer og regioner blev anset som et vigtigt element af MANU-teamet i forhold til at sikre at MANU ikke skulle ende med at være for personafhængigt. Forandringsparathed blandt fagpersonerne understøttede implementeringen, men som MANU-koordinatoren påpegede i et interview, er støtte fra kollegaer og den lokale ledelse mindst lige så vigtig. MANU-teamet beskrev, hvordan de tilstræbte at støtte både de engagerede fagpersoner som stod helt alene med MANU i deres by, og de steder hvor forandringsparatheden og troen på MANU generelt var lav. Denne støtte omfattede telefonsamtaler, levering af materiale, tilbud om at afholde kurer, inddragelse af Sundhedsledelsen, anvendelse af incitamenter, eller støtte til at finde finansiering til en højere normering.

MANU-koordinatoren nævnte at nogle regioner eller byer ikke anså det som muligt at implementere MANU. Dette blev begrundet med udfordringer som høj arbejdsbyrde, normering og manglende ledelsesopbakning, som førte til at man valgte at afkorte MANUs omfang, som tidligere beskrevet. Disse udfordringer blev også nævnt af
interviewede fagpersoner, som noget de forventede at opleve eller allerede oplevede. Enkelte påpegede vigtigheden af at have enten ledelsen eller en idsjæl til at vise vejen for implementeringen.

Forældrene, som er modtagere af MANU-programmet, er afgørende for om implementeringen lykkes i sidste ende. Ved udviklingen af MANU blev forældrenes behov vurderet på baggrund af international litteratur og grønlandske studier, der viser, at et stort antal børn vokser op med belastninger i barndommen. I løbet af de observerede kurser, interview med fagpersoner og i drøftelser med referencegruppen blev rekrutering og fastholdelse af forældre til MANU-undervisningen gentagende gange diskuteret. Samtidig understregede en sundhedsplejerske i et interview, at ’det tager tid før MANU bliver noget gravide og fædre helt naturlig vil deltage i’.

**Perspektivering**

MANU blev født ud af en kontext hvor der var både politisk og sundhedsfagligt interesse i at styrke forældres kompetencer med henblik på at øge trivslen blandt børn og familier generelt. På de første to år er MANU-teamet nået langt med programmets nationale udrulning. I MANUs første to leveår har der især været fokus på formidling af programmets materiale, uddannelse af fagpersoner og udvikling af yderligere MANU-materiale. MANU-teamet bestræbte sig på at imødekomme behovet for grønlandsk forældremateriale og sikre, at så vidt muligt alt relevant fagpersonale deltog i kurset.

De præsenterede resultater er blevet drøftede med Ph.d.-projektets referencegruppe, og erfaringer draget på baggrund af disse blev diskuteret med henblik på at bruge denne viden fremadrettet i den videre implementering af MANU og lignende initiativer. Drøftelserne kan sammenfattes til at det er vigtigt helt fra start at vurdere systemets og kontekstens implementeringskapacitet, som programmet ønskes udviklet og implementeret i. Pointer drøftede af referencegruppen var:

- **Medtænke organisationens struktur og kapacitet når programmet udkiles og implementeres inden den endelige politiske beslutning og inden programmet udrulles nationalt.**
- **Sikre at arbejdsgruppen har de nødvendige kompetencer (fx viden om implementeringsprocesser) og ressourcer til at varetage udviklingen og implementeringen af programmet.**
- **Kortlægge og vurder hvilke andre indsatser programmets materiale skal eksistere sammen med eller evt. erstatte.**
- **Fortsætte samarbejdet med reference- og styregruppen fra udviklingen af programmet til under implementeringen for løbende at kunne drøfte udfordringer i implementeringen og evt. revidering af programmet.**
- **Tidligere inddragelse af kommunale samarbejdspartnere for at understøtte samarbejde og ejerskab af programmet på tværs af sektorer fra begyndelsen.**


Litteratur


Policy brief based on Paper II in KAL and DK
Naartunermiit angajoqqaanngornermut tunngatillugu angajoqqaat eqqarsaatersuutaat, aamma angajoqqaanngornissamut piareersaat MANU pillugu misilittagaat

Allattut: Christine Ingemann (chin@sdu.dk), Ingelise Olesen & Christina VL Larsen

Misissuinermut tunuliaqutaq


Sammisanut attuamassutillinnut tunngatillugu angajoqqaat ataaasikkaat isummersuaataat MANU-mik


Sammisanut attuamassutillinnut tunngatillugu angajoqqaat ataaasikkaat isummersuaataat MANU-mik


Misissuinermi paasisat

Tulliuttumi misissuinermi paasisat pingaarnerpaat allaaserineqassapput, sammisanut tallimaasunut ukununngaa aggutaaameqartut: 1) angajoqqaanngortussanngorneq, 2) toqqissisimaneq, 3) ataatsimoorneq, 4) ernissamut angajoqqaanngornissamullu piareersarneq, aamma 5) MANU-mik tunnuussisarneq.
Naartunissamik aalajangerneq
Peqataasuq angajooqaujinnassut aqangakqerqan aalajangerneq. Angajooqaqajunissamik aalajangerneq tukkulluqeq aallukkan centralia aallajarneq tarperssormeqa." (Ataataq 4)

1. Angajooqaan gortussanngor neq

Angajooqaqajunissamik aalajangerneq Peqataasuq angajooqaujinnassut aqangakqerqan aalajangerneq. Angajooqaqajunissamik aalajangerneq tukkulluqeq aallukkan centralia aallajarneq tarperssormeqa." (Ataataq 4)

Aningaasaqarnissarput eqqaarsaarnissat

Meeqqap pilersorsinnaa aama, meeqqaminnut tunniukkusullugu pingaartinnerpaartaasa ilaat tassaavoq toqqissisimaneq. Toqqissisimaneq peqataasuq aalajangerneq tukkulluqeq aallukkan centralia aallajarneq tarperssormeqa." (Ataataq 4)

2. Toqqissi-simaneq

Angajooqaqajunissamik aalajangerneq Peqataasuq angajooqaujinnassut aqangakqerqan aalajangerneq. Angajooqaqajunissamik aalajangerneq tukkulluqeq aallukkan centralia aallajarneq tarperssormeqa." (Ataataq 4)

3. Ataatsimoorneq

Angajooqaqajunissamik aalajangerneq Peqataasuq angajooqaujinnassut aqangakqerqan aalajangerneq. Angajooqaqajunissamik aalajangerneq tukkulluqeq aallukkan centralia aallajarneq tarperssormeqa." (Ataataq 4)
Allat misigisaannik tusarnaarneq
Peqataasut erninissaminnut angajooqqaangornissaminnullu nalinginnaasumik anaanamininnik, qatangrutmininnik, iluqatamininnik imaluunniit ikkungutmininnik ernereerisesamunik oqaloqateqartanermikkuq piareersartarpit.


Meeqqap atugarissaamissaa aamma perorsamissaa pillugut nalominermi siunnersomeqarnissamut ittsersomeqarnissamullu peqataasut atassuteqarfiq pingaaruteqarpit. MANU-mut peqataanermi angajooqqaangortussat allat misilittagaanq aamma MANU-mi samminteqartut pillugut siummersuutanaanq limilirgisiinanerat amerlasuunit iluarineqarpoq.

"Angaqooqqaangortussat allat naappillugut nuannerpoq, aamma angajooqqaannermik misilittagaqaraersut. Tikilluauqasaaasutut misigisimanarqonjavuqin mugoppaa, aamma naapeqatigisakka sunk avitsaqatigisinnaanerluguq kileqartutut misigisimanngilang." (Anaanaq 3)

Eqqarsaalit misigisussutillu pillugut aappariittut oqaloqatigiinneq ilaannut nudaajuvoq, ilaannullu taamaananni. Angult tunuursimaartutut imminnut oqaluttuaripput, aamma attaveqarfigisartakpanunt siunnersomeqarnissamik ujartuinissamininnik ajormusortiitluutik, naqk ataatat allat taama misigisaqartut oqaloqatiginnisaat pisirajaqartikkalurflugu.


Pisortaniit neqeroorutit

MANU-muq peqtaasimutsat ataatatsimut isigalugul neqeroorumuuk iluqarimaarinninertik oqaluttuarivaat.

"MANU pitsaaasuuvq. Isumaqarpunga naartusut tamamik peqataaffigisariaqarluuraka. MANU iluaqitiluguruq kisimittut puutseerveersiinartalutunniit misigisimanngiit." (Anaanaq 9)

Angajooqqaangornissamut aappariittit piareersamemrut MANU suligut ilaqaqutasimarnerq ataataasup ataatipsi ima oqqaasertalerrpaq:

"Piareersamitsinnut ilaqaqutasorsorjussuuvq. MANU-mi oqaloqatigilmurpet angerlarsimaffimitni oqaloqatigiltarntaininni allaaneruvuq. Aamma marulllluta ataatsinut piareersarsinnaanerput nuunaarutigisorjussuura." (Ataataq 1)
5. MANU-mik tunnissisarne

MANU-p pissaarsiariumnassua


"Sulinunep naalaniingittisutput peqataasarsimassagaluarpunga. Naartunermua naalaq suillinni kinillerassutaka kissaitqimagavara, emnininnut ataiilluqtu angingaarsisassakka amerlaneriuussammuta." (Anaanaq 8)

Pindaartik anguitul umiuissartik pissaarlutigalugu MANU-mut peqataaaneq ajorput, aammali MANU-mik soqitqiniinninaartik pissaarlutigalugu, ataataasup atatsip nassuaanerutut:


MANU-p annterussua


Aamerlaasut akulikitiskim MANU-mik illiniartinsinni uterpet peqataaaneq ajorput, aammali MANU-mik soqitqiniinninaartik pissaarlutigalugu, ataataasup atatsip nassuaanerutut:

MANU-p imarisaa


Abunnyurtik, aamngaa suqitqiniinninaartik pissaarlutigalugu, ataataasup atatsip nassuaanerutut: 

"Sulinerup nalaaniingittisutput peqataasarsimassagaluarpunga. Naartunermua naalaq suillinni kinillerassutaka kissaitqimagavara, emnininnut ataiilluqtu angingaarsisassakka amerlaneriuussammuta." (Anaanaq 8)

Peqaaqatut tamurlunangajammik MANU-mik illiniartinsinni uterpet peqataaaneq ajorput, aammali MANU-mik soqitqiniinninaartik pissaarlutigalugu, ataataasup atatsip nassuaanerutut:


Allaaserisanik allanik siiqussineq

Angaajeqaat nammineq pisiaqeqattitatik tunullilugut, aamngaa attasuteqarflitik allangortillugut, aamngaa suqitqiniinninaartik emnissiurtiomin, tixunersimenu allangunguissaaq allangunguaatqeq maniimput. Meererisap toqogsissiinnerermik aamngaa aqayrianiartamiqarput aqeqqeqeqamissuutuni aqilamarnersoq pillugut angaajeqaat

Abunnyurtik, aamngaa suqitqiniinninaartik pissaarlutigalugu, aamngaa suqitqiniinninaartik pissaarlutigalugu, ataataasup atatsip nassuaanerutut:

"Sulinerup nalaaniingittisutput peqataasarsimassagaluarpunga. Naartunermua naalaq suillinni kinillerassutaka kissaitqimagavara, emnininnut ataiilluqtu angingaarsisassakka amerlaneriuussammuta." (Anaanaq 8)
soqutiginninnerat aamma ilinniartitsinermut peqataanissaminmut aamma atuakkap MANU-p atuarnissaanut periarfissaqussissiat (ass. sulifik imaluunniit inuttut pisinnaajunnaernerit) apequtaapput.


Ismannaastumak isumassuqfuusilunliq avatanguisegarmiik qalukkeennisan, illutigilugulu angajoqqaajunernut illersornissaa aamma ilaqquttit ilaatininnissaat angajoqqaangnorlanan unammiqerluqmarluninnaavoq. Angajoqqaajunernut ikaarsaamernmi angajoqqaat inississiqginninninni nutamaq iminnunattu nasaariniqaaqasassutut, naminnneqqeq angajoqqaarqarsanit allaanerumusik ililorursullutilli taakkununannaq tapersersoomeqanissamik siunnersoomeqanissamilluni piqariatititilununi ajornakusoosinnalluni. Ataatsimoorneeq, toqquisammeneeq, angajoqqaauq aqtimmik nasaarinnarlut, naminnneeq meeraasiminemaner eqqarsatginissaa, aamma attassuteqarfiit nasaariqsaatat tasaapput sammisat MANU-mi sammineqartartut. Sammisat allaaserisatigut paassissutissinnertut aamma imaluuniq qalooqoqillununi suugiaartenut atorlugit aattsamismut isigatuqeqatirim sammineqartartut, kiisanni sammineqartartut taakkukalodilrugut oqaluatitsimminnan aamma angajoqqaat ataaasikkaat apequtaasaartut.

**MANU-p siunissami atornissaanant inassuteqaatit**


**MANU-mi ilinniartitsinermuq angajoqqaanik peqataasunik allanik tusamaarneeq angajoqqaanit iluariaqraaqanqqaarpoq. MANU-mi sammineqartut ilaqaqtaalullutilli naleqquqkaluarut angajoqqaat illisimasanik timitienerumik pissaarigarnisaminnik kisaaatqarput, asserssuqalugul inorlarneeq uffaaeq imaluunniit.**


Sulineeq pissutigalugu iniinartitstinermut peqataasinnessaanneq angutit peqataaneq ajormenanntu kimisi pissutaasutut oqaatigineqangitloga. Angutit ataatsumut isigalugut eqqarsaatiinnimik isummmamimmilu oqaatiginnissanenimmuk ajornakusoortisiasartarput pillugu peqataasut nussiuappat, tamannalu MANU-mi qituluvut. Tamatumu sanatigatiiq angutit peqataasut angutinikuq namminneq inississimaffimmissut inississimaffeqartunnik allanik oqaloqarnissamak pisariaqartitstililit oqaatigivaat, aammalu aqqqissuussamik ataatat naapeqatigitjattarfalerinnaannertat isigisinnallugu. MANU ataatanut naapeqagitjittarfimmik neqernoorteqarlunu misiliisinnavaaq, imalununut pisariaqartitstineq tamanna matsussuserniiarlugu iniinartitstinerup naalani angajuqqaat eqqamanutat aggutaarsinnaanallugu. Iniinartitstinnermi pinngortitamik aamma timitaliinernik ilangngussineq immaq paqogutit angutit amerlanerusut peqataasinnessamak kajumissuseqalerstitsisinnavaaq.


Periuseq
Allakkiaini matumuni siunertarineqartoq tassaavoq ph.d.-nnngomiutigalugu sulinummi angajuqqaanik, angajuqqaangomissamut piareersaammi MANU-mi peqataasimasunik aamma peqataasimannngitsunik, apersuerinit naatsumik saqqqummiunneqarnissaaq. Allakkiaq illisimatuussutsikkut allaaserisaq talluuttumi taaneqartoq tunngavigalugu dansikusit kalaallisullu allannaqarpoq:  

Side 6 af 8
Angajoqqaanik itsiliilluni apersuinerit nunap immikkoortuuni qitiusumik peqqinnissaqarfinni toqqaameqartuni pingasuni ingerranneqarput, pingaarnertut nunap immikkoortuuni illoqarfinni apersuinerit ingerrallutigit, illoqarfinni mikinerusuni aamma nunaqarfinni apersuinerit oqarasuaatikut ingerranneqarlutik, imalunnuit naartutsut ernissaminnut atallitugu nunap immikkoortuuni qitiusumik peqqinnissaqarfimminneranni ilannunguneqarlutik.


### Tabel 1. Apersuinerit pillugit takussutissiaq.

<table>
<thead>
<tr>
<th>Nunap immikkoortua</th>
<th>Sumillik</th>
<th>Aapparrinnik apersuineq</th>
<th>Amanik ataaasiakkaaniq apersuineq</th>
<th>Angutinik ataaasiakkaaniq apersuineq</th>
<th>Angutit peqatigalugit Immersoqatigilfussumik Isummersoqatigilfussumik</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>1 GL</td>
<td>4 GL, 2 DK</td>
<td>2 GL</td>
<td>/</td>
</tr>
<tr>
<td>Illoqarfik imaluniit nunararfik</td>
<td>/</td>
<td>3 GL</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>3 GL; 1 DK</td>
<td>8 GL</td>
<td>/</td>
<td>1 GL angutit pingasut peqatigalugit</td>
</tr>
<tr>
<td>Illoqarfik imaluniit nunararfik</td>
<td>1 GL</td>
<td>1 GL</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>4 DK</td>
<td>3 GL, 6 DK</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Illoqarfik imaluniit nunararfik</td>
<td>/</td>
<td>2 GL</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

GL tassaaavoq kalaallisut apersuineq aamma DK danskisut apersuineq.

### Tabel 2. Peqataasut ilisamaaasumnit takussutissiaq.

<table>
<thead>
<tr>
<th>Nunap immikkoortua</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
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<td>13 Aap</td>
<td>7 Aap</td>
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<td>9 Naamik</td>
<td>11 Naamik</td>
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<td>22 Aap</td>
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<td>MANU-mik atuartitsinernut peqataasimasut</td>
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<tr>
<td>4 Naamik</td>
<td>9 Naamik</td>
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**Najoqquitat**


Forældres refleksioner fra graviditet til forældreskabet og deres oplevelser med forældreforberedelsesprogrammet MANU

Af: Christine Ingemann (chin@sdu.dk), Ingelise Olesen & Christina VL Larsen

Baggrund for undersøgelsen

Det foregående notat pegede på behovet for at undersøge forældres perspektiver på MANU, men også mere grundlæggende hvad forældres syn er på forældreskab og opdragelse. For at et program kan implementeres med succes, er det vigtigt at medtænke forældres behov og ressourcer.


Enkelte forældres perspektiver på relevante emner blev indsamlet under udviklingsprocessen af MANU, men det er fortsat usikkert, hvordan MANU imødekommer forældres behov generelt. Derudover viser tidligere undersøgelser i Grønland vigtigheden af at integrere kultur, værdier og lokal praksis i Grønlands sundhedsfremmende og forebyggende indsatser samt sundhedsvæsenet (Olesen et al., 2020; Rink et al., 2021; Aagaard, 2017). Derfor er det vigtigt at sætte fokus på forældres perspektiver og erfaringer for at forstå MANUs implementeringsproces, hvad der hindrer eller understøtter implementering, og om programmet har potenti et til at opfylde sit tilstande. Først ved at undersøge forældres erfaringer med overgangen til forældreskabet og deres værdier i børneopdragelse. Derefter ved at sammenligne disse erfaringer med MANUs indhold og deres deltager i MANU. Projektet er initieret og udviklet i tæt samarbejde med en referencegruppe, som består af centrale sundhedsfaglige og kommunale nøglepersoner fra både ledelses- og praksisniveau.

Undersøgelsens fund

I det følgende gives et overblik over undersøgelsens vigtigste fund, som er samlet under følgende fem emner: 1) på vej til at blive forældre, 2) toqqissismaneq – tryghed, 3) ataatsimoorneq – fællesskab, 4) forberedelse på fødsel og forældreskab, og 5) leverancen af MANU.

**1. På vej til at blive forældre**

**Beslutning om graviditet**

Deltagere havde lignende såvel som forskellige udgangspunkter for forældreskab, hvor nogen tog det som det kom, andre havde beslutet sig for at blive gravid inden, og for nogle deltagere kom graviditeten uventet. Støtten fra deres partner og forældre har været vigtig, især når barnet var helt uventet.

**Overgangen til forældreskabet**

For alle deltagere er overgangen til forældreskabet en stor omvæltning, hvor de går fra et frit ungdomsliv til et livslangt ansvar.

"Man får et stort ansvar efter fødslen, som man skal have resten af livet. Det var måske det, der har været det mest overvældende for mig." (mor 4)

Overgangen har også ført til bevidste livsstilsændringer i form af at begrænse eller afstå fra alkohol, eller at komme ud af et misbrug.

**Økonomiske muligheder**

At kunne forsørge barnet og sikre at barnet ikke mangler noget nævnes af mange deltagere. Den vigtigste forberedelse er at købe de nødvendige praktiske ting til barnets ankomst (f.eks. tøj, barnevogn). Ydermere diskuterer mange vigtigheden af at have et arbejde, afslutte en uddannelse og flytte i egen bolig. Sidstnævnte er dog et spørgsmål om lange ventelister.

"Der er kun tilbud på lejligheder ved [byområde]. Det egnner sig ikke at bo der, når man har fået et barn. Der bliver drukket, og de skændes. […] Vi vil ikke bo der." (far 3)

"Det er mærkeligt at forestille sig, at vi bliver en familie, mens vi stadig bor hos hans forældre." (Mor 6)
2. Tøqqissimaneq – tryghed

Tøqqissimaneq (tryghed) er noget af det vigtigste for forældre de vil give til deres barn. De fleste deltagere beskriver det som et trygt miljø, som er fri for alkohol, hash og vold, men det omfatter også et roligt hjem, stabilitet, prioritering af barnets behov og fri for bekymringer. Det ønsker deltagerne at opnå ved at give kærlighed, omvåb og, og ved at kunne tale om det der kan være svært. Nogle deltagere beskriver tryghed i forhold til deres egen barndomsoplevelser, hvor alkohol har fyldt en del i deres hjem:

"Det er det værste man oplever i sin barndom. Når forældrene drikker sig fulde, så forandrer de sig fuldstændig. […] Det er barskt og utrygt." (far 2)

Forældre ønsker at skabe et stabilt hjem med rutiner og grænser, hvor deres børn lærer vigtigheden af at gå i skole, være selvstændige, få selvstødt og lære at være åbne og nysgerrige på livet. God kommunikation og respekt var også vigtige værdier.

3. Ataatsoomorneq – fællesskab

Ataatsoomorneq (fællesskab) fremgår som en overordnet vigtig værdi for barnets opvækst blandt deltagerernes beskrivelser. Fællesskabet opstår i samvær med familiemedlemmer og personer i ens nærmeste netværk. Fællesskabet formes ved at lære om ens forfædre og kende til ens familierelationer, at man samles til højtid og at spise sammen jævnligt. Oplevelser i fællesskabet er noget, deltagerne husker tilbage fra deres egen barndom og ønsker at videregivne til deres barn. At nyde naturen med familien ved at sejle, plukke bær eller gå på jagt er også en vigtig oplevelse som de ønsker at overlevere.

Fællesskabet eksisterer også på afstand, når fx bedsteforældre ikke bor i samme by, så er det vigtigt at barnet kender til dem og at familiemedlemmer følger med i barnets udvikling gennem beskeder eller videocald på trods af afstanden.

4. Forberedelse på fødsel og forældreskab


"MANU er en god ting. Jeg synes alle grave allid deltage i det. Med MANU føler man sig ikke alene eller forvirret" (mor 9)

En far beskriver, hvordan MANU hjælper dem med at forberede sig til forældreskabet som par:

"Det har hjulpet os meget. Vores samtaler i MANU er anderledes end derhjemme. Og det, at vi to kan forberede os sammen, det er noget, jeg har været meget glad for." (far 1)

Offentlige tilbud


"MANU er en god ting. Jeg synes alle grave allid deltage i det. Med MANU føler man sig ikke alene eller forvirret" (mor 9)

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sammentrængt med andet litteratur

Det er en stor omvæltning for forældre at skulle omsætte deres liv ved at sætte egne behov til side og omlægge deres netværk, hvor for eksempel venner rykker længere væk. Det er vigtigt for forældre, at deres barn oplever tryghed og omsorg. Gennem et godt samarbejde som forældre, og ved at sætte grænser ønsker forældre at opdrage deres børn til at være respektfulde, selvskre og selvstændige. Efter forældre er bedsteforældre den vigtigste familierelation til barnet. Oplevelser i fællesskaber er en vigtig del i barnets opvækst.

5. Leverancen af MANU


MANUs tilgængelighed

Næsten alle deltagere blev tilbudt at deltage i MANU. De fleste forældre modtog undervisning i grupper, mens enkelte deltagere fik MANU i individuelle konsultationer. Få deltagere synes at have deltaget i hele ni undervisningsgange. Andre deltog kun nogle enkelte gange på grund af arbejde, sygdom eller andre personlige hindringer.

"Jeg ville have deltaget, hvis det ikke var i arbejdetiden. Mens jeg var gravid, ønskede jeg at samle flere timer på arbejdet for at være berettiget til mere barbelsessætte." (mor 8)

Især mænd deltog ikke i MANU, fordi de skulle arbejde men også pga. manglende interesse for MANU, som en far forklarede:

"Jeg var lidt ligeglad med at gå til MANU. Jeg tænkte bare, at vi kan klare det selv. Men nu efter at have givet mig, tror jeg, det hjælper mig." (far 4)


MANUs format


"Alle øvelserne var gode. De hjælper os til at lære hinanden bedre at kende om hinanden" (mor 10)

Nogle deltagergav gerne modtage mere vejledning i, hvordan man håndterer sit parforhold efter fødslen. Mange forventede at få mere praktisk forberedelse i MANU undervisningen, for eksempel om hvordan man bader eller holder en baby. Nogle fik møde nævner, at deres mandlige partner fandt MANU for teoretisk og at det handlede for meget om følelser.

MANGE deltagere søgte også information fra bøger, internettet, Facebook-grupper, smartphone-applikationer (f.eks. om fosterets udvikling) og podcasts, såsom den grønlandske podcast om fødselsoplevelser 'Emineq'.

MANUs indhold

Mødre beskriver at de under graviditeten mest var optaget af at forberede sig på fødslen, hvilket kan forklare hvorfor de fleste hovedsageligt har deltaget i den MANU undervisning som omhandler fødslen. Andre emmer, forældre husker fra de sessioner, de deltog i, varierede blandt dem, men de værdsatte at modtage information om, hvordan en nyfødte sover og spiser, hvordan man lærer at skelne døds gråd og hvad man kan gøre. Ydermere beskriver de at have reflekteret over deres egen barndom og hvordan de gerne ville være som forældre, de og blev også bevidst om, hvem der er i deres netværk. Deltagere sætter pris på at de har et sted til at kunne tale sammen eller bare at få disse emner gennemgået.

"Jeg mærker øvelserne sætter tanker i gang i mit hoved" (mor 11)

Nogle deltagergav gerne modtage mere vejledning i, hvordan man håndterer sit parforhold efter fødslen. Mange forventede at få mere praktisk forberedelse i MANU undervisningen, for eksempel om hvordan man bader eller holder en baby. Nogle fik møde nævner, at deres mandlige partner fandt MANU for teoretisk og at det handlede for meget om følelser.

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"Jeg var lidt ligeglad med at gå til MANU. Jeg tænkte bare, at vi kan klare det selv. Men nu efter at have givet mig, tror jeg, det hjælper mig." (far 4)
støtte og råd fra dem. Ataatsimoorneq (fællesskab/community), toqqissimaneq (tryghed), at finde vej som forælder, reflektere over ens barndom, og identificere ens netværk er emner, der behandles i MANU. De behandles som overordnede emner, i en oplysende tekst og/eller i samtaleøvelserne, men hvor meget disse emner diskuteres i detaljer afhænger af underviseren og den enkelte forælder.

**Anbefalinger til MANU fremadrettet**

I interviewdelen om MANU relatinge forældrenes svar sig til MANUs materiale, format og tilgængelighed. Ifølge Gilmer et al. (2016) kan et forældreforberedelsesprogram være universelt (dvs. tilgængeligt for alle) hvis det er meningsfuldt for forældrene, og når det er tilgængeligt i et format og på et tidspunkt, der passer dem. Henværende undersøgelse peger på muligheder om hvordan MANU kan blive styrket som tilbud, som omhandler: a) revidering af MANU-bogens format, b) fremhæve at MANU skaber et rum til refleksion for kommende og nye forældre, c) undersøge muligheder for at lave MANU undervisning mere tilgængelig for forældre, og d) finde muligheder for at involvere og engagere mænd i højere grad.


At lytte til andre deltagende forældre i MANU-undervisningen værdsættes af forældrene. Selvom MANU emnerne er nyttige og relevante, ønsker forældrene at få mere praktisk viden, for eksempel at lære at bade eller holde en nyfødt. At inkludere sådanne elementer i sessionerne ville også imødekomme nogle deltageres ønske om at undervisningen var mindre stillesiddende. Forældreprogrammet Inunguiniq i Nunavut (Canada) inkluderer for eksempel naturen i mindst en af deres undervisningsgange (Amagoalik, 2019). Det kunne også være interessant at udforske om undervisningen kan laves om til en form for samtalerum.

Deltagerne har ingen klar mening eller idé om, hvornår det ville være bedst for dem at deltage i MANU undervisningen. I løbet af dagen er arbejdet i vejen og efter arbejde kan det være svært når man allerede har børn og så skal finde børnepasning. Til sammenligning tilbyder Inunguiniq forældreprogram børnepasning som en del af programmet, så forældre kan deltage i sessionerne (Amagoalik, 2019). Dette kræver og afhænger dog af lokale ressourcer og organisation af MANU.

Ikke at kunne deltage i undervisningen på grund af arbejde nævnes ikke som den eneste årsag til, at mænd ikke deltager. Deltagerne beskriver, hvordan mænd generelt har sværere ved at udtrykke deres tanker og refleksioner, mens dette er et omdrejningspunkt i MANU. Derudover udtrykker mandlige deltagere et behov for at tale med mænd i samme situation, som de er, og de kunne eventuelt se at en organiseret fædregruppe er en mulighed. MANU kunne afprøve at tilbyde fædregruppe eller opdele forældre i grupper i sessioner for at imødekomme dette behov. At integrere naturen og praktiske komponenter i undervisningen kunne muligvis motivere flere mænd til at deltage.

Selvom de fleste deltagere ikke har deltaget i alle MANU undervisninger, er muligheden for at kunne gøre det værdsat. Ud fra deltagernes erfaringer kan undervisningen beskrives som et rum væk fra de daglige opgaver – et rum, hvor kommende forældre tager sig tid som par til at reflektere og diskutere. Dette er en værdifuld mulighed for at nå ud til forældre og støtte dem, hvilket gør det endnu vigtigere, at lokale undervisere har de nødvendige ressourcer til at skabe et sådant rum gennem MANU.

Forældres forestillinger over oplevelser af forældreksab behandles generelt i forældreprogrammet MANU, men oplevelsen og fremmedet af MANU afhænger af, hvordan det er organiseret og lokalt udbydes. Samtaleøvelserne i MANU udfordrer forældrenes forestillinger om forældreksab, men kun i de undervisningsgange forældre deltager i, da næsten ingen bruger MANU-bogen udenfor undervisningen. MANU har mulighed for at skabe et rum for
forældre at reflektere og forberede sig. Men for at MANU skal være universel tilgængelig efter hensigten og nå både mor og far, kunne undervisningsformatet genbesøges med inspiration fra f.eks. andre arkiske forældreprogrammer. Næste skridt i herværende projekt er først at dykke dybere ned i forældres perspektiver på familiens roller i barnets opvækst samt at identificere de lokale muligheder og udfordringer ved at implementere MANU.

Metode
Dette notat har til formål at give et kort overblik over ph.d.-projektets interviews med forældre, som både har deltaget og ikke deltaget i forældreforberedelsesprogrammet MANU. Notatet er skrevet på dansk og grønlandsk på baggrund af følgende videnskabelig artikel:


Kvalitative interviews blev afholdt med forældre i tre udvalgte sundhedsregioner, hvor vi primært interviewede i regionsbyerne, mens enkelte mindre byer og bygder blev inkluderet ved hjælp af telefoniinterviews eller når gravide var på regionshospitalet i forbindelse med deres fødsel. Dataindsamling blev foretaget i 2020. 38 kvinder og 15 mænd deltog i undersøgelsen. Deltagere kunne selv vælge om de vil interviewes på grønlandsk eller dansk. Hvis de har valgt grønlandsk, blev interviewene gennemført af Else Jensen, og hvis de har valgt dansk, blev interviewene gennemført af Christine Ingemann. Tabel 1 giver et overblik over de afholdte interviews med indikation for hvilket sprog de blev afholdt på. Tabel 2 giver en oversigt over deltagernes alder, deres nyfødtes alder eller om de var gravide på interviewtidspunktet, om de har ældre børn, om de er sammen med moren eller faren til deres nyfødte barn, og om de har deltaget i nogen form for MANU undervisning.

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<th>Individuelt interview med mand</th>
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<td>4 på GL, 2 på DK</td>
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<td>By eller bygd</td>
<td>/</td>
<td>3 på GL</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>B</td>
<td>Regions by</td>
<td>3 på GL; 1 på DK</td>
<td>8 på GL</td>
<td>/</td>
<td>1 på GL med 3 mænd</td>
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<td></td>
<td>By eller bygd</td>
<td>1 på GL</td>
<td>1 på GL</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>C</td>
<td>Regions by</td>
<td>4 på DK</td>
<td>3 på GL, 6 på DK</td>
<td>/</td>
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<td>By eller bygd</td>
<td>/</td>
<td>2 på GL</td>
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GL indikerer at interviewet foregik på grønlandsk og DK på dansk.

Tabel 1. Oversigt over interviews.

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| Nyfødtes alder eller gravid på interviewtidspunktet |
| Gravid: 2 |
| 1-6 måneder: 5 |
| 7-12 måneder: 5 |
| 13-15 måneder: 1 |
| Ukenkend: 1 |

| Äldre børn? |
| 5 Ja |
| 8 Nej |
| 13 Ja |
| 9 Nej |
| 13 Ja |
| 9 Nej |

| Sammen med nyfødtes far/mor? |
| 12 Ja |
| 22 Ja |
| 14 Ja |
| 3 Ja |

| Deltaget i MANU undervisning |
| 9 Ja |
| 4 Nej |
| 13 Ja |
| 9 Nej |
| 17 Ja |
| 1 Nej |

Side 5 af 6
Litteratur


