ORIGINAL RESEARCH

Reforming foodservice in elderly care: National actions and local outcomes

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Abstract

Aim: The aim was to explore the outcome, on a local level, of steering, organisation and practices of elderly care foodservice by Swedish municipalities, and changes relative to national actions.

Methods: A survey using a web-based questionnaire about elderly care foodservice targeting all Swedish municipalities (n = 290) was conducted in 2006 and 2013/2014. The questionnaire included the topics: organisation of foodservice, its practice in elderly care and steering devices such as guidelines and policies. Based on the share of a rural population, municipalities were divided into groups: rural ($\geq 50\%$), urban ($< 50\%$) and city ($\leq 20\%$).

Results: The response rate from municipalities was 80% in 2006 and 56% in 2013/2014; 45% participated in both surveys. The results showed increased use of local food policies ($P = 0.03$) and meal choice ($P < 0.001$), while access to clinical/community dietitians declined ($P = 0.01$) between the surveys. In home-help services, daily delivered cook-serve meals declined ($P < 0.001$) and chilled meals delivered three times a week increased ($P = 0.002$) between the surveys. City municipalities used private foodservice organisations the most ($P < 0.001$), and reported reduced use of cook-serve systems in favour of chilled. In rural municipalities, the use of public providers (98%) and a cook-serve system (94%) were firmly established. Urban municipalities were placed between the other groups.

Conclusions: National actions such as soft governance and benchmarking appear largely to determine local level outcomes. However, conditions for adapting these measures vary between municipality groups. While efficiency enhancing trends were prominent, questions remain whether national actions should be expanded beyond performance to also examine their consequences.

Key words: dietitians, food policy, foodservices, health services for the elderly.

Introduction

Old age may lead to a need for elderly care in which the provision of meals is an essential component. These meals are fundamental in the daily lives of older adults who depend on support from the welfare service.¹ However, poor food intake and malnutrition in elderly care have been highlighted in numerous studies as examples of problematic areas for dependent older adults.² Multiple actions have been initiated, for example, the 2007 guidelines by the Council of Europe aiming to implement multidisciplinary strategies to promote and tackle malnutrition.³ Nevertheless, a continued need for guidelines, policies and access to

adequate nutritional competence is still emphasised.^{4,5} Key actors with nutritional competence are clinical/community dietitians and foodservice dietitians. While clinical/community dietitians advise individuals on tailored diets, provide nutrition counselling and educate professionals, foodservice dietitians are responsible for ensuring the provision of nutritionally adequate, safe and tasty meals.^{6,7} Moreover, the menus offered in elderly care need to be carefully planned and audited by dietitians to ensure they meet nutritional, social and cultural needs, and provide variety.⁸ An example of providing variety is through offering a choice of meals from a menu, an action that is shown to increase meal satisfaction among patients and residents.⁹

In this elderly care sector of the welfare service, different actions aimed at reducing malnutrition and improving the quality of meals have been undertaken simultaneously with reforms aiming to reduce costs and enhance efficiency.^{10,11} As a consequence, the resource-intensive foodservice has implemented cost-saving actions with reduced use of cook-serve systems, in which food is cooked, kept hot for a short period of time and then served. Instead, there has been increased use of various chilled food technology systems

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where prepared food is rapidly chilled to be later reheated and served.^{12,13} The latter allows for reduced delivery frequency since these meals have a longer shelf-life, and is now common practice in home delivered meal services.^{14,15} In several developed countries, including Sweden, there is a gap between a growing older population and public resources.¹⁶ This gap, together with a movement from a collective approach to one taking individual needs into account,¹⁷ has resulted in a changed public sector management, often referred to as New Public Management. Elderly care and foodservice organisations that were earlier managed only by the public sector in each municipality in Sweden can now be contracted out to private providers.¹⁴ This requires audits and follow up routines because each municipality is held responsible for the outcome regardless of whether none, parts or all of the elderly care or foodservice is contracted out to a private provider.¹⁸

In Sweden, elderly care is politically directed and regulated by framework laws, regulations and actions controlled by the government and national authorities.¹⁹ On a local level, each of the 290 municipalities, run by elected local political councils, has extensive autonomy concerning responsibility for all aspects of elderly care including the steering, organisation and practices of foodservice. Because of the extensive autonomy, and the varying needs and conditions, the resulting outcomes can be diverse.²⁰

As in many other countries, malnutrition and quality aspects of elderly care meals have been debated over the years. In order to meet needs and achieve progress, national authorities have been undertaking reforms and auditing through soft governance actions. Soft governance can be described as using rules that are voluntary and not legally binding.²¹ Two prominent actions conducted by Swedish national authorities are: the annual surveys for benchmarking purposes in which data have been collected from municipalities since 2007 (including indicators for meals, e.g. meal choice),²² and the national recommendations for meals for adults in elderly care launched in 2011.²³

To our knowledge, it is not known how the municipalities steer, organise and practice this soft governance at a local level alongside actions to enhance efficiency and quality improvements. The aim of the present study is to explore the outcome, on a local level, of steering, organisation and practices of elderly care foodservice by Swedish municipalities, and changes relative to national actions.

Methods

This article builds on the results from a repeated survey sent to all Swedish municipalities ($n = 290$) in 2006 and in 2013/2014. In 2006, a comprehensive questionnaire comprising 78 items was developed by Umeå University and the National Board of Health and Welfare (NBHW) (hereafter referred to as SI). The questionnaire was pilot-tested by foodservice dietitians and distributed by NBHW by email to all municipalities ($n = 290$). Due to the broad spectra of questions, an enclosed cover letter recommended that various professionals, for example, foodservice dietitians, clinical/community dietitians

and elderly care managers employed by the municipality, respond jointly. A reminder was sent out three times.

In 2013/2014, a follow-up survey (hereafter referred to as SII) based on SI was conducted. By excluding background items and merging 'yes/no items' with their follow-up questions, SII was shorter, comprising 61 items. This version was pilot-tested for comprehensibility by foodservice dietitians and then distributed to all municipalities ($n = 290$) by email along with a cover letter similar to that sent in SI. Two reminders were sent out and additional telephone call reminders were made by the first author to further encourage responses.

The cover letters informed that responses from the surveys were not confidential, although single municipalities would not be identified in the presentation of the results. One response per municipality covering residential care homes and home-help services was requested even if, for example, all or parts of the foodservice organisation was contracted out, or if the municipality used several food technology systems. There were 12 questionnaire items within the three topics from the questionnaires presented in this article: (i) steering and follow up, (ii) organisation of foodservice and (iii) practice of foodservice in residential care homes and home-help services. The questions used are presented in Table 1.

Population and demographic data for each municipality were obtained from Statistics Sweden.²⁴ A classification by Eurostat and the Organization for Economic Cooperation and Development is used to describe and analyse the municipalities, and to divide them into groups based on population density, size and proximity to population agglomerations, referred to in the present study as *population density*.²⁵ Here, the municipality groups are defined as:

- Rural ($\geq 50\%$ of the population live in rural areas)
- Urban ($< 50\%$ of the population live in rural areas)
- City ($\leq 20\%$ of the population live in rural areas and, with neighbouring municipalities, a combined population of at least 500 000 inhabitants).

Responses from SI and SII were analysed using IBM SPSS Statistics for Windows (Release 20.0, 2011; IBM Corp, Armonk, NY, USA). Ordinal data from the surveys were dichotomised (see Table 1) in order to keep the sample size large enough in each group to allow for comparisons between municipality groups, and analyses of differences between the two surveys. Descriptive statistics, Pearson's chi-squared test and Fisher's test, were used to analyse group differences. The nonparametric McNemar's paired-samples test was used to compare the data between SI and SII, and the binomial test was used for small samples. Only municipalities that had participated in both surveys were included when comparing the two surveys. The level of significance was set at 5% (significant result if $P < 0.05$). Multiple tests have been performed, which means the total significance level is $> 5\%$ used in a single test and therefore the significance of the different test results must be interpreted with care. Ethical approval was received by an advisory statement from the Regional Ethical Review Board of Medical Sciences in Uppsala (Reg. no. 106 2013/386).

Table 1 Questions from Surveys I and II identified as key characteristics included in the present studyi) *Steering and follow-up routines*

- Do the foodservice providers comply with the National Food Agency's recommendations on meals for older adults?^(a)
- Do you have policies, guidelines or other equivalent documents for the elderly care foodservice provider?^(b)
- Is adherence with the policy or equivalent document followed up?^(b)

ii) *Organisation of foodservice and access to competences*

- Are elderly care meals supplied by the municipality? (public foodservice provider)^(a)
- Are elderly care food and meals supplied by a private foodservice provider?^(a)
- Do you have access to a clinical/community dietitian/s?^(a)
- Do you have access to a foodservice dietitian/s?^(a)

iii) *Practice of providing foodservice in residential care and home-help service*

- What food technology system is used for meals in residential care homes? Several answers can be given^(c)
- Is there an option of menu choices in the residential care homes?^(d)
- Is there an option of menu choices in the home-help service?^(d)
- Which services are offered to older adults living at home in need of help with cooking? Several answers can be given^(e)
- If ready-to-eat meals are provided, what is the delivery form and frequency? Conventional, daily delivery; chilled, daily delivery; chilled, delivered ≤ 3 times per week; modified atmosphere, delivered ≤ 1 time per week; frozen, delivered ≤ 1 time per week?^(d)

Answer alternatives:

^(a) Yes = (yes, in all/yes, in most operations), no = (yes, in some/yes, in very few/no, not in any operation).

^(b) Yes/no.

^(c) Hot; cold; cold (cook-chill); frozen; other.

^(d) Yes = (yes, for everybody/yes, for most), no = (yes, for some/no, for a few/no, not for anyone/other).

^(e) Seven alternatives, presented in Table 3.

Results

The response rate was 80% ($n = 231$) in SI, 56% ($n = 162$) in SII and 45% ($n = 131$) for municipalities participating in both surveys. The distribution of participating municipalities in SI was consistent throughout the country, while in SII and for those participating in both surveys, rural municipalities were underrepresented and urban municipalities overrepresented by approximately 5% points, respectively (Figure 1).

More than 80% of the municipalities reported consulting the national recommendations for meals for older adults (Table 2) since their introduction in 2011 and the overall use of another steering device, that of local food policies,

increased significantly between SI and SII ($P = 0.03$). Of all the municipalities using a local food policy in SII, 75% reported following-up on the policy goals that had been set which is a significant decline from SI ($P = 0.002$). Overall, close to 90% in each survey reported using a public foodservice organisation but the distribution varied significantly between municipality groups in SII ($P < 0.001$). Rural and urban municipalities reported a higher and stable level of use of public foodservice organisations, whereas city municipalities reported a higher and increased level of use of private foodservice organisations ($P = 0.01$).

There was a significant decline ($P = 0.005$) of the municipalities having access to clinical/community dietitians between the surveys (Table 2). In SI, significantly more

Figure 1 The distribution % (n) of municipality groups (rural, urban and city) in Sweden and their participation in Survey I, Survey II and both surveys. (■), Rural; (■), urban; (□), city.

Table 2 Steering and organisation of elderly care foodservice

	Survey I (n)			Distribution (%)			P-value ^(a)	Survey II			Distribution (%)			P-value ^(a)	P-value ^(b)
	Total	Yes	Total (%)	Rural	Urban	City		Total (N)	Yes (n)	Total	Rural	Urban	City		
Steering															
National recommendations	230	162	70.4	66.7	70.5	87.0	0.16 ^(d)	161	133	82.6	82.4	85.5	66.7	0.22 ^(c)	NA
Local food policy	161	141	87.6	80.6	91.9	95.0	0.10 ^(d)	162	133	82.1	81.0	80.7	93.8	0.52 ^(d)	0.03 ^(e)
Follow up on local food policy								128	96	75.0	73.5	73.4	86.7	0.62 ^(d)	0.002 ^(f)
Organisation															
Public foodservice provider ^(g)	228	199	87.3	90.1	86.5	78.3	0.30 ^(c)	160	143	89.4	98.4	89.0	53.3	<0.001 ^(d)	0.82 ^(f)
Private foodservice provider ^(g)	227	9	4.0	1.0	3.8	17.4	0.01 ^(d)	156	9	5.8	0.0	5.0	33.3	<0.001 ^(d)	1.00 ^(f)
Clinical/community dietitian	226	86	38.1	37.4	36.5	47.8	0.61 ^(d)	161	33	20.5	19.0	18.1	40.0	0.16 ^(d)	0.01 ^(f)
Foodservice dietitian	230	143	62.2	52.0	70.5	69.6	0.02 ^(c)	161	110	68.3	65.1	72.3	60.0	0.50 ^(c)	0.68 ^(e)
Foodservice dietitian, manager								158	119	75.3	83.9	77.8	26.7	<0.001 ^(d)	NA

NA, not applicable.

^(a) Differences between municipality groups.^(b) Differences between Surveys I and II.^(c) Pearson's chi-squared test of relationship between groups (exact two-sided *P*-value).^(d) Fisher's exact test of relationship between groups (exact two-sided *P*-value).^(e) Nonparametric McNemar's paired-samples test for comparison between surveys (exact two-sided *P*-value).^(f) Nonparametric binomial test for small samples for comparison between surveys (exact two-sided *P*-value).^(g) Due to the possibility of multiple answer, percentages do not add up to 100% (see Table 1).

urban and city municipalities had access to a foodservice dietitian ($P = 0.02$). In SII, access to a foodservice dietitian holding a managerial position was more prevalent in rural and urban municipality groups ($P < 0.001$).

In both surveys, a cook-serve food technology system was predominantly used, although the extent of use varied between the municipality groups ($P = 0.01$) in SI and ($P = 0.04$) SII (Table 3). In SII, the chilled food technology system (short shelf-life) was used significantly less frequently in rural municipalities and most frequently in city municipalities ($P = 0.02$).

Between the surveys, the practice of offering meal choices more than doubled in residential care homes and increased significantly in home-help services ($P < 0.001$). Again, the difference between municipality groups was significant, with meal choices being more common in city compared to rural municipalities in both residential care homes ($P = 0.002$) and home-help services ($P < 0.001$).

In home-help services, the predominantly used service, that of home delivered ready-to-eat meals produced by a public foodservice organisation in the municipality, decreased overall between the surveys ($P = 0.002$). This service was most frequently reported by rural and least frequently reported by city municipalities in both SI ($P = 0.01$) and SII ($P = 0.02$) (Table 3). The most frequent users of the predominant cook-serve ready-to-eat meal with daily delivery were rural municipalities in both SI ($P = 0.004$) and SII ($P = 0.009$); however, this had declined significantly overall ($P = 0.001$). Instead, the use of chilled ready-to-eat meals delivered three times a week had increased ($P = 0.002$).

Discussion

Between the surveys, municipalities reported an overall increased and extensively used practice of offering meal choices and in the use of steering devices such as local food policies. However, follow-up routines for the policies and the number of municipalities having access to clinical/community dietitians had declined. In home-help services, a change from daily delivery of ready-to eat meals (cook-serve), towards chilled ready-to-eat meals delivered three times a week was reported between the surveys. Differences in outcomes between the municipality groups were apparent and the result indicates an increased gap. In rural municipalities, the use of a cook-serve system and public foodservice providers were firmly established and foodservice dietitians in managerial positions were well-represented. City municipalities had reformed the most between the surveys by adopting the characteristics of New Public Management, for example, privatisation, meal choice and chilled food technology, to a greater extent than rural and urban municipalities. This reform strives for both cost-effectiveness and individualism. The results for urban municipalities were found to be in between the other two groups. A struggle between striving for national equity and local autonomy seems to be present in the present study, as was similarly reported in the study by Fredriksson and Winblad.²⁶

Table 3 Practice of providing foodservice in residential care homes and home-help service

		Answers (n)		Distribution (%)				Differences	
	Survey	Total	Yes	Total	Rural	Urban	City	Groups, P-value ^(a)	Surveys, P-value ^(b)
<i>Food technology systems</i>									
Conventional (cook-serve) ^(c)	I	227	198	87.2	94.1	79.6	91.3	0.01 ^(d)	
	II	162	139	85.8	93.7	81.9	75.0	0.04 ^(e)	1.00 ^(f)
Chilled (short shelf-life) ^(c)	I	226	40	17.7	12.0	21.4	26.1	0.10 ^(e)	
	II	162	39	24.1	14.3	27.7	43.8	0.02 ^(e)	0.31 ^(g)
Cook-chill (long shelf-life) ^(c)	I	227	29	12.8	7.9	18.4	8.7	0.07 ^(e)	
	II	162	17	10.5	7.9	9.6	25.0	0.15 ^(e)	1.00 ^(f)
Cook-freeze ^(c)	I	227	4	1.8	n = 1	n = 3	0.0	NA	
	II	162	2	1.2	n = 1	n = 1	0.0	NA	NA
<i>Meal choice</i>									
Residential home care	I	225	50	22.2	15.8	22.5	50.0	0.002 ^(d)	
	II	156	77	49.4	35.5	53.1	92.3	<0.001 ^(d)	<0.001 ^(f)
Home-help service	I	227	99	43.6	31.7	46.6	82.6	<0.001 ^(d)	
	II	157	96	61.1	42.6	69.1	93.3	<0.001 ^(d)	<0.001 ^(f)
<i>Meals in home-help service offered to all or more than half of the older adults</i>									
Shop-purchased ready-to-eat meal ^(c)	I	227	61	26.9	21.8	26.9	50.0	0.03 ^(d)	
	II	162	42	25.9	27.0	22.9	37.5	0.46 ^(e)	0.77 ^(f)
In-home cooking (<20 minutes) ^(c)	I	227	96	42.3	39.6	37.5	77.3	0.002 ^(d)	
	II	162	58	35.8	36.5	31.3	56.2	0.16 ^(d)	0.50 ^(f)
In-home cooking (>20 minutes) ^(c)	I	227	33	14.5	13.9	14.4	18.2	0.86 ^(e)	
	II	162	11	6.8	6.3	4.8	18.8	0.11 ^(e)	0.25 ^(f)
Accompanied to a nearby restaurant ^(c)	I	227	51	22.6	23.8	20.2	28.6	0.61 ^(e)	
	II	162	23	14.2	6.3	14.5	43.8	0.002 ^(e)	0.13 ^(f)
Restaurant-purchased meal ^(c)	I	227	22	9.7	5.9	8.7	31.8	0.004 ^(e)	
	II	162	24	14.8	14.3	12.0	31.8	0.16 ^(e)	0.01 ^(g)
Ready-to-eat meal from private provider ^(c)	I	227	59	26.0	15.8	30.8	50.0	0.002 ^(d)	
	II	162	34	21.0	9.5	27.7	31.2	0.01 ^(e)	0.31 ^(g)
Ready-to-eat meal from public provider ^(c)	I	226	161	71.2	79.0	69.2	45.5	0.01 ^(d)	
	II	162	92	56.8	69.8	50.6	37.5	0.02 ^(d)	0.002 ^(f)
<i>The ready-to-eat meal: delivery form and delivery frequency</i>									
Conventional (cook/hot-hold)/daily	I	228	128	56.1	68.3	47.1	43.5	0.004 ^(d)	
	II	123	46	37.4	51.9	29.0	11.1	0.01 ^(e)	0.001 ^(g)
Chilled (short shelf-life)/daily	I	220	47	20.8	16.0	24.3	26.1	0.27 ^(e)	
	II	118	27	22.9	20.0	22.4	40.0	0.38 ^(e)	1.00 ^(g)
Chilled (short shelf-life)/three times a week	I	225	37	16.4	11.0	20.6	21.7	0.12 ^(e)	
	II	113	34	30.1	23.9	36.2	22.2	0.36 ^(e)	0.002 ^(f)
Chilled (long shelf-life)/once a week	I	225	56	24.9	18.0	28.4	39.1	0.06 ^(d)	
	II	116	31	26.7	16.3	34.5	33.2	0.08 ^(e)	0.45 ^(g)
Cook-freeze/once a week	I	225	1	0.4	0	0	n = 1	NA	
	II	117	1	0.9	n = 1	0	0	NA	NA

NA, not applicable.

^(a) Differences between municipality groups.^(b) Differences between Surveys I and II.^(c) Due to the possibility of multiple answers, percentages do not add up to 100% (see Table 1).^(d) Pearson's chi-squared test of relationship between groups (exact two-sided P-value).^(e) Fisher's exact test of relationship between groups (exact two-sided P-value).^(f) Nonparametric McNemar's paired-samples test for comparison between surveys (exact two-sided P-value).^(g) Non-parametric binomial test for small samples for comparison between surveys (exact two-sided P-value).

The municipalities' high adherence to the national recommendations and increased use of local food policies are seen to play an important role in the steering of foodservice in elderly care. Also, because city municipalities have a high level of follow-up routines regarding local food policies, it

can be assumed that they have a greater need to carry out quality control of private foodservice providers. This is discussed by Erlandsson *et al.*¹⁸ as a consequence of privatisation in elderly care, and it is further supported by Power²⁷ arguing that audit practices have gained impact. However,

food policies alone may not guarantee quality assurance or the prevention of malnutrition, and inadequate follow-up routines would further reduce the scale of their impact.²⁸ Then again, placing nutrition issues on the political agenda²⁹ makes it clear that policies serve as useful steering devices.⁵ The shift towards increased use of private foodservice organisations in city municipalities seen in the present study is consistent with the Swedish government's reforming intent to open up the welfare service sector, and elderly care in particular, to privatisation.¹⁸ This finding is also in agreement with Stolt and Winblad³⁰ who found that densely populated areas attract private organisations to a greater extent.

In a study on perceived barriers for improving foodservices for older adults, Walton discusses a need for both clinical dietitians and foodservice managers (the latter comparable to foodservice dietitians in Sweden), due to their different roles.³¹ In the present study, however, only 20% of all municipalities had access to a clinical/community dietitian showing a significant decline from 2006. This development raises concerns, because these key actors are needed to optimise the nutritional status of older adults.³²

External evaluation and accreditation are shown to be influential motivational factors³³ and in the present study, it is clear that the annual benchmarking survey conducted by national authorities²² plays an important role. The option of meal choices as one of the benchmarking indicators has, since its introduction, led to its significantly increased practice in the municipalities. According to earlier studies, offering meal choices might help in the maintenance of personal control, and improve food intake and foodservice satisfaction.^{9,34} However, Wright *et al.* found that a time lapse between meal choice and consumption was associated with poorer food intake.⁹ This might overshadow the good intentions of an individual oriented practice as a certain delay is inevitable depending on food technology system and organisation.

The distribution of meals is a resource-intensive aspect of foodservice practice in home-help services.¹² Our results confirm the efforts aimed at cost reduction, because the use of ready-to-eat meals (cook-serve) delivered daily had decreased the most between the two surveys, while the use of chilled ready-to-eat meals delivered three times a week had increased the most. Although with varying points of departure, all municipality groups indicated that they had aimed for this cost-reducing approach because chilled meals allow for a reduced distribution frequency.¹² The choice of food technology system in home-help services also has consequences for the recipient. A chilled food system with low delivery frequency can offer freedom from waiting for the meal delivery.³⁵ At the same time, this practice moves the responsibility for food safety, for example, storing and reheating, to the recipients.³⁶ The social aspect of this service also needs consideration. Whilst frequent deliveries might help reduce social isolation, a system with low delivery frequency does not.³⁷ Preference regarding choice of food system is individual and depends on a complex mix of

factors, which may affect the dependent older adult's food intake in various ways.

The strengths of the present study are its national coverage with comprehensive representation of municipalities, along with its novel approach. A potential drawback is the lower response rate in SII. Plausible reasons for this are that it received limited attention because the main sender was not a national authority and a presumed general survey fatigue.³⁸ The city group in the present study represents a large population yet contained few municipalities, which is a weakness that must be kept in mind when interpreting the results.

In summary, soft governance and benchmarking devices as incentives for national actions appear substantial drivers of local level outcomes. However, conditions for adapting these actions vary between municipality groups and would seem to be particularly tailored towards densely populated municipalities. Moreover, prominent trends aimed at enhancing efficiency through measures such as increased use of foodservice technology and privatisation, a relaxation in monitoring policy goals and numbers of clinical dietitians employed, can be identified. Nevertheless, identifying trends that may reduce problems related to meal experiences and food intake is more difficult. This raises questions over whether national obligations concerning such welfare services should be expanded beyond performance, to also examine their consequences. Furthermore, it also raises questions concerning the need for professional profiles in setting policies and transforming them into practice, as well as incorporating controller functions. The need for such a professional profile constitutes both a challenge and an opportunity for dietitians, in education, practice and in research.

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Conflict of interest

The authors have no conflict of interest to declare.

Authorship

YMS conceived the initial design of the study and was responsible for the data collection (Survey I). MSJ was responsible for the development of the study, data collection (Survey II), analysis and drafting of the manuscript. YMS and MN supervised the study and contributed to drafting and editing the manuscript. IP was involved in the data analysis and editing the manuscript. All authors approved the final version of the paper.

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