University of Colorado
Anschutz Medical Campus

Department of Pediatrics
Prevention Research Center for Family and Child Health
Mail Stop 8410
13121 East 17th Avenue
Aurora, Colorado 80045

International Nurse-Family Partnership® (NFP)

PHASE THREE ANNUAL REPORT Revised December 1, 2023

Phase Three - Randomized Controlled Trial (RCT).

This phase is established to estimate program effects on outcomes of clear public health importance that align with the outcome domains in the original US trials and that address additional goals of that country. This work is designed to determine the added value of the program for the populations and contexts in which it is being delivered. The expected research methodology is a Randomized Clinical Trial (RCT) as this provides the strongest evidence of program impact. In some circumstances, it may not be feasible or appropriate to undertake an RCT (e.g. where the population size is too small to estimate benefits reliably or where there are serious cultural concerns). In these circumstances, consideration will be given to use of quasi-experimental designs. Countries are encouraged to conduct complementary qualitative studies, which can be helpful in understanding results of the RCT. During this phase, the implementing entity may seek approval to continue recruitment of clients in existing pilot and/or RCT sites until analysis and reporting of the RCT data are complete. Countries are expected to continue completing annual reports during this phase.

Purpose of annual report:

By using quantitative and qualitative data, the annual report creates an opportunity for each country's leadership team to reflect on progress and develop quality Improvement plans for the following year.

Completing the report:

The country license holder is requested to coordinate the completion of this report, with contributions from the national implementing body, and others, as required.

Please note: If you are unable to complete any items in the report template, please indicate whether this data is not collected in your country or is not able to be analysed at this time. Where terms used in the report template are generic, please specify how items are measured in your country. Where you have adapted your data collection schedule/timings or approach to accommodate local systems, please adapt the document as necessary to take account of this. If you have any questions regarding the content of this document, please do not hesitate to get in touch with your NFP International Consultant.

The report should be sent to the NFP Partner lead at least three weeks before the Annual Review meeting. If there are any issues, contact Global Director or Global Coordinator. Further guidance on the conduct of the annual review meeting can be found on the 'International NFP Resources' page of the international website.

PART ONE: PROGRAM OVERVIEW

Name of country:	Norway	Dates report covers (reporting period):	01.01.2023 – 31.12.2023
Report completed by:	National Office at RBUP (Regional Centre for Children and Youths Psychological Health) and Bufdir (The National Directorate for Children-, Youth- and Family Affairs)	Date submitted:	19.01.2024

The size of our program:

	Number
Fulltime NFP Nurses	25
Part time NFP Nurses	6
Fulltime NFP Supervisors	5
Part time NFP Supervisors	0
Full time NFP Team Coordinators/Administrators	4
Part time NFP Team Coordinators/Administrators	1
Total	41

- We have 5 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 6,2

- Current number of implementing agencies/sites delivering NFP: 5
- Number of new sites over the reporting period: 0
- Number of new teams over the reporting period: 0
- Number of sites that have decommissioned NFP over the reporting period: 0

- Successes/challenges with delivery of NFP through our implementing agencies/sites:

Contact with local leaders, both in the host municipality/township and in the local advisory boards, is deemed crucial for the successful implementation of the program. A positive and supportive attitude has overall developed within the local advisory boards. Local leaders in host municipalities/districts are increasingly contributing to supporting and developing the implementation of the program. It is intriguing to observe the diversity among individual municipalities and districts, noting how they address implementation and challenges in various ways. This contributes valuable insights regarding potential national rollout possibilities. The need for additional leadership meetings varies between sites and is adjusted accordingly. Similarly, some local advisory board meetings are conducted through digital platforms, depending on the preferences of each local advisory board.

The "Mor i Norge" (MiNs) study (RCT study) commenced on June 1, 2023, and extensive meeting activities have taken place to ensure optimal recruitment for the study in all sites. Initially, there was some skepticism among the local advisory boards and referrers. However, after the launch, there is generally positive support for recruitment to the study and an understanding that it must be carried out. We recognize the

challenge of recruiting enough participants, and continuous efforts are being made to focus on how to increase recruitment for the study.

Site: Rogaland (South-West)

The team has 6 family nurses, 1 supervisor and 1 administrator. One family nurse and one local leader left in 2023. These changes are handled well in the team and the host municipality. The site counts 7 municipalities, and it is expected that they will expand to 9 during early 2024. There is a good collaboration among the municipalities within the site, and there are many previous experiences with inter-municipal cooperation. In 2023 recruitment of clients has proceeded, and an increase is anticipated once the two new municipalities join. There is a concern about insufficient recruitment in view of the study. The team have meetings on regular basis with referrals /potential referrals to keep up focus on the recruitment to the study. There have also been meetings with the research team and the services at the site to increase the recruitment pace. The local advisory board works well.

Site: Oslo

The team has 8 family nurses, 1 supervisor and 1 administrator. The previous supervisor resigned and one of the previous family nurses has taken on the role of supervisor. A new family nurse has been engaged from early 2024. The new supervisor has been a family nurse since 2016 and she is doing well as supervisor for the team and in cooperation with leaders in the host township.

A reorganization has been undergoing in the host township, and the team moved to new, unfinished premises in December. Individual team members handle this restructuring differently.

There are five townships on the site and the collaboration with the team is working well. The team must navigate various services, and it's not always clear-cut as organizational structures may differ in each township.

A good atmosphere in the local advisory board is developing and the meetings have become more effective during the year.

A steady recruitment of clients, although increased efforts are needed to reach the desired number of participants in the study. The team have meetings with referrals /potential referrals and the approach to the study has developed to become more positive both in the local advisory board and among the universal services. Meetings with the research team and the referring services on the site have been conducted, to support increased recruitment pace.

Site: Agder (South-East)

The team in Agder consists of 7 family nurses, 1 supervisor, and 1 administrator. Agder is one of the three new sites in phase 3, and the team began in January 2022. The team have had long-term sick leave and several part-time sick leave. This has been solved by hiring 2 new family nurses initially on a temporary basis. These positions will become permanent in early 2024. The previous administrator resigned, and a new administrator has started. There is good cooperation at the leadership level, and the team receives strong support from the host municipality.

The site includes 13 municipalities and covers a large area in the southern part of Norway. The team has a main office located in the host municipality and a smaller office in another municipality in order to reduce travel for the nurses. Furthermore, the host municipality has purchased an electric car to reduce use of private vehicles.

Recruitment is well underway but not sufficient to meet the required number for the study. One of the larger municipalities has a preventive program that is less extensive than “Sammen på vei” but targets

almost the same group. Effective work is done both on the local advisory board and with the referrers to boost recruitment.

Site: Vestland (West)

The team in Vestland consists of 6 family nurses, 1 supervisor, and 1 administrator. They are one of the three new sites and have had some management challenges since the start in 2022. Efforts have been made to address these challenges in various ways, both within the team and in collaboration with local leaders and the national office. In 2023 there have been several changes in the team. Additionally, a significant reorganization took place, and in January 2023, the team relocated to new premises.

The site includes 9 municipalities and covers a large area in the west of Norway.

The implementation of the programme in Bergen has been a bit fragmented due to several changes among key staff representing the leadership at the host municipality. During 2023 the nearest local leader has become more closely involved in the follow-up of team. Also, the psychologist that supports the teams on a regular basis has had a more intensive follow-up of the team. The national office works closely and intensively to support good development for the team and to support the program delivery.

In spite of the challenges the recruitment is proceeding. There are some municipalities which recruit few clients to study. The local advisory board is working to address recruitment challenges and is highly supported by leaders in the host municipality.

The host municipality has a department for privacy, and it has been challenging for them to agree on the data processing agreement. A considerable amount of time has been spent on this by the National Office and Bufdir in order to find an acceptable solution for the site.

Site: Trøndelag (Mid-Norway)

The team consists of 7 family nurses, including one on long-term sick leave, 1 supervisor, and 1 administrator. They are one of the three new sites and began in January 2022. There are a little and varying degrees of part-time sick leave, which have been addressed by hiring a temporary substitute at 100%, with plans to transition to a permanent position in 2024. The team receives strong support from the leadership in the host municipality.

Originally the site covered three municipalities but expanded to 6 during 2023. Recruitment in the new municipalities started in December 2023. Recruitment to the study is progressing well, although it may not be sufficient to meet the needs for the study.

The local advisory board works effectively, comprising representatives from all municipalities, a broad range of services, experienced consultants/clients, and a politician. There is considerable enthusiasm for the implementation and adaptation to local contexts, with significant engagement in recruiting participants for the study.

The host municipality works to find solutions for transportation, as the team covers a large area, and there is significant wear and tear of private cars, as well as costs associated with use of personal vehicles.

The host municipality is actively participating in a national trial of a digital health platform. The team utilizes this platform for all documentation and other record-keeping, in addition to the specific data collection for the Family Nursing Practice study. Thus far, the team has primarily had positive experiences with the system.

Description of our national/ implementation / leadership team capacity and functions

License holder name: The Directorate for Children, Youth and Family Affairs (Bufdir)

Role and Organisation: The National Directorate is reporting to the Ministry of Children, Youth and Family Affairs. The Directorate is in charge of the up-bringing sector and is to facilitate a safe up-bringing for

children and youth, as well as leading the child protection services at national level and providing certain specialized services for local authorities targeted at vulnerable children and their families. The Directorate is the license holder and is responsible vis a vis the Ministry of Children, Youth and Family Affairs for the assignment to test NFP in Norway till 2027. The Directorate is also responsible vis a vis UCD to ensure that the license requirements and core elements of the program is complied with, as well as following the phases of the program. The program is funded by the Government.

Description of our National implementing capacity and roles:

1. Clinical Leadership:

In 2023 6 persons have been working full time at the national office.
Main responsibilities for the national office:

- Implementing NFP in Norway
- Education and training
- Develop and adjust program material
- Follow-up and support for the teams
- Collaboration with the local NFP-areas
- Data collection and analysis

Norway's Clinical Lead, Tine Gammelgaard Aaserud, has been in this position since 2015. She is a midwife and has a master's degree in health and empowerment with a master's thesis focused on women's experience of home visits by midwives in early maternity. The clinical lead is heading the National Office, in addition she has the main responsibility for securing collaboration with the five sites and their leadership and for carrying out the local advisory board meetings. She is also in close contact with the local leaders to support the supervisors and the teams.
The Special Advisor, Kristin Lund, has been in this position since 2016. She specializes in paediatric psychology, and she is a Licensed Supervisor in Marte Meo. Her knowledge of tools for assessing dyadic parent -child relationships is useful in the process of developing an alternative to DANCE. Kristin is responsible for guiding family nurses and supervisors in child-parent interaction, and she visits the teams for Marte Meo video guidance every sixth week, in addition to individual online follow-up twice a week.
The Senior Advisor, Emma Broberg, has her clinical background in Public Health working as a public health nurse and as a family therapist. She has been Supervisor for the NFP team in Oslo since the beginning of 2016 and joined the National Office in January 2021. She supports the clinical lead by having close contact with the supervisors in how to conduct the supervision with the nurses and supporting the team.
The Development Coordinator, Sofie Johnsen, has been in this position since 2022. She has a bachelor's degree in psychology, and a master's degree in work and organizational psychology. Her main responsibility was maintaining the website, follow-up of the team coordinators and other administrative responsibilities. She was part of the NFP national team until December 4th, 2023.

2. Data analysis, reporting and evaluation:

The two remaining members of the national office:
Data Advisor, Marte Dalane-Hval, has been in this position since 2018. She has a master's degree in health and social psychology and a bachelor's degree in psychology. This year, she took an educational course about privacy and security information. At the national office, she is responsible for the data collection, reporting, and the further development of the digital data collection solution.
Advisor, Frida Abel, has been in this position since 2021. She holds a bachelor's degree in social work with a specialization in intercultural studies. Her professional background includes experience in social work at NAV, as well as in substance abuse care and prison care. Additionally, she holds a master's degree in interdisciplinary health research from the University of Oslo. Currently, she divides her time equally between the National Office and a research project focused on developing a new parent-child interaction assessment tool (see point 6 "other" for more information).

3. Service development/site support:

To ensure effective and consistent program delivery across all five sites, four local advisory board meetings and four leadership meetings in the host municipality/district are planned annually for each site. The leadership meetings are carried out with the local leader from the host municipality/township, the supervisor, and the national clinical lead. Additionally, an annual meeting is held at each site. In 2023 a weekly meeting between clinical lead, senior advisor and the supervisors from all five sites has been conducted.

4. Quality improvement:

National office is continuously working with quality improvement of the program.

5. NFP Educators:

The National office has overall responsibility for the education and training in "Sammen på vei". We allocate training based on who has the most expertise in the various subject areas. In addition, we have brought in experienced family nurses to contribute to parts of the training. We have had very good experiences with this and have received positive feedback that this is valuable.

We have also benefited from external lecturers on specific topics:

- Domestic violence: Henning Mohaupt.
- Marte Meo video guidance: Maria Aarts
- Motivational Interview: Tom Barth and his successor Monica Island

6. Other (please describe)

Advisor, Frida Abel, from the National Office and two researchers from The Regional Center for Child and Youth Mental Health (RBUP) are working with Norwegian experts in parent-child interaction to design an innovative assessment tool for evaluating parent-child interaction within families with children aged 0-6 years. The objective is to initially test and refine this assessment tool for the family nurses in “Sammen på vei” with subsequent plans for broader implementation in other Norwegian child health services.

Key points about the project include:

- The primary responsibility for the development lies with the researchers at The Regional Center for Child and Youth Mental Health (RBUP), where the National Office for “Sammen på vei” is situated.
- The project is structured into distinct work packages, encompassing a literature review, a concept mapping study (https://doi.org/10.17605/OSF.IO/TC8XZ), and an e-delphi study (https://doi.org/10.17605/OSF.IO/W3A89) aimed at developing the scales for the tool.
- The anticipated timeline involves testing the initial version of the tool with family nurses in spring 2025, with ongoing efforts to refine and assess its psychometric properties, including validity and reliability.
- The Directorate is providing financial support for the project and will consider how the tool can be adopted in other services in collaboration with relevant sectors.

Description of our local and national NFP funding arrangements:

The program is fully funded by the national government till 2027, with some minor contributions by the local authorities in implementing sites.

Current policy/government support for NFP:

It was stated in the national budget in October 2021 that the program is to be funded for the period of 2021-2027. The program was also mentioned in the National budget for 2024 which is securing earmarked funding. The current Minister does not have the same ownership of the program as previous Ministers. However, the program continues to be referred to in several new strategic government papers and action plans which is positive. The program is also considered highly relevant to the child protection reform in Norway and the stronger emphasis on preventive child protection measures at the municipal level.

Organisation responsible for NFP education:

Not applicable

Description of any partner agencies and their role in support of the NFP program:

It is still a challenge to get the Health Directorate and its Ministry of Health engaged in Sammen på vei. We would have thought that the RCT on Sammen på vei would be of interest to them since the RCT via the control group will give interesting information about the effect of the universal pre-natal and post-natal services. However, in spite of sharing study protocol about ongoing RCT they have shown little interest in the study. Moreover, we recognize that their involvement is very important in view of a possible roll-out of the program.

Other relevant/important information regarding our NFP program:

Another productive and intense year for the National office has passed by. To balance the ongoing implementation of the program in the five sites on one side and to facilitate the support and understanding of the RCT study on the other has at times been challenging. The Directorate has chosen a strategy with regard to the study which emphasise the importance of a certain level of collaboration between AFI which is undertaking the RCT and RBUP being in charge of the implementation of the programme. This is partly linked to the fact that it is the nurses who are screening and recruiting participants to the study.

The recruitment to the RCT started in June 2023. The recruitment to the study has been challenging due to a variety of factors. The most important is probably that the programme has a narrow target group (3-4% of all first-time pregnant women) and that the recruitment base in each of the 5 sites is limited when recruiting both to the intervention group as well as to the control group. The Directorate and the National Office is looking at the possibility to expand the number of municipalities/townships within the existing sites.

In 2023 the Directorate commissioned an assessment to explore possible models for national roll-out of the programme. The report was finalised by PWC by the end of November 2023 and gives the Directorate recommendations about possible models. The assessment included a socio-economic analysis which concluded that the proposed models is considered profitable. The Directorate will discuss the report with the National Office and assess if we need to pursue some elements during phase 3.

The Directorate also commissioned the production of two films about the programme. One is designed as a reportage and one as an informative film. Both will be used internally and externally targeted to various audiences.

PART TWO: PROGRAM IMPLEMENTATION

Clients

Number (#) of NFP clients participating in the program at any point over the last year: 378.

- Current clients: Pregnancy phase (n & %): 42 clients (14 %) at 31.12.23 (time point)
- Current clients: Infancy phase (n & %): 163 clients (54 %) at 31.12.23 (time point)
- Current clients: Toddler phase (n & %): 97 clients (32 %) at 31.12.12 (time point)

Nursing Workforce

- Average client caseload per nurse: 10

The nurses have between 1 and 15 clients. A couple of the newest nurses only have one or two clients right now but are building their caseload.

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	32	5	5	42
# of staff who left during reporting period	3	1	1	5
% annual turnover	9,4 %	20 %	20 %	11,9 %
# of replacement staff hired during reporting period	2	2	2	6
# of staff at end of reporting period:	30	5	5	40
# of vacant positions	3	0	0	3

Reflections on NFP nurse/supervisor turnover/retention during reporting year:

With the expansion to five sites, we have observed a turnover in NFP teams, similar to other services. We have experience with both long-term and short-term sick leave, as well as instances where employees leave for other reasons. The effects of this are that we get challenged by handling the training for temporary and newly engaged staff members.

- Successes/challenges with NFP nurse/supervisor recruitment:

In four out of five sites, there has been successful recruitment for vacant positions. However, it is increasingly challenging to recruit public health nurses and midwives. In two of the sites, there is a high number of applicants whenever a position is advertised. We believe this may be attributed to a very positive attitude towards NFP, and in general, there are slightly fewer recruitment challenges in these two sites. In the other two sites, the recruitment is adequate, but the number of applicants is not high. This is attributed to the overall situation, as there is also a distinct positive attitude towards NFP in those sites. In the last and fifth site, there have been some challenges, which we believe may have affected the recruitment of new family nurses.

- Any plans to address workforce issues:

Most of the teams have a mix of midwives and public health nurses. One of the teams has had only one midwife over the years and they struggle slightly to keep the midwives in the team. Experiences from other teams indicate that it works well when there are multiple professionals from each category. Being the only one with a given professional background can feel isolated,

and it can become more challenging in terms of sharing expertise within the team. There is a focus on recruiting midwives to the team when opportunities arise.

NFP education

- Briefly describe your NFP education curricula (nurse and supervisor, plus any additional education for associated team members (Family Partnership Worker/Mediators) or others (e.g. Local Advisory Group members).

For all nurses and supervisors:

NFP training modules:

In September we carried out the toddler training. This imply that the main group of nurses that joined the program in 2021 has completed the program education. Because of the situation regarding short and long-term sick leave and new family nurses coming on board there is now a group of 8 family nurses who have either not completed the training or started the training.

Joint gatherings:

We have carried out four gatherings for all the nurses, supervisors and team coordinator this year.

- 2 days with a focus on data collection, data reports, recruitment, and inclusion criteria.
- 2 days assigned to understanding program delivery and the use of program materials.
- 2 days with domestic violence training
- 1-day Motivational interview
- 1 day Video Guidance and Marte Meo

For supervisors:

The supervisors have gatherings one day every 6 weeks. These gatherings are often in connection with the joint gathering. The National Office prepares and plans the theme for the day in advance of each meeting. The focus is on deepening the various aspects of the program. And to help them understand the complex role of being a supervisor. They all have different personal work backgrounds and experiences, and the 5 sites also have different municipal practices.

Team Coordinators/administrators:

The five team coordinators/administrators attended all our joint gatherings throughout the year. At some of the gatherings, we had a separate program for the team coordinators on one day, while at other gatherings, they were with the family nurses and supervisors on both days.
Some of the themes with the team coordinators has been their role in the RCT study, receiving referrals, various reporting, and sharing of experiences.
We have received feedback from the team coordinators that they enjoy participating in the gatherings with the family nurses, even if the topic is not always directly relevant to their tasks. It is about better understanding what the family nurses are working on and how they can help and support the nurses in their daily work.

- Changes/ improvements to NFP education since the last report

From spring to October, the National Office collaborated with Henning Mohaupt, an expert in the field of domestic violence, to customize and adjust the IPV flout cart to the Norwegian context. This development was informed by (1) the insights the National Office has accumulated over the past seven years, (2) Mohaupt's experience and expertise in the Norwegian context, (3) discussions with the FNP in England regarding their updates to the IPV, and (4) conversations with family nurses about their experiences.

In October, family nurses underwent a full-day refresher session with Mohaupt on the topic, followed by a second day assigned to the revised learning set.

- Successes/challenges with delivery of NFP education:

Like last year we invited the experienced nurses and supervisors to contribute during the toddler week. Their contribution to groupwork and discussions was very useful.
Bringing experienced nurses together with the new nurses in training and in all the gatherings we have, has turned out to be very successful. The new nurses report that this is a key importance for them when learning the program.

The supervisors and the family nurses report that they find it motivating and encouraging that we as the program develops in Norway consecutively work on adjusting the NFP material to the Norwegian context. To create a good understanding both for the nurses but also for everyone the programme collaborates with, it is important that the NFP materials correspond to the Norwegian context and legislation.

The supervisors are responsible for arranging extended team conferences to immerse in selected theoretical topics. The plan for which topics and when this is to be carried out is developed together with the National Office. Both the nurses and supervisors report this to be very useful. Some nurses report that they find that joint training and planned gatherings can be a bit overwhelming in terms of content and scope. It is therefore important that they have sufficient time at in their respective teams to discuss and reflect on what they have learned.

Reflective Supervision

- Successes/challenges with NFP nurse reflective supervision:

The supervisors report that reflective supervision overall is going well. They find the material and documents useful though the 3 new supervisors are still in a learning phase. They report that they together with the nurses still are exploring and practicing on how to understand and use the supervision documents. They report that this is a very positive thing to do together, and that they all learn a lot from it.

Because of changes in roles for instance when a nurse takes on the supervisor role, they might experience challenges in cooperation and communication within the teams. The supervisors report that supervision and teams conference some time is challenging. They have to plan the supervision with each nurse thoroughly, they report that while it is useful, it is also time consuming and emotionally demanding.

- Successes/challenges with reflective supervision to our supervisors:

The National Office continues to be in close contact with supervisors in meetings once a week. In addition, they are offered an open supervision weekly. There is still a lot for the new supervisors to learn and integrate. The National Office needs to strike the balance between providing them with a good understanding of the program and at the same time helping them overcome local challenges or obstacles. This is more challenging in some of the implementing sites than for others. We have experienced that when the National Office offers easy access to contact us for any questions it makes the workday easier for them.

We focus on the use of motivational interviewing (MI). MI is included in the weekly supervision with supervisors, to help them focus on MI in their supervision with nurses in the teams. It has been very successful that we arranged a day for the supervisors exclusive with our MI specialist. This gave them the opportunity to learn and discuss the use of MI focus both in supervision and also in the program.

- Successes/challenges with delivery of reflective supervision to our associated team members (Family Partnership Worker/Mediator)

Throughout the year, the team coordinators and two of us from the National Office have had a one-hour meeting every other week. The purpose of these meetings is to create a sense of community among team coordinators across teams, establish an information channel to and from the National Office, and address any questions. Each meeting begins with a status update where everyone shares how things are going in their respective teams and if there is anything specific on their minds. Following that, the National Office typically provides some information, such as updates on data collection, upcoming gatherings, or changes in program materials. The team coordinators then share this information with their teams. In the meetings we also address questions from the team coordinators, whether they are pre-submitted or arise during the meeting.

The group has functioned well throughout the year, and we find that team coordinators are increasingly sharing updates on how things are going within their teams, indicating a high level of trust within the group. We have welcomed two new team coordinators during the year, and it has been important to get to know them and integrate them into the group. Due to changes among the staff at the national office, next year we plan to have meetings every third week, with only one representative from the National Office attending. We will assess throughout the year how frequently it is appropriate to hold meetings.

Additionally, sometimes we have joint meetings with supervisors and team coordinators if there is information that is important for both groups to receive. This has worked well, and it will be continued with in 2024.

NFP Information System

- High level description of our NFP information system, including how data are entered:
  We have a digital data collection system called “NFP-portal”. The family nurses bring their personal iPad to the home visits and fill out the data forms on their iPad. They can also log into the NFP-portal from their computer. The supervisor and the team coordinator/administrator fill out the data forms about supervision and team meetings.

  In the data portal, the nurses can choose a client, and see which data forms are completed and which data forms need to be completed. Each family nurse can only see their own clients. The supervisor and the team coordinator have access to all clients in the team, and the advisor at the National Office have access to all clients in all teams.

  Our data is stored in the digital data collection system. When we analyse the data, we extract the data we want to look at in more detail to a platform called Services for sensitive data (TSD). TSD is developed and operated by the University of Oslo. In TSD we also store our videos used for video guidance.

- Commentary on data completeness and/ or accuracy:
  The nurses are generally very skilled at completing data forms. Nevertheless, we see a need to closely monitor the data collection to ensure that all forms are completed on time and in the correct manner. Throughout the year, the data advisor at the National Office responsible for data has participated in team meetings in the five sites. In these meetings, she has presented data based on the teams' preferences, and they have discussed various data forms and questions. This has been important to ensure consistency in filling out the forms.

  If a data form is not completed, the family nurse should specify the reason for this. It could, for example, be that they did not have time to fill out the form within the deadline or that the

participant had a break in the program when the form was supposed to be filled out. In 2024, we hope to take a closer look at which data forms are not being filled out and see if we can identify any patterns.

- Reports that are generated, how often, and for whom:
  In the data portal, the family nurses have access to some automatic reports for each of their clients. The reports are based on GAD-7 (anxiety scores), PHQ-9 (depression scores), Home Visit Encounter Form and Client Intake Form (Control and Mastery and Feelings). The family nurse can look at the reports in preparation for a home visit or together with their client.

  The supervisor and the team coordinator have access to an automatic report based on Home Visit Encounter Form and Alternative Home Visit Encounter Form for the entire team. The National Office has reports for all the five teams.

  The supervisor and the team coordinator also have access to automatic reports based on the different supervision- and team meetings data forms. They can see how many weekly supervisions each family nurse has gotten and what they have talked about. We are currently updating the supervision- and team meetings data forms and are making the reports more useful for clinical practice.

  The data advisor at the national office also generates some reports based on our data.
  - Annual reports for each of the five NFP-regions.
  - Data for quarterly reports to the Ministry of Children-, Youth- and Family Affairs
  - Annual report to UCD
  - Other reports based on request

- Our reflections on our information system - what we need to do to improve its functionality, usefulness and quality:
  We are generally very satisfied with our data collection solution. It works well, and there are few technical errors. We will, however, continue to have data meetings with the teams to ensure the quality of data collection and input from the teams. We will further work on reports that the supervisor can use in their weekly supervision sessions. These reports will include both those based on the weekly supervision form and also provide the supervisor with an overview of each family nurse's activity and participants.
  We are also working on improving the reports for each of the five NFP-sites, in order for them to be useful for leadership at each of the sites. It is important for us to provide relevant data to each of the NFP-sites and the municipalities, thereby highlighting the importance of data collection and the program.

Any other relevant information:

PART TWO: PROGRAM IMPLEMENTATION - NFP CORE MODEL ELEMENTS (CMEs)

Please complete the table below to identify how the CMEs are being monitored/assured, benchmarks for your country, progress against benchmarks, and actions planned or undertaken to address any challenges. Where there is a need to add more content than space allows, please add appendices as necessary. Please explain any missing data or analyses.

NB: Where any temporary variances to the CMEs have been agreed, please indicate these in the text box below as well as completing Appendix 2 of this document

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% voluntary participation Monitored /assured by: (e.g. by signed informed consent) Family Nurses	100 % voluntary participation	
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: Family Nurses	100 % first time mothers	We regularly receive feedback from collaborating services indicating that it is inconsistent not to admit multipara. When a woman gets pregnant with her second child and realizes that she faces numerous challenges, it seems almost unreasonable that she cannot receive the assistance that we believe would be most beneficial for her.
3. Client meets socioeconomic disadvantage criteria at intake	The *eligibility criteria* for inclusion in the program in our country are: 1. Perceived neglect, physical/mental, violence/abuse or bullying	100 % clients enrolled who meet the country's eligibility criteria	See Table 1 in Appendix 1.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	2. Contact with child protection services in own upbringing 3. Little social support from family and network 4. Persistent or serious conflicts in relationship with partner or others 5. Difficulties in utilizing relevant services being offered 6. Not working or in education, and a low level of education 7. Persistent low income/difficult economy 8. Mental challenges 9. Drug problems 10. Young age There must be two or more criteria present for inclusion This includes the socio-economic criteria of: Application of these criteria are assured and monitored by: Supervisors and family nurses in collaboration with the National Office		
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy.	% of NFP clients receive their first home visit no later than the 28th week of pregnancy	We see that some clients are recruited late in the pregnancy (week 26-28) and they don't always

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
later than the 28th week of pregnancy.	b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	88 % of eligible referrals who are intended to be recruited to NFP are enrolled in the program 20 % of pregnant women are enrolled by 16 weeks' gestation or earlier	receive the first home visit before the 28th week of pregnancy. One of the team's thoughts about clients' enrolling early in pregnancy: "We find it important to recruit clients early in pregnancy. Relationship work takes time. Therefore, there is a feeling of having a completely different starting point for the work that is done when the family nurse gets to meet the client early in the pregnancy. When clients are referred to us around week 26, our experience is that the weeks go very fast, and thus a greater feeling of not being able to go through all the topics that we see are relevant and desirable from the client's perspective." Only 20% of our participants are recruited before week 16. There can be several reasons for this. First and foremost, we must emphasize that we provide the program to a selected group, not as in most other countries where clients are automatically included based on age. This may be a reason why we

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			may find it more difficult to recruit early. Antenatal care in Norway is well developed, so women receive good follow-up early in pregnancy even if they are not being included in NFP. We experience that in some cases, the pregnant woman meets with the midwife later in pregnancy, making inclusion before week 16 difficult to achieve (midwives are the ones who refer the most). There may be reasons why midwifes and others do not mention the RCT at the first meeting, as it may be desirable and necessary to get to know the woman better first. It can also be an extra strain to mention the RCT the first time they meet, which again could mean later inclusion. The data show that 88% of those who meet the criteria for participation say "yes" to participating in the RCT, so we manage to include most of those who are relevant, thanks to good referrers such as midwives and general practitioners.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			One of the teams reports that they had fewer inquiries in 2023 than in 2022, possible because of some skepticism from referrers around recruiting to a RCT where the mother is not guaranteed the NFP-program. Another team reports that women often contact their general practitioner first, and they do not always refer the client to us before week 16.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned a single NFP nurse.	100 % clients are assigned a single NFP nurse • 6 % (N=23) of the clients have changed family nurse permanently/for a longer period in 2023. • Most of the clients changed family nurse because the family nurse either quit the job, went on long-term sick leave, or switched positions within the team (from family nurse to supervisor). • 4 of the clients changed family nurse because they moved to a different NFP-area and continued with the program there. • In addition to the 23 clients, some participants have briefly changed family nurses due to sick leaves.	
6. Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.	Our National benchmark set is: ____% visits take place in the home We have not developed benchmarks on this.	84 % visits take place in the home % breakdown of where visits are being conducted other than in the client's home: Family/Friend's Home: 1 % Public Health Office: 2 % NFP-Office: 5 % Doctor/Clinic: 0 % Telehealth (phone): 2 %	

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		Telehealth (video): 0 % Café: 2 % Other: 4 % 27 % of visits where second parent of child is present 3 % of visits where other family member was present	
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.		• _____% of clients being visited on standard visit schedule • Average number of visits by program phase for clients on standard visit schedule is _____ • _____% of clients being visited on alternate visit schedule • Average number of visits by program phase for clients on alternate visit schedule is_____ Average number of completed visits for clients who have completed each phase: Pregnancy: • Average: 8.0. • Range: 1 – 26 Infancy: • Average: 20.0 • Range: 7 – 48	We do not collect data on how many clients are visited on standard or alternative visit schedule.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	a) Length of visits by phase country benchmarks are: • Pregnancy phase: • Infancy phase: • Toddler phase: b) Client attrition by program phase country benchmarks are: _____% attrition in Pregnancy phase _____% attrition in Infancy phase _____% attrition in Toddler phase	Toddlerhood: • Average: 15.1 • Range: 2 - 63 • Length of visits by phase (average and range): Pregnancy phase: • Average: 84 minutes. • Range: 15 – 220 minutes. Infancy phase: • Average: 82 minutes. • Range: 12 – 210 minutes. Toddler phase: • Average: 78 minutes. • Range: 15 – 240 minutes. Client attrition by phase and reasons: 1 % attrition in Pregnancy phase (of the clients active this year) 4 clients left the program in pregnancy phase in 2023. • 1 client perceived that they had sufficient knowledge or support • 1 client left because they get enough help from other services/programs	We are working on reducing the length of the home visits, now that the case load is getting larger.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		• 2 clients left the program for other reasons 7 % attrition in Infancy phase (of the clients active this year) 28 clients left the program in infancy phase in 2023: • 5 clients moved to an area where NFP is not available • 1 client was lost to follow-up • 2 clients left the program because the babies are no longer in mothers' custody • 4 clients perceived that she had received what she needed from the program • 8 clients perceived that they had sufficient knowledge or support • 4 clients did not want to continue the program with a new family nurse • 1 client refused NFP after report to Child Welfare Services • 3 clients left the program for other reasons 3 % attrition in Toddler phase (of the clients active this year) 13 clients left the program in toddler phase in 2023:	

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		• 2 clients moved to an area where NFP is not available • 1 client was lost to follow-up • 1 client left the program because the babies are no longer in mothers' custody • 2 clients left because she didn't have time for visits • 3 clients did not want to continue the program with a new family nurse • 2 clients refused NFP following report to Child Welfare Services • 2 clients left the program for other reasons In addition, 32 clients graduated the program in 2023.	
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by (eg standardized job description); National Office Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc.	100 % NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree	Most of the teams have a mix of midwives and public health nurses. One of the team has had only one midwife over the years and they struggle a bit to keep the midwives in the team. Experiences from other teams indicate that it works well when there are multiple professionals from each category. Being alone in one's professional background can feel isolating, and it can become more challenging in

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			terms of sharing expertise within the team. There is a focus on recruiting midwives to the team when opportunities arise. There is also a general shortage of midwives in Norway. In one of the teams, there have been challenges in finding enough qualified applicants for the family nurse positions.
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula _____% of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	_____% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities 96 % completion of team meetings, 91 % completion of case conference and % completion of education sessions	92 % (N=24) completed toddler training 97 % (N=35) of the family nurses and supervisors completed domestic violence training
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
the five program domains.			
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	100% of 4-monthly Accompanied Home Visits completed (against expected).	31 % of 4-monthly Accompanied Home Visits completed	The teams completed 28 accompanied home visits in 2023. We are working towards increasing the number of accompanied home visits.
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100% of NFP teams have an assigned NFP Supervisor 100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurses).	100 % of NFP teams have an assigned NFP Supervisor 60 % (N=640) of reflective supervision sessions conducted	Reasons for cancelling reflective supervision: • 12 % were cancelled due to scheduling conflicts • 13 % were cancelled due to illness • 15 % were cancelled due to other reasons, often because of joint national NFP-gatherings for the teams or for the supervisors
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous	No benchmark. Monitored/assured by:	Progress: Our data collection solution works well, and the teams are skilled at gathering data. We are constantly working to achieve better utilization of data in clinical practice, including	

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.		through the further development of reports in our digital data collection solution. This is an ongoing effort.	
14. High quality NFP implementation is developed and sustained through national and local organized support	_____% of Advisory Boards or equivalents held in relation to expected _____% attendance at Advisory Boards held in relation to expected Or alternative benchmark: Monitored/assured by (including other measures used to assure high quality implementation):	95 % of Advisory Boards or equivalents _____% attendance at Advisory Boards	The attendance is usually very good with about 75-100% attendance.

Domain coverage*

Please complete with your country benchmarks and average (for proportion of time spent within each domain during visits)

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35 – 40 %	31 %	14 – 20 %	22 %	10 – 15 %	21 %
Maternal Role (My Child and Me)	23 – 25 %	32 %	45 – 50 %	47 %	40 – 45 %	43 %
Environmental Health (My Home) My Family & Friends (Family & Friends)	15 – 22 %	22 %	17 – 25 %	19 %	17 – 25 %	19 %
Life Course Development (My Life)	10 – 15 %	15 %	10 – 15 %	12 %	18 – 20 %	17 %

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):
In 2021/22, we made revisions and adaptations to suit the Norwegian context. Our goal was to make the mapping of resources, risks, and stages of change more open, allowing for transparency and understanding and to involve clients actively in this process. Openness in goal-setting work has been crucial, ensuring agreement between the client and family nurse on the goals set within each program area. A system for regular evaluations is conducted with the client and family nurse, at least at the end of each phase (pregnancy, infancy, and toddler phases). The goal-setting document is designed to be a "living" document, adaptable to the client's (and family nurse's) wishes and needs. The adaptation and revision involved a structure based on personalization, recognizing that each client has distinct characteristics and needs. Some may struggle in one aspect of their lives but be confident and skilled in other areas. Consequently, we developed a goal-setting document, based on tailor-made intervention.
We have developed a guideline (work plan) for recommended topics relevant in the different phases, which the family nurse uses as support in planning. Additionally, we have developed guidelines for how to use the work plan.
This transition has been challenging for some of the family nurses in the two established teams, who previously used visit-to-visit guidelines. The use of the new documents has required more planning before each home visit, as they are now tailored to each client's individual goal-setting plan.

In the data describing international benchmarks and our actual percentages, it is interesting that we are still within what is expected in each program area. This reassures us that we are overall continue delivering the program as intended, despite changes in the revised goal-setting documents.

PART THREE: PROGRAM IMPACTS

Countries report on data indicative of program outcomes to demonstrate continuing achievement of the three NFP program goals:

1. Improve pregnancy outcomes 2. Improve child health and development 3. Improve parents' economic self-sufficiency

Please complete the tables below and/or add any additional text or diagrams in Appendix 1. Where terms used in the report template are generic, please specify how items are measured as necessary. Please explain any missing data or analyses.

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)** (2016 – 2022)	**Current Period (n/%)** (2023)
Age (range and mean)	Range: 15 – 44 Mean: 27.2	Range: 16 – 43 Mean: 28.6 See table 2 in Appendix 1.
Race/ethnicity distribution	69 % (N=297) of clients are Norwegian/Scandinavian. 31 % (N=131) of clients have another ethnicity than Norwegian/Scandinavian.	79 % (N=117) of clients are Norwegian. 21 % (N=32) of clients have another ethnicity than Norwegian. See table 3 in Appendix 1.
Income (please state how this is defined) The annual median salary in Norway in 2022 was around 572 000 NOK (USD 52,000/ EUR 49,000).	79 % (N=325) of clients had an annual income of less than USD 53,000. 9 % (N=38) of clients had an annual income above USD 53,000. 12 % (N=49) of clients didn't want to/couldn't answer this question.	78 % (N=115) of clients had an annual income of less than USD 53,000. 16 % (N=23) of clients had an annual income above USD 53,000. 7 % (N=10) of clients didn't want to/couldn't answer this question.
Inadequate Housing (please define) • Staying with friend(s) temporarily	Staying with friend(s) temporarily: 1 % (N=5)	Staying with friend(s) temporarily: 0 % (N=0)

• Residential care (treatment center, maternity home) (Residential care can be both inadequate and adequate housing. Housing for the homeless is e.g. inadequate, but a client that currently lives at a treatment center, can normally have an adequate housing alternative)	Residential care (treatment center, maternity home): 2 % (N=8)	Residential care (treatment center, maternity home): 0 % (N=0)
Educational Achievement	Primary school: 27 % (N= 113) High school: 30 % (N= 127) Vocational school: 4 % (N= 15) One-year program at university or college: 4 % (N= 18) Bachelors' degree: 20 % (N= 84) Masters' degree: 13 % (N= 56) PHD: 1 % (N= 4) Other: 1 % (N=5)	Primary school: 22 % (N= 32) High school: 39 % (N= 58) Vocational school: 4 % (N= 6) One-year program at university or college: 1 % (N= 1) Bachelors' degree: 18 % (N=26) Masters' degree: 14 % (N= 20) PHD: 0 % (N= 0) Other: 3 % (N=5)
Employment status	55 % (N= 233) of clients were in employment.	58 % (N=86) of clients were in employment.
Food Insecurity (please define)	Not Applicable	Not Applicable
Ever In the care of the State (as a child or currently)	Foster Parents: 8 % (N= 34) Residential Care: 10 % (N= 41) (as a child)	Foster Parents: 5 % (N= 8) Residential Care: 6 % (N= 9) (as a child)
Obesity (BMI of 30 or more)	12 % (N=55)	16 % (N=19)
Severe Obesity (BMI of 40 or more)	2 % (N=9)	3 % (N=4)
Underweight (BMI of 18.5 or less)	9 % (N=38)	4 % (N=5)
Heart Disease	3 % (N=15)	4 % (N=5)
Hypertension	1 % (N=6)	1 % (N=1)
Diabetes – T1	1 % (N=3)	0 % (N=0)
Diabetes – T2	1 % (N=5)	0 % (N=0)
Kidney disease	1 % (N=5)	1 % (N=1)
Epilepsy	2 % (N=10)	2 % (N=3)
Sickle cell Disease	0 % (N=1)	0 % (N=0)
Chronic Gastrointestinal disease	7 % (N=34)	8 % (N=10)
Asthma/other chronic pulmonary disease	14 % (N=63)	20 % (N=24)

Chronic Urinary Tract Infections	7 % (N=33)	5 % (N=6)
Chronic Vaginal Infections (e.g., yeast infections)	6 % (N=26)	6 % (N=7)
Sexually Transmitted Infections	16 % (N=71)	26 % (N=32)
Substance Use Disorder	11 % (N=51)	15 % (N=19)
Mental Illness: Anxiety	50 % (N=226)	70 % (N=86)
Mental Illness: Depression	52 % (N=235)	67 % (N=83)
Eating Disorder	19 % (N=85)	29 % (N=36)
ADHD (ADHD was added to the list in 2020, so we do not have data from the years before this)	7 % (N=33)	18 % (N=22)
Learning difficulties	13 % (N=59)	18 % (N=22)
Behavioural problems	8 % (N=36)	10 % (N=12)
Other (please define)		

Please comment below on the characteristics of your client population, including analysis of STAR (or equivalent) data and reviewing trends over time. Please include comments on:

- *The extent to which your data analysis indicates that your program is serving families with multiple overlapping needs*

The target group for the program in Norway consists of individuals facing complex challenges, and through our exploration process we identify those who need the program the most. Therefore, we know that clients in the program have multiple overlapping needs. We continue to observe a high percentage of individuals who have experienced or are currently dealing with anxiety and depression. The figures for 2023 are even higher than before (70 % anxiety and 67 % depression). This aligns well with the fact that mental health difficulties are the inclusion criteria that most clients meet (see Table 1 in Appendix 1). It is also interesting that 29 % of the new clients in 2023 are currently or have previously experienced eating disorder.

We have many clients with higher education (33% in 2023), while 58% of the clients were employed. Higher education does not necessarily imply good functioning, and we observe that clients with higher education also have a significant need for the program.

- *What you know about the characteristics of eligible families who are offered the program but decline to participate.*

Table 4 in Appendix 1 shows inclusion criteria for clients enrolled and women who declined participation in 2023. The 19 potential clients who declined participation had an average of 3.3 inclusion criteria. The clients who enrolled had in comparison an average of 4.2 inclusion criteria.

Alterable Maternal Behavior/ program impacts for clients (please complete for all the time periods where the data is collected)					
	Intake	**36 Weeks of Pregnancy**	**Postpartum**	**12 months**	**18 months**
Anxiety (n, % moderate + clinical range) Generalized Anxiety Disorder 7 (GAD-7)	N = 502 20 % moderate anxiety 15 % severe anxiety	N = 304 18 % moderate anxiety 7 % severe anxiety	N = 456 17 % moderate anxiety 8 % severe anxiety	N = 185 11 % moderate anxiety 9 % severe anxiety	N = 135 18 % moderate anxiety 5 % severe anxiety
Depression, (n, % moderate + clinical range) Patient Health Questionnaire-9 (PHQ-9)	N = 508 28 % moderate depression 16 % moderately severe depression 4 % severe depression	N = 304 29 % moderate depression 10 % moderately severe depression 2 % severe depression	N = 456 20 % moderate depression 9 % moderately severe depression 2 % severe depression	N = 183 19 % moderate depression 8 % moderately severe depression 4 % severe depression	N = 135 17 % moderate depression 6 % moderately severe depression 4 % severe depression
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours) We changed the questions about smoking and drug use in June 2020. We have added the question “Do you smoke now/at the moment”? It will be interesting to see how these numbers change/develop when more data forms are filled out. This data form is now being filled out four times during the program: pregnancy intake, 36 weeks of pregnancy, 12 months and 18 months.	20 % (N=114) of clients have been smoking in the pregnancy, including before they found out that they were pregnant. 3 % (N=13) of clients smoke daily.	9 % (N=25) of clients have been smoking in their pregnancy. 3 % (N=6) of clients smoke daily.		26 % (N=45) of clients have been smoking since their baby was born. 6 % (N=8) of clients smoke daily.	 6 % (N=5) of clients smoke daily.

	1 % (N=5) of clients smoke sometimes. 95 % (N=354) of clients are not currently smoking.	0 % (N=1) of clients smoke sometimes. 97 % (N=207) of clients are not currently smoking.		7 % (N=10) of clients smoke sometimes. 87 % (N=120) of clients are not currently smoking.	8 % (N=6) of clients smoke sometimes. 86 % (N=69) of clients are not currently smoking.
Snus use (A popular tobacco product in Norway)	27 % (N=154) of clients have been using snus in pregnancy, including before they found out that they were pregnant. 8 % (N=29) of clients use snus daily. 3 % (N=12) of clients use snus sometimes. 89 % (N=331) of clients are not currently using snus.	21 % (N=57) of clients have been using snus in pregnancy. 8 % (N=17) of clients use snus daily. 5 % (N=10) of clients use snus sometimes. 87 % (N=186) of clients are not currently using snus.		23 % (N=32) of clients use snus daily. 6 % (N=8) of clients use snus sometimes. 71 % (N=98) of clients are not currently using snus.	23 % (N=18) of clients use snus daily. 5 % (N=4) of clients use snus sometimes. 72 % (N=57) of clients are not currently using snus.
Alcohol, (n, % during pregnancy, units/last 14 days)	38 % (N=220) of clients have been drinking during the pregnancy,				

Same changes in the data form as mentioned above.	including before they found out that they were pregnant. 0 % (N=1) of clients are currently drinking sometimes. 100 % (N=370) of clients are not currently drinking alcohol.	100 % (N=214) of clients are not currently drinking alcohol.		56 % (N=81) of clients are currently drinking sometimes. 44 % (N=64) of clients are not currently drinking alcohol.	56 % (N=45) of clients are currently drinking sometimes. 44 % (N=36) of clients are not currently drinking alcohol.
Marijuana, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	5 % (N=24) of clients have been using marijuana during the pregnancy, including before they found out that they were pregnant. 100 % (N=370) of clients are not currently using marijuana.	100 % (N=216) of clients are not currently using marijuana.		1 % (N=2) are using marijuana once a month or less frequently 99 % (N=140) of clients are not currently using marijuana.	3 % (N=2) are using marijuana once a month or less frequently 97 % (N=76) of clients are not currently using marijuana.
Cocaine, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	1 % (N=8) of clients have been using cocaine during the pregnancy,				

	including before they found out that they were pregnant. 100 % (N=367) of clients are not currently using cocaine.	100 % (N=212) of clients are not currently using cocaine.		100 % (N=138) of clients are not currently using cocaine.	100 % (N=74) of clients are not currently using cocaine.
Other street drugs, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	2 % (N=9) of clients have been using other street drugs during the pregnancy, including before they found out that they were pregnant. 100 % (N=368) of clients are not currently using any other street drugs.	100 % (N=213) of clients are not currently using any other street drugs.		100 % (N=144) of clients are not currently using any other street drugs.	100 % (N=75) of clients are not currently using any other street drugs.
Excessive Weight Gain from baseline BMI - Pregnancy, (n, %)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Other: Physical activity How often are you so physically active that you become short of breath or sweaty?	Never: 15 % (N=55) Less than once per week: 20 % (N=76)	Never: 17 % (N=36) Less than once per week: 15 % (N=33)		Never: 17 % (N=25) Less than once per week: 14 % (N=21)	Never: 15 % (N=13) Less than once per week: 14 % (N=12)

	1 time per week: 13% (N=50) 2 times per week: 19 % (N=73) 3-4 times per week: 17 % (N=65) 5 times per week or more: 15 % (N=56)	1 time per week: 14 % (N=31) 2 times per week: 15 % (N=33) 3-4 times per week: 20 % (N=43) 5 times per week or more: 19 % (N=41)		1 time per week: 9 % (N=13) 2 times per week: 23 % (N=34) 3-4 times per week: 24 % (N=36) 5 times per week or more: 15 % (N=22)	1 time per week: 12 % (N=10) 2 times per week: 27 % (N=23) 3-4 times per week: 17 % (N=15) 5 times per week or more: 15 % (N=13)
Mastery, (n, mean) Low Mastery = 19 or under. Not Low Mastery = 20 or more.	Intake: N = 546 Mean = 21.3 Low mastery: 31 % (N= 170)	6 months: N = 314 Mean = 22.1 Low mastery: 21 % (N= 67)	12 months: N = 228 Mean = 21.8 Low mastery: 25 % (N= 58)	18 months: N = 149 Mean = 21.8 Low mastery: 23 % (N= 35)	24 months: N = 123 Mean = 22.4 Low mastery: 20 % (N= 24)
IPV disclosure, (n, %)	Pregnancy: 18 % (N= 51)	Infancy: 18 % (N=39)	Toddler: 11 % (N=9)		
	6 Months	**12 Months**	**18 months**	**24 Months**	
Reliable Birth Control use, (n, %) Condoms, birth control pills, patch, quarterly birth control injection, hormonal implant, IUD Hormonal and IUD Non-Hormonal	49 % (N=162)	55 % (N=129)	46 % (N=72)	52 % (N=62)	
Subsequent pregnancies, (n, %)	3% (N=10)	10% (N=23)	18% (N=28)	27% (N=35)	
Breast Feeding, (n, %)	**First postpartum visit:** Breastfeeding:	**6 months:**	**12 months:**	**18 months:**	**24 months:**

We changed the question "Have you been breastfeeding the baby exclusively since the birth?" to "Have you breastfed your baby?" in June 2020. We also added a question "How are you currently feeding your baby?"	92 % (N=301) have breastfeed their baby. <u>Currently feeding their baby:</u> 61 % (N=191) are exclusively breastfeeding. 26 % (N=83) of clients breastfeed non-exclusively. 13 % (N=40) of clients are not breastfeeding.	35 % (N=101) of clients are exclusively breastfeeding. 23 % (N=66) of clients breastfeed non-exclusively. 42 % (N=123) of clients are not breastfeeding.	43 % (N=78) of clients breastfeed non-exclusively. 57 % (N=105) of clients are not breastfeeding.	26 % (N=32) of clients breastfeed non-exclusively. 74 % (N=92) of clients are not breastfeeding.	11 % (N=9) of clients breastfeed non-exclusively. 89 % (N=74) of clients are not breastfeeding.
Involvement in Education, (n, %)	23 % (N= 75)	23 % (N=53)	20 % (N=30)	29 % (N=37)	
Employed, (n, %)	53 % (N= 148)	52 % (N=111)	58 % (N=80)	54 % (N=66)	
Housing needs, (n, %)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
DANCE (or equivalent), (mean - 2, 9, 15, 22 mos.) The data shows the percentage of clients who have received video guidance from NFP and the reasons why the remaining clients have not received video guidance from NFP. Based on data from late 2021 until now.	**3 – 6 months:** 90 % (N=173) of clients receive video guidance <u>Reasons why the rest of the clients does not receive video guidance from NFP:</u> 4 % (N=7) of clients receive	**12 months:** 54 % (N=36) of clients receive video guidance <u>Reasons why the rest of the clients does not receive video guidance from NFP:</u> 1 % (N=1) of clients receive	**20 months:** 29 % (N=8) of clients receive video guidance <u>Reasons why the rest of the clients does not receive video guidance from NFP:</u> 4 % (N=1) of clients receive		

	video guidance by another service 5 % (N=9) of clients does not want to be filmed 1 % (N=1) of clients where the family nurse has assessed that the family does not require video guidance 1 % (N=2) of clients does not receive video guidance of other reasons	video guidance by another service 21 % (N=14) of clients does not want to be filmed 12 % (N=8) of clients where the family nurse has assessed that the family does not require video guidance 12 % (N=8) of clients does not receive video guidance of other reasons	video guidance by another service 18 % (N=5) of clients does not want to be filmed 25 % (N=7) of clients where the family nurse has assessed that the family does not require video guidance 25 % (N=7) of clients does not receive video guidance of other reasons		
Father's involvement in care of child, (n, %) During the past three months, how often did the baby's biological father spend time taking care of and/or playing with the baby?	He does most/all of the care: 2 % (N= 6) Every day: 58 % (N=190) 3-6 times a week: 10 % (N=34) Once or twice a week: 6 % (N =20)	He does most/all of the care: 4 % (N= 9) Every day: 56 % (N=130) 3-6 times a week: 7 % (N=16) Once or twice a week: 7 % (N=16)	He does most/all of the care: 3 % (N= 5) Every day: 52 % (N=80) 3-6 times a week: 10 % (N=16) Once or twice a week: 10 % (N =16)	He does most/all of the care: 4 % (N= 5) Every day: 47 % (N=59) 3-6 times a week: 10 % (N=13) Once or twice a week: 11 % (N =14)	

	1-3 times a month: 2 % (N= 7) Less than once a month: 3 % (N= 11) He has not spent time caring for or interacting with the baby: 18 % (N=60)	1-3 times a month: 4 % (N= 9) Less than once a month: 4 % (N= 10) He has not spent time caring for or interacting with the baby: 19 % (N=44)	1-3 times a month: 2 % (N= 3) Less than once a month: 5 % (N= 8) He has not spent time caring for or interacting with the baby: 17 % (N=27)	1-3 times a month: 6 % (N= 7) Less than once a month: 6 % (N= 7) He has not spent time caring for or interacting with the baby: 17 % (N=21)	
Other (please define)					

Please comment below on the program impacts for clients, as indicated by the data provided (include comparisons where possible e.g. to previous years, to equivalent populations etc.)**:**
In which areas is the program having greatest impact on maternal behaviors? Which are the areas of challenge?

86 % of our clients have mental difficulties as one of their eligibility criteria, so this is a common eligibility criterion for our clients.
From the GAD-7 data, we see that the percentage of participants with moderate to severe anxiety varies, but generally ranges between 15-20% for moderate anxiety and 5-15% for severe anxiety. This indicates that a significant portion of this population experiences anxiety symptoms at a moderate to severe level.
The PHQ-9 data shows that the prevalence of depression also varies, with 17-28% of participants experiencing moderate depression, 6-16% with moderate to severe depression, and 2-4% with severe depression. These numbers suggest that depression is a significant problem among this group, with a notable portion experiencing moderate to severe symptoms.

Based on our data, we see that the percentage of severe anxiety decreases from the time the client starts in the program to its conclusion when the child turns two years old (from 15% at intake to 5% at completion). Similarly, we see that moderate depression and moderately severe depression decrease from intake to completion. This is encouraging. However, it is not a goal that all anxiety and depression should be cured by participating in the NFP. It is

unrealistic to believe that participation in NFP will lead to the disappearance of anxiety and depression. What we aim for is to help clients learn to manage their anxiety in their everyday life to avoid that the client's mental challenges occupy too much space in the family's life.

When it comes to Mastery scores, we see that the average mastery score slightly increases over time, from 21.3 at intake to 22.4 when the child is two years old. We notice that the proportion of clients with "Low Mastery" decreases from 31% at intake to 20% at graduation. This suggests a general improvement in the sense of mastery over time among our clients, which we consider encouraging.
The increase in average mastery and the reduction in the proportion with "Low Mastery" may indicate that our clients have developed better coping strategies. It might also be the case that they have had positive experiences that have improved their overall sense of mastery.

Tobacco: Few of our clients do smoke cigarettes, which is in line with the general population in Norway. The proportion of snus-use is higher, and as mentioned in previous annual reports, it is a trend in the general population in Norway to use snus instead of cigarette smoking.

Alcohol: The data shows that 38% of our clients have consumed alcohol during pregnancy. This includes before they knew they were pregnant, so we assume that the number of those who knowingly drank alcohol during pregnancy is lower. At week 36, none of our clients report alcohol consumption.

Marte Meo video guidance (equivalent to DANCE): The data shows the use of video guidance when the child is between 3 and 6 months, at 12 months, and at 18-20 months. At the age of 3–6 months, 90% of clients receive video guidance, and all our family nurses use video during home visits. This may indicate that new parents are concerned with and interested in this form of guidance. We see a gradual decrease in the use of video guidance as the child reaches 12 and 18-20 months, with 54% at 12 months and 29% at 20 months, respectively. This could be about parents' increasing confidence in their parenting role, which means they do not see the same need for guidance using video. It could also be about the child starting kindergarten, and that it's harder to find time to film and give feedback on the film with only the afternoons available. We would also like to emphasize that from a central level (National Office), we have asked family nurses to be most concerned with offering video guidance at the first point in time, to ensure good follow-up and focus on interaction in the early days. Video guidance at 12 and 18-20 months, we have wanted the family nurses to have a more flexible approach, as reflected in the family nurse's conclusion that in a quarter (1/4) of the families, they consider it less suitable with video guidance. The family nurses' assessment is often made in consultation with the National Office, based on the idea of tailoring the follow-up to each family's needs and situation. Finally, it should be mentioned that there have been challenges associated with filling out the data form regarding video, leading to some incomplete data in this area. We are in the process of adjusting these misunderstandings. Therefore, we hope to say more comprehensively about the use of video guidance in the time to come.

Regarding father's involvement in care of child, it's worth noting the following: Based on the data, we see that between 50-58% of fathers are involved in daily care for the child, which is positive and encouraging. On the other hand, we see that 17-19% of fathers do not have contact with the child, which will affect the child's development and the father's relationship with the child. Promoting positive father involvement is especially important in families where the mother has challenges that may affect her parenting competence.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks' gestation)	0	0 %
Very preterm (28-32 weeks' gestation)	2	0,4 %
Moderate to late preterm (32-37 weeks' gestation)[1]	29	6 %
Low birthweight (please define for your context) Low birthweight: below 2500 g	25	7 %
Large for Gestational Age (LGA) (please define for your context)		
Other (please define)		

Please comment below on your birth data:

Our data is consistent with the Norwegian birth data in general.

[1] https://www.who.int/news-room/fact-sheets/detail/preterm-birth

Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	Up to date: 97 % (N=339) Not up to date: 2 % (N=8) Does not want to vaccinate the child: 1 % (N=2)	Up to date: 98 % (N= 226) Not up to date: 1 % (N=2) Does not want to vaccinate the child: 1 % (N=3)	Up to date: 98 % (N=156) Not up to date: 0 % (N=0) Does not want to vaccinate the child: 2 % (N=3)	Up to date: 99 % (N=128) Not up to date: 1 % (N=1) Does not want to vaccinate the child: 0 % (N=0)
Hospitalization for Injuries	0 % (N=1)	1 % (N=1)	1 % (N=1)	3 % (N=2)
ASQ scores requiring monitoring (grey zone)	Communication: 1 % (N=4) Gross Motor: 2 % (N=6) Fine Motor: 5 % (N=16) Problem Solving: 3 % (N=10) Personal Social: 1 % (N=4)	Communication: 3 % (N=6) Gross Motor: 3 % (N=7) Fine Motor: 3 % (N=6) Problem Solving: 5 % (N=11) Personal Social: 1 % (N=2)	Communication: 6 % (N=9) Gross Motor: 4 % (N=6) Fine Motor: 4 % (N=5) Problem Solving: 5 % (N=7) Personal Social: 4 % (N=6)	Communication: 10 % (N=12) Gross Motor: 6 % (N=7) Fine Motor: 4 % (N=5) Problem Solving: 6 % (N=7) Personal Social: 3 % (N=4)
ASQ scores requiring further assessment/referral				
ASQ-SE scores requiring monitoring (grey zone)	Social Emotional: 2 % (N=7)	Social Emotional: 1 % (N=3)	Social Emotional: 1 % (N=2)	Social Emotional: 3 % (N=4)
ASQ-SE scores requiring further assessment/referral				
Child Protection (please define for your context) Do you know if anyone has/have you reported concerns to the Child Welfare Services in the last 6 months regarding suspected abuse or neglect?	10 % (N=34) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 2 % (N=8) of clients were referred to the Child Welfare Services by the Family Nurse.	6 % (N=14) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 1 % (N=3) of clients were referred to the Child Welfare Services by the Family Nurse.	10 % (N=16) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 1 % (N=2) of clients were referred to the Child Welfare Services by the Family Nurse.	7 % (N=8) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 2 % (N=3) of clients were referred to the Child Welfare Services by the Family Nurse.
Child Protection (please define for your context)	8 % (N=27) of clients were referred to the Child	7 % (N=17) of clients were referred to the Child	8 % (N=12) of clients were referred to the Child Welfare	4 % (N=5) of clients were referred to the Child Welfare

Do you know if anyone has/have you recommended that the Child Welfare Service implement voluntary support services for the family in the last 6 months?	Welfare Services by other than the Family Nurse. 6 % (N=20) of clients were referred to the Child Welfare Services by the Family Nurse.	Welfare Services by other than the Family Nurse. 3 % (N=6) of clients were referred to the Child Welfare Services by the Family Nurse.	Services by other than the Family Nurse. 4 % (N=7) of clients were referred to the Child Welfare Services by the Family Nurse.	Services by other than the Family Nurse. 2 % (N=3) of clients were referred to the Child Welfare Services by the Family Nurse.
Other (please define) Where/by whom is the child looked after during the day? More than one option is possible We added this question to our data collection in June 2020.	Kindergarten: 0 % (N=0) Family kindergarten: 0 % (N=0) Childminder: 0 % (N=0) At home with parent(s): 97 % (N=227) At home with other family members: 6 % (N=15) If kindergarten, full-time or part-time: Full-time: N/A Part-time: N/A	Kindergarten: 44 % (N=63) Family kindergarten: 0 % (N=0) Childminder: 1 % (N=2) At home with parent(s): 53 % (N=76) At home with other family members: 7 % (N=10) If kindergarten, full-time or part-time: Full-time: 95 % (N=60) Part-time: 5 % (N=3)	Kindergarten: 79 % (N=73) Family kindergarten: 0 % (N=0) Childminder: 1 % (N=1) At home with parent(s): 15 % (N=14) At home with other family members: 2 % (N=2) If kindergarten, full-time or part-time: Full-time: 96 % (N=70) Part-time: 4 % (N=3)	Kindergarten: 87 % (N=72) Family kindergarten: 0 % (N=0) Childminder: 0 % (N=0) At home with parent(s): 7 % (N=6) At home with other family members: 2 % (N=2) If kindergarten, full-time or part-time: Full-time: 100 % (N=30) Part-time: 0 % (N=0)

Please comment below on your child health/development data

Referrals to Child Welfare Services: We see a consistent pattern throughout the age groups, indicating that a higher percentage of referrals to Child Welfare Services are made by others than the family nurse. We see that there are multiple services surrounding the family, involved in the children's lives and attentive to potential child welfare concerns. On some occasions, it is preferable for services other than NFP to report to child protective services, allowing the family nurse to continue the follow-up in the family even though child protective services are involved.

The percentage of clients referred to Child Welfare Services seems relatively stable across different age groups, with a slight uptick at 18 months. This might signal ongoing child protection concerns as the child ages, and perhaps attending kindergarten can be linked to the increase in referrals, when the children meet kindergarten staff, who have knowledge and possible concerns about child development.

It is expected that there will be more referrals to the child welfare services in NFP, as they are in a precarious situation. Referral to child welfare services does not reflect the number of care takeovers, only that concerns about the child's situation are reported. Of the 45 clients that left the program in 2023, 14 of them left due to referrals to the child welfare services. Of all the referrals to child welfare services in 2023, there were 13 clients where the follow-up by NFP was stopped due to custody transfer/care takeover.

ASQ: In examining the ASQ data, we note only minor differences when compared to the figures from 2021 and 2022. Consistently over the past years, we have observed a greater number of children in the grey zone (those requiring monitoring) at 24 months as opposed to 6 months. This trend is consistent across all areas except for Fine Motor skills, where the percentages are identical at both 6 and 24 months. The reference benchmarks within the ASQ are of particular interest to us, and we are looking forward to seeing if the Randomized Controlled Trial (RCT) results will highlight any developmental differences between our group and the information/control group.

A study on the prevalence of suspected developmental delays, based on a Norwegian longitudinal sample of 1555 infants and their parents attending regular health check-ups, explored the prevalence of such delays at 4, 6, and 12 months (Valla et al., BMC Pediatrics (2015) 15:215, DOI 10.1186/s12887-015-0528-z). The results indicate that during the first year of life, developmental delays are most frequently observed in the motor area, with particular attention needed for prematurely born infants. Premature birth (<37 gestational weeks) was linked to delays in the communication area at 4 months, and in the fine motor and personal-social areas at 6 months. The risk of developmental delays escalates with decreasing gestational age, a phenomenon likely due to the developmental stage of the central nervous system at birth. The study also found no significant correlation between maternal education and the five developmental areas assessed by the ASQ. This suggests that, at these early stages of development, biomedical factors may exert more influence on development than the parents' educational level.

In comparison with our data at 6 and 12 months, we find that most children are developing typically. Additionally, the incidence of premature births (<37 gestational weeks) within NFP is 6.4%, mirroring the situation across the Norwegian population.

Kindergarten: In Norway, the coverage of kindergartens is notably extensive. Norway guarantee kindergarten for children in their second year of life, and the cost is low, to ensure that as many as possible can take advantage of the kindergarten for their children. The data form can be misleading with only 44% attending kindergarten at the age of 1. Many children start in the months after their first birthday, so by 18 months, we see that the percentage has increased to 79%. By the age of 2, the percentage of children attending kindergarten is 87%, which is very close to the average in the general population.

Additional analyses

Please insert here any additional analyses undertaken to further explore program impacts

Client experiences

Please insert here any materials you would like to present regarding client experiences of the program. This can include collated client feedback, a case study or by clients providing video evidence etc.

Feedback from a client (May 2023):

"I was referred to NFP/Sammen på vei by the health station early in pregnancy due to mental illness. Even though I was happy to become a mother, the situation was marked by recurring depression and anxiety, physical complaints, dark thoughts, and uncertainty about the future. I quickly got along with "my" family nurse. She took her time to get to know me. She is completely open and non-judgmental, curious, and encouraging. She asks good questions that make me reflect. I had several dark thoughts I was surprised to share, but it felt safe because she had created a safe space for it. I never felt that she judged anything I said. Her encouraging comments are stored in me and help me stand firmer in the choices I make as a mother.

Specific things I and my partner have found useful include what we learned about the baby's signals. My husband has benefited from learning about the tolerance window and Circle of trust. For me, it has been important to realize how my own childhood affects the present and my own parenthood and to have talked through this. Throughout the pregnancy, I looked forward to her visits, and we still do. She shows genuine joy in meeting the baby, which is the best a mother knows. I feel very lucky and privileged to have been part of this program - and sad that not all first-time parents get the same opportunity. It can be hard to pinpoint exactly "what we got out of" the program, because what has been invaluable is the constant support, I feel I have had all the way. There is no doubt that our daughter will benefit from this for the rest of her life."

Experience written by a family nurse, about using video guidance in a family:

The client joined Nurse-Family Partnership (NFP) when she was 16 weeks pregnant. She struggled with several issues that resulted in her shutting other people out when things got difficult. She also found it hard to accept that anyone could love her without getting tired of her.

She found it hard to bond with her son when he was born. There was little contact between them, and she found it difficult to soothe the baby, who cried a lot. Her partner took much care of the child. The family nurse began filming when the boy was three months old. She showed the client clips where the baby sought out her and stretched out towards her. This prompted a change in the client's perception of both her and her child. She was visibly moved and was able to see that her baby was actually seeking her. She said: "Look, he does love me!"

The family nurse has done several more recordings since then, and the client constantly learns new aspects. She has become good at interpreting the child's signals. This was the start of what has developed into a deep relationship between the client and her son.

Interview with a family about what they like about NFP/Sammen på vei:

They like that they have one person (the same family nurse). They also like the flexibility, and it has been useful that the meetings are in their own home. The parents highlight that the family nurse adapts the appointments, so the father can join. It has been helpful that the family nurse is honest about the

challenges in the family. The family have had challenges with cleanliness, and the family nurse has been honest and explicit about areas that they needed to improve. They found it hard to take at the time, but afterwards they saw the importance for the child that there was focus on having a clean house. The family nurse helped with an application to the municipality to assist in the practical keeping of the house. This experience made the family more open to support from others as well. They say that in the beginning it was hard for to let someone into their space, because they had made so much effort in making their home a safe space. Their previous experiences with external assistance have been negative, especially with others telling them what to do They have gained a new perspective on this after joining NFP.

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	0	
Maternal death	0	
Other	0	

Any other relevant information or other events to report:
No

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

- Briefly describe your system for monitoring implementation quality:
- Advisory board meetings
- Meetings with local leaders in the municipalities
- Weekly online meetings with the supervisors
- Joint gatherings for the supervisors.
- National joint gatherings for all supervisors and family nurses
- Maintaining and improving the internal website and program material
- Reports to and from the NFP sites.
- Systematic data collection and use of data to guide clinical practice
- Cooperation with other competence units at RBUP to ensure that we are professionally updated.
- At the national level: shared results framework and overview of annual key deliverables between the Directorate and RBUP. As well as shared risk analysis and management. These are visited on a quarterly basis.
- Quaterly reporting on programme status to the Ministry of Children-, Youth- and Families.

- Goals and Objectives for CQI program during the reporting period:
  - Further development of our internal website
  - Development of education curricula, both overall and individual.
  - Development of material for preparation before gatherings and trainings

- Outcomes of CQI program for the reporting period
  We have further developed the internal website. We will continue this in 2024.
  The development of education curricula and material are ongoing.

- Lessons learned from CQI initiatives and how these will be applied in future:

We see that to measure the outcomes of quality work, it would be more appropriate to provide more specificity in our goals. Our previous goals have been somewhat general, making them difficult to measure. Often, these are things that need to be worked on over several years.

- Goals for CQI in next year:
- We aim to work with continuous updates in line with professional development to ensure effective program delivery.
- Guidelines and framework for digital home visits
- Develop education plan for turnover and temporary employees.
- Carry out structured evaluation of the new and adapted flow cart and guidelines related to domestic violence.
- Carry out structured evaluation of the new and adapted Marte Meo Learning Set. This also includes the development of a standardized training and certification program for video guidance in NFP.
- Further develop reports in the NFP portal to ensure the use of data in clinical practice.
- Enhance reporting to and from the NFP-areas.

Program innovations tested and/or implemented this year (this includes both international and local innovations)

- Program innovations tested[2]:

- Program innovations implemented:

Marte Meo Learning Set

We have used Marte Meo video guidance from the very start in 2016. In collaboration with Maria Aarts, the founder of Marte Meo, we have developed Marte Meo Learning Set for use in NFP during the last year. This Learning Set is more tailored to the families in NFP and available to our family nurses. We don't provide therapy, but rather parent information and guidance. We invite the parents to get to know the world of the child. This is the content of the new Marte Meo Learning Set.

Marte Meo is a video-based method for providing information about how to support development in daily interactions. This information is obtained from short video clips of their everyday interactions. We believe that all parents have competence that can be strengthened using video clips of interaction from everyday situations. Therefore, video guidance is provided to all the families in NFP. The client and her child are the main participants, but we also provide it to the child's father if wanted.

Short explanation of the Learning Set:

The Learning Set consists of two main dimensions. The first dimension is about following by giving the child space to take initiative in free play, where the child's own desire to establish contact is the starting point. The second dimension is about the parents' ability to provide positive leadership in structured everyday situations.

For each dimension there are five parental behaviors/elements.

For following we have:

1. Attentive waiting
2. Contact initiatives
3. Responding to the child's initiatives
4. Naming/giving words to describe what happens.
5. Developmental dialogue/Turn-taking

For positive leading we have:

1. Connection moment and clear start
2. Confirming the child's response
3. Naming
4. Step-by-step instruction
5. Clear end

And for each parental behavior/element, we describe what we look for (a development-oriented check list) and why this is important for the child and for the interaction.

We provide video guidance when the child is 3-6 months, 12 and 18 months, or when needed/wanted.

The video guidance is carried out by family nurses filming parent and child at home, for 2-5 minutes. Together with the Licensed Supervisor in Marte Meo at the National office, we review the content together, and agree on which clips should be shown to parent at the next home visit. Based on the content in the feedback session, the family nurses do new recording of the interaction. This is done for the next two to five/six home visits, and again at 12 and 18 months.

The supervision to the family nurses: The special adviser visits each team every six weeks for joint group guidance. In addition, family nurses are offered individual guidance every Tuesday and

Thursday, which takes place by booking a time, and then the guidance is conducted over Teams. Family nurses have provided feedback that both individual and group guidance are useful and meaningful for them."

Domestic Violence:
From spring to October, the National Office cooperated with Henning Mohaupt, customizing, and adjust the IPV flout cart and guidelines to the Norwegian context. Please refer to p. 7, "NFP Education, Changes/ improvements to NFP education since the last report," for more information.

- Findings and next steps:

Marte Meo Learning Set:
Using video, gives an opportunity to get an external perspective on the interaction, from someone who does not know the family in the same way as the family nurses do. It serves as a kind of quality check. The family nurses find it useful to study the interaction with an external person, and to receive feedback on what is good and what needs further work in each dyad. Both positive and challenging situations are discussed. We can discuss the developmental message behind problem behavior, by saying: "This child has not yet had the opportunity to learn to develop these skills." We receive feedback from parents that they appreciate the video guidance because it is so concrete and directly related to their daily life and their experiences.
So far, we do not have a measurement tool to assess the quality of parent – child interactions, but we hope that the assessment tool for evaluating parent-child interaction within families with children aged 0-6 years (described in part one) can be a useful contribution for us.

Domestic Violence:

The supervisors and family nurses report that the new documents and structure for work with domestic violence is very useful. It corresponds better to Norwegian legislation, which helps both the family nurses, and the child protection service to understand the purpose of program. We will carry out a thorough evaluation this spring. The results from this will contribute to further adjustment of the material if needed.

Temporary Variances to CMEs

For each variance agreed please attach a report of the variance evaluation methods and findings to date in Appendix 2 to this document

Additional Approved Model Elements (AAMEs)

Please complete Appendix 3 for any Additional Approved Model Elements for your country.

RCT or equivalent commissioned Research

Research team and their institutions:
AFI (The Labour Research Institute) is conducting the RCT on behalf of the Directorate. AFI is linked to OsloMet and is a social science institute performing multidisciplinary, action-oriented research. Anne Grete Tøge and Eirin Pedersen are project managers of a multidisciplinary research team consisting of researchers from subject areas like social politics, nursing and health inequalities, RCT, welfare politics and social economics. The researchers come from various research and competence institutions which are highly relevant to the planned research. Pedersen was part of the team conducting the evaluation in phase 2, which the Directorate considers to be a strength. The Norwegian research team also have a reference group of international experts with representatives who have been involved in RCTs in other NFP countries.

For information about the content of the RCT and for primary and secondary outcomes for the RCT reference is made to the study protocol which can be shared upon request.
Brief outline of research methodology: Reference is made to mentioned study protocol.
Details of progress to date: The actual recruitment to the study started beginning of June 2023. By the end of 2023, 96 (8.11) participants had been recruited to the study. The recruitment process is slower than anticipated by AFI and several measures has been put in place to increase the recruitment pace. The reasons for this are multifaceted, but a major point is that the recruitment base (target group) is limited. Joint efforts are being made by local stakeholders, the NFP teams, the National Office and AFI.
Expected reporting period and consultation with UCD prior to publication: N/A at this point in time.

PART FIVE: ACTION PLAN

LAST YEAR:

Our planned objectives for last year:

RBUP:

- Carry out the Toddler training in week 36 (September 2023) as planned in the curricula
- Change the Danger assessment tool (for use in IPV intervention) to a tool that is used by other services in Norway and are more relevant in the Norwegian context.
- Joint gatherings for all teams as planned in the annual plan, to share experiences and continue education and development.
- Have a routine of the reporting system for the sites.
- Have meeting/ gathering for local leaders in the host municipalities to enhance the understanding of the program and the balance between the demands from the program and the National Office and the local organization and system in each site.
- Develop a plan for how to take care of the training and maintenance of MI for NFP Norway in the future.
- Develop a plan for our MI specialist retirement.
- Further develop the digital data collection system and automatic reports
- In 2023 we will continue to improve and develop "Kompasset". We will adjust and develop new facilitators, develop informative/education videos, and modules.
- RBUP; continuing developing a new observational instrument of parent-child interaction for families with children aged 0-6 years that is suitable for Norwegian/Nordic conditions.

Bufdir:

- Bufdir will follow closely the effect study and have regular meetings with AFI. Bufdir will continue to encourage a good information flow between AFI and National Office, NFP Teams and key actors at the level of the municipality as local advisory boards.
- Continue to secure the best possible use of available funding while the needs of the programme are increasing beyond available funding.
- Continue to follow-up with the National Archive Office how Bufdir best can safeguard that its collection of personal data in the programme is in line with the Archive Law and on the other side the participants right/possibilities to have information about themselves removed from registered files and journals if in line with other existing laws like health law and law on child protection. As well as safeguarding a child's right as a youth or adult to have access to relevant information from the time their mother was enrolled in the programme in, for instance, a case of complaint.
- Continue to explore the opportunity to improve the collaboration with the Directorate of Health and a closer collaboration with their Ministry.

Progress against those objectives

RBUP: Overall, we have achieved our planned objectives for 2023.

Bufdir: The three first bullets have been pursued, although the issue linked to the National Archive Office is still pending. With regard to the last bullet this issue remains a major challenge.

Reflections on our progress:

RBUP:

Some of our planned objectives are ongoing projects, which we will continue in 2024. One example is to further develop more structured and predictable plans for education and training.

Bufdir: After several years where we have tried to make the Directorate of Health interested in the programme without success there is limited energy to move this forward.

NEXT YEAR:

Our planned objectives for next year:

RBUP:

- Digital home visits: Carry out introduction and training in how to conduct digital home visits.
- Develop structure and plan for education and training to take care of new employees and family nurses, turnover and sick leave.
- Carry out foundation week for this group spring 2024 and then infancy September 2024, to be followed up with toddler week April 2025.
    - We also want to create a more sustainable and predictable structure for taking care of education in the years to come. This includes Newborn behavioral observation (NBO), Marte Meo, Domestic violence.
    - Develop a pre-Learning pack
- Plan for team-based learning. We want to develop this in collaboration with our 5 supervisors.
- Carry out three joint gatherings, for all the supervisors and nurses.
- Two joint gatherings for the consultants in child protection service.
    - Invite all employees in the child protection service in each site to a conference, half, or full day together with the NFP team. Topic: Information about the program and how to promote positive collaboration. Responsibility for this is both the National office and the supervisors.
- One joint gathering for the psychologists
- To increase recruitment to the RCT study, we will work intentionally with information and support at multiple levels.
- Continue the regularly meetings and cooperation with the local leaders and local advisory boards.
- Special adviser Kristin Lund and Maria Aarts will develop a standardized training and certification for the Marte Meo Learning Set for NFP.
- We will look at opportunities how to include the partner of the client/the father to a greater extent.

Bufdir:

- Continue to provide strategic oversight of the programme, joint results framework, risk assessment and risk management.
- Manage and follow-up AFI on the RCT.
- Assess jointly with RBUP and AFI possible measures to be taken in 2024 to increase the recruitment base of the study.

Measures planned for evaluating our success:

RBUP: We are working to achieve more structured evaluation and feedback at multiple levels.

Bufdir:

- Joint results framework and risk assessment
- Satisfactory progress of RCT according to plan
- Outcome of joint assessment

Any plans/requests for program expansion?

N/A. Only expansion of municipalities/townships at existing sites.

Please note with permission, all completed annual reports are uploaded to the restricted pages of the international website so that every implementing country can mutually benefit in sharing their progress and achievements.

Please indicate your country's willingness to share this report in this way by checking one of the boxes below:

I agree to this report being uploaded onto the restricted pages of the international website ☑

I do not agree to this report being uploaded onto the international website ☐

PART SIX: RECORD OF MEETING FOR GLOBAL COLLABORATIVE GUIDANCE GROUP

Date of meeting:

Attendees from presenting country:

Attendees from reviewing country:

Reviewing country confirmation: Yes No If no, please indicate which areas were missing and how this was addressed in the meeting:

Key learning points arising from the meeting:

1.	
2.	
3.	

Appendix 1: Additional data analyses and /or graphic representations of the data

Table 1: Inclusion criteria for all clients enrolled in 2023 by team and total. % of all clients enrolled with this criterion

	Rogaland (Southwest)	Oslo (East)	Agder (South)	Trøndelag (Central)	Vestland (West)	Total
Perceived neglect, violence/abuse or bullying	90 %	77 %	88 %	85 %	79 %	83 %
Contact with child welfare in your own upbringing	38 %	14 %	54 %	40 %	21 %	31 %
Little social support in family and network	55 %	48 %	46 %	35 %	46 %	47 %
Persistent or serious conflicts with partner or others	31 %	43 %	58 %	60 %	13 %	41 %
Difficulties in utilizing relevant services being offered	14 %	18 %	27 %	20 %	21 %	20 %
Not in work, education, and a low level of education	55 %	14 %	54 %	40 %	38 %	37 %
Persistent low income/difficult economy	38 %	27 %	62 %	40 %	29 %	38 %
Mental difficulties	83 %	86 %	88 %	95 %	92 %	88 %
Drug problems	17 %	5 %	23 %	30 %	21 %	17 %
Young of age	24 %	9 %	19 %	25 %	13 %	17 %

Table 2: Age (mean and range) for clients enrolled in 2023 by team and total

	Rogaland	Oslo	Agder	Trøndelag	Vestland	Total
Mean	26.9	31.5	26.1	28.1	28.5	28.6
Range	17 – 38	18 – 43	18 – 40	21 – 41	16 – 39	16 – 43

Table 3: Ethnicity for clients enrolled in 2023 by team and total

	Rogaland	Oslo	Agder	Trøndelag	Vestland	Total
Norwegian	72 %	67 %	83 %	96 %	86 %	79 %
Other	28 %	33 %	17 %	4 %	14 %	21 %

Table 4: Inclusion criteria for clients enrolled in 2023 and clients who declined participation in 2023. % of all clients/potential with this criterion

	Enrolled in 2023	Declined participation in 2023
Perceived neglect, violence/abuse or bullying	83 %	58 %
Contact with child welfare in your own upbringing	31 %	21 %
Little social support in family and network	47 %	32 %
Persistent or serious conflicts with partner or others	41 %	37 %
Difficulties in utilizing relevant services being offered	20 %	5 %
Not in work, education, and a low level of education	37 %	37 %

Persistent low income/difficult economy	38 %	47 %
Mental difficulties	88 %	63 %
Drug problems	17 %	16 %
Young of age	17 %	16 %

Appendix 2: Evaluation of temporary CME variances

Please complete the table below for each variance agreed for your country.

CME #:
Temporary Variance to CME agreed:
Brief description of approach taken to testing the variance:
Methods for evaluating impact of variance:
Findings of evaluation to date:

CME #:
Temporary Variance to CME agreed:
Brief description of approach taken to testing the variance:
Methods for evaluating impact of variance:
Findings of evaluation to date:

Appendix 3: Additional Approved Model Element (AAME)

AAME agreed:
Reflections and findings in relation to use of the AAME