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 analyzed 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):	01.01.2024 – 31.12.2024
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:	

The size of our program:

	Number
Fulltime NFP Nurses	30
Part time NFP Nurses	3
Fulltime NFP Supervisors	5
Part time NFP Supervisors	0
Full time NFP Team Coordinators/Administrators	5
Part time NFP Team Coordinators/Administrators	0
Total	43

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

- 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. To ensure optimal recruitment for the study there has been taken several actions. The researchers have attended many advisory board meetings and have also attended on local meetings for referrers in places where recruitment has been low. They are also currently conducting workshops with midwives in all

five areas. We have learnt that recruitment to the study demands continuous attention due to the turnover in all services and the fact that the services have a wide range of caseload. However, after the launch of the study, there has developed a generally positive support for recruitment to the study and an understanding that it must be carried out.
To be sure to recruit enough participants to the study we have in agreement with the Ministry had phase 3 extended till the end of 2028, which imply that the recruitment period run until medio 2026. Furthermore, we have extended the Oslo site with one more municipality, called Lørenskog. Since 2020, when we began phase three, Lørenskog has annually inquired about the possibility of joining the NFP programme. Their motivation is crucial for ensuring successful cooperation and expansion from the outset. Recruitment from this new municipality will commence in January 2025

Site: Rogaland (South-West)
The team consists of 6 family nurses, 1 supervisor, and 1 administrator. The site now includes 9 municipalities. The collaboration among the municipalities within the site is good, and there are many previous experiences with inter-municipal cooperation. In 2024, client recruitment has continued, but despite the addition of two new municipalities, recruitment has not increased. The team regularly visits services which recruit for the study. In the largest municipality, referrals have slightly decreased, and focused work is being done to strengthen collaboration and recruitment. The local advisory board has been working to keep members engaged in meetings, and feedback about these meetings has improved. The board has requested one or more digital meetings in 2024. We have held one digital meeting this year. Generally, physical meetings seem to foster more engagement.

Site: Oslo
The team consists of 8 family nurses, 1 supervisor, and 1 administrator. A new family nurse joined in early 2024. The new supervisor, who has been a family nurse since 2016, is performing well in her supervisory role and in collaborating with leaders in the host township.
A reorganization has been underway in the host township, and the team moved to new, unfinished premises in December 2023. Individual team members have responded differently to this restructuring, leading to additional meetings to address these issues. The national office participated in these meetings alongside local leaders, working closely to support positive development.
Due to the need for expansion of the Oslo site, discussions were held on how to best manage the process. The experience with the Oslo team, the largest in Norway, has shown that balancing daily tasks such as program delivery, supervision, team meetings, and local collaboration is challenging. The supervisor often feels that she and the team are short of time. This is the primary reason for deciding to split the team into two when a new municipality joins. Consequently, we are now planning to have two host townships in Oslo. The plan is for the teams to work closely together in as many ways as possible. A new supervisor will be engaged in early January, hopefully from the existing team.
The municipal leaders from the two host townships are very supportive of the expansion. The collaboration is marked by a strong willingness to tackle tasks effectively and to learn important lessons for a potential national rollout.

The five existing townships on the site cooperate well with the team. The team must navigate various services, and organizational structures may differ in each township, making this a complex task.
A positive atmosphere is developing within the local advisory board, with members engaging in productive debates about challenges and solutions.
Client recruitment is steady, although increased efforts are needed to reach the desired number of study participants. The team holds meetings with current and potential referral sources, and the approach to the study has become more positive both within the local advisory board and among universal services. Meetings with the research team and referring services on the site have been conducted to support an 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. 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 southern Norway. The team has a main office in the host municipality and a smaller office in another municipality to reduce travel for the nurses. Additionally, the host municipality has purchased an electric car to minimize the use of private vehicles.
Recruitment is progressing well but varies throughout the year. One of the larger municipalities has a preventive program that is less extensive than NFP but targets a similar group. This program was presented at an advisory board meeting, leading to productive discussions on how to best cooperate and ensure sufficient recruitment to the MiNS-study. During the summer, the midwifery services in the largest municipality faced staffing challenges and chose not to call in pregnant women for their first consultation, expecting GPs to handle this according to national guidelines. This is believed to have contributed to low recruitment for several months in this municipality, which typically recruits the most participants in the entire site.

Site: Vestland (West)
The team in Vestland consists of 6 family nurses, 1 supervisor, and 1 administrator. This is one of the three newest sites and has faced management challenges since its inception 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 2024, the team experienced significant changes and challenges. The supervisor left, and a family nurse from the team stepped into the supervisory role. One family nurse left in 2023, and a new nurse joined in spring 2024. Another family nurse left before summer, and one more is leaving in February 2025. Two new family nurses have been hired, with one having started this autumn and the other starts in January 2025. The national office is working closely and intensively to support the team's development and program delivery.
The site includes 9 municipalities and covers a large area in western Norway.
Despite the challenges, recruitment is progressing. Some municipalities are recruiting fewer clients for the study. The local advisory board is actively working to address these recruitment challenges and is strongly supported by leaders in the host municipality.

The host municipality has a privacy department, and agreeing on the data processing agreement has been challenging. The National Office and Bufdir have spent considerable time finding 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. This is one of the three new sites and began in January 2022. The team receives strong support from the leadership in the host municipality.

Originally the site covered three municipalities and expanded to 6 during 2023. Recruitment for the study is progressing well, and the nurses are now beginning to understand the limits of what constitutes a satisfactory caseload in a Norwegian site.

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 2028. 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 2024 5 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. She also has weekly meetings with the directorate.

The Special Advisor, Kristin Lund, has been in this position since 2016. She specializes in pediatric 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 Special Advisor, Emma Broberg, has her clinical background in Public Health working as a public health nurse and as a family therapist. She has been the Supervisor for the NFP team in Oslo from the beginning of 2016 until she 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 teams.

Cecilie Forstrøm is a special advisor and was new to the National office in April 2024. She has a background as a public health nurse, with a master's in nursing with a community health Services perspective. She works closely with the clinical lead and is among other things assisting and taking part in the local advisory board meetings.

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. At the National office, she is responsible for the data collection, reporting, and the further development of the digital data collection solution. She also has regular meetings with the team coordinators in each team.

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). She has been on maternal leave since March this year.

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, together with the new senior advisor and the national clinical lead. Additionally, an annual report meeting is held at each site.
To support the supervisors in each team there are weekly meetings between clinical lead, special advisor and the supervisors from all five sites. In 2024 all these meetings have been conducted. Of the 20 local advisory board meetings only two have been conducted digitally.

4. Quality improvement:

The National Office is continuously working on quality improvement of the program.
Quality improvement is emphasized at multiple levels, as outlined below:

- Maintaining close dialogue between Bufdir and the National Office, focusing on program progress and challenges.
- The continuous collection and use of data in clinical practice and the yearly and quarterly reporting is central to the quality assurance of the program.
- Facilitating effective implementation and cooperation through the municipalities, including local advisory boards representing all participating municipalities
- Maintaining close dialogue with the supervisors through weekly meetings and six gatherings pr year
- Continue to give family nurses access to digital video guidance in Marte Meo twice a week, in addition to the group sessions every six weeks with the special adviser from the National Office.
- Continue to provide training in line with NFP program
- Hosting experience-sharing gatherings with all NFP teams twice per half-year to ensure updated knowledge, development, and sharing of important experiences in phase three.
- Developing websites and a digital training platform

5. NFP Educators:

The National office has overall responsibility for the education and training in NFP. We allocate training based on who has the most expertise in the various subject areas. In addition, we use experienced family nurses to contribute to parts of the training. We have very good experiences with this and have received positive feedback from the family nurses. One family nurse in team Rogaland has 10 % of her position earmarked for the development and implementation of education in close collaboration with the National office.
We also have benefited from external lecturers on specific topics:

- Domestic violence: Henning Mohaupt
- Marte Meo video guidance: Maria Aarts
- Motivational Interview: Monica Island
- Mentalization: Lise Røyneberg Veiberg

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 NFP with subsequent plans for broader implementation in other Norwegian child health services. Special advisor, Kristin Lund, has been a part of the Expert group from the beginning, and will now take a more active role in the project to ensure that the assessment tool is tailored and user-friendly for NFP.

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 NFP 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. For more information the two web addresses can be visited.
- 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 like the child protection services and healthcare services.

Description of our local and national NFP funding arrangements:

The program is fully funded by the national government till 2028, 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. In August 2024 the programme was extended to 2028 and this was reflected in the National budget for 2025 launched in October 2024. Moreover, the programme has been moved to the chapter regarding child protection services. The NFP programme is being linked directly to the ongoing child protection reform which is emphasizing the importance of municipalities increased responsibility for preventive work in order to avoid more evasive and more expensive interventions both at the individual and the societal 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. But in course of the year, we have had collaboration with the Health Directorate regarding joint text on policy documents and assignments on early intervention more broadly and the importance of the first 1000 days of a child's life. We consider this a step in the right direction and hope that there will be new opportunities in 2025.

Other relevant/important information regarding our NFP program:

As already mentioned, last year the Directorate choose a strategy with regard to the study which emphasized 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 was partly linked to the fact that it is the nurses who are screening and recruiting participants to the study.
The recruitment to the RCT, called MiNs, started in June 2023. In course of 2024 it became evident that it would not be possible to recruit the requested number of participants within the pre-set recruitment window running till June 2024. The Directorate therefore approached the Ministry and asked for an expansion of phase three from the end of 2027 till the end of 2028, which would allow us to recruit till the end of June 2026. After negotiations back and forth, the Ministry finally approved of the expansion meaning an additional year of funding. We are immensely grateful for this decision by the Ministry.
In addition to the above, the Directorate and the National Office looked at various options to have the existing sites expanded with additional municipalities in order to boost the number of participants to the study. After having considered different scenarios we landed on the municipality of Lørenskog which has a socio-demographic profile which fits well with the criteria for the target group of the Norwegian programme. The municipality is also quite big in an Norwegian context.

The expansion has to be handled within the regular annual budget and with the exisiting human resources, as a consequence we have had to be creative in the way that we organize the expansion dividing the Oslo team in two.

PART TWO: PROGRAM IMPLEMENTATION

Clients

Number (#) of NFP clients participating in the program at any point over the last year: 427.

- Current clients: Pregnancy phase (n & %): 49 clients (17 %) at 31.12.23 (time point)
- Current clients: Infancy phase (n & %): 100 clients (35 %) at 31.12.23 (time point)
- Current clients: Toddler phase (n & %): 140 clients (48 %) at 31.12.12 (time point)

Nursing Workforce

- Average client caseload per nurse: 9,3

The nurses have between 2 and 13 clients. A couple of the newest nurses only have a few 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	0	0	3
% annual turnover	9 %	0 %	0 %	7 %
# of replacement staff hired during reporting period	5	0	0	5
# of staff at end of reporting period:	34	5	5	44
# of vacant positions	0	0	0	0

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. During 2024 we have developed a plan for training which covers both temporary and permanent engagement.

- 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 family nurses and supervisors:

NFP training modules:

In April we carried out Foundation week for a group of 7 new family nurses. The same group received their education in Domestic violence in May and Infant training in September.

Joint gatherings:

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

- In February: 1 day with a focus on how to use data collection and how to carry out digital home visits. 1 day with deepening, reflection and discussion around the fundament for the program and the theory and knowledgebase (Unit one)
- In May: 2 days assigned to understand the goalsetting work and materials and the use of supervision and joint home visits
- In September: 1-day with NBO refreshing and 1-day with self-care for caregivers
- In November: 1-day assigned deepening in mentalization and 1 day refreshing and deepening in domestic violence

Marte Meo Video Guidance:

We have established a Marte Meo training program for the family nurses and supervisors, which involves participation in group sessions with Marte Meo licensed supervisor from National office every six weeks, within each NFP-team. Together with Maria Aarts, we have designed six group sessions with specific themes to cover, primarily focusing on using clips that demonstrate various elements and presenting how to use these clips in feedback to the family. In addition, time is allocated for reviewing films, providing an opportunity to learn from each other. Between group sessions, individual guidance is offered digitally via Teams. When a family nurse can demonstrate 4-6 successful processes of video guidance in families, she will be certified as Marte Meo trainer. During the certification process, the family nurse needs to record giving feedback in the families, to ensure the delivery of Marte Meo video guidance as intended. To be certified, the family nurse needs to document developmental progress in parent-child interactions and child development in at least 4-6 families.

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. The supervisors as they grow into the role will often suggest topics, they feel the need to deepen.

Team Coordinators/administrators:
The five team coordinators attended all our joint gatherings throughout the year. At three of the gatherings, we had a separate program for the team coordinators on one day and they were together with the teams the other day. At one gathering, the team coordinators, family nurses and supervisors were together both days.

The topic for two of the gatherings was developing reports for the team coordinators. The gatherings have been together with the data advisor and UFI (who have developed our data portal). The goal is to make their job of recording recruitment data easier and make it easier to show data to the team and the Advisory boards. We will continue this work in 2025.

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

We have worked closely together with our new contact and specialist in motivational interview Monica Øyen Island, as the previous specialist is retyring. We have also continued the close collaboration with Henning Mohaupt, our expert in the field of domestic violence. Similarly, we have maintained regular collaboration with the founder of the Marte Meo method, Maria Aarts, to ensure a strong connection between NFP and Marte Meo.
Overall, we have reflected on our joint gatherings to ensure the content to be useful and appropriate. To ensure program delivery in the future we will need to use the experience gathering for both deepening and use of the content/materials of the program. And at the same time ensure that we are always professional up to date regarding professional research on important aspects.

- Successes/challenges with delivery of NFP education:

As we did last year, we invited experienced family nurses and supervisors to contribute to the education and gatherings. Their contribution to groupwork and discussions was very useful. Bringing experienced family nurses together with the new family nurses in education and in all the gatherings we have, has turned out to be very successful. The new family nurses report that this is of key importance for them when learning about the program. Further feedback from the supervisors and family nurses has also made us realize the need for involving external specialists and professionals to help us deepen different topics both in the training and in our joint gatherings. We have therefore worked on how to strike the balance between using external specialists and internal resources. It is important to have these discussions to keep focus on the content on the program. External resources can help us to be updated on different topics and areas in the program, including new knowledge and research.

The supervisors and 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 family nurses, but also for everyone the program 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 is to be carried out in consultation with the National Office. Both the family nurses and supervisors report these conferences to be very useful, however some family 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 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 report that they together with the family nurses still are exploring and practicing on how to understand the material and document. They sometimes find this demanding, and the result has often been that the family nurses don't use them. Feedback from this has made us try out adjusted documents. This was done in late 2024 and we are curious about how this will develop next year.
Some of the supervisors find supervision and teamwork more demanding than others. Because of changes in roles, for instance when a family nurse takes on the supervisor role, they might experience challenges in cooperation and communication within the teams.

- Successes/challenges with reflective supervision to our supervisors:

The National Office continues to be in close contact with supervisors in meetings once a week and 1 day joint gathering every 6-8 weeks. In addition, they are offered open supervision weekly. 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 family nurses in the teams. It has been successful that we arranged an exclusive day for the supervisors with our MI specialists. This gave them the opportunity to learn and discuss the use of MI both in supervision and also in the program.

The development in the follow-up of the supervisors is positive. As they grow more into and understand their role, they also take on more responsibility. This includes taking responsibility for forwarding and distributing information and learning, to seek understanding and to seek help when they feel challenged. In 2024 the supervisors had more responsibility in education and our joint gatherings, ex. when the topic was supervision.

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

Throughout the year, the team coordinators and the data advisor from the National Office have had a one-hour meeting every third week. The purpose of these meetings has been 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. They also have increasingly contact outside of the meeting and call each other when they have a question. The group members have different education and work experience, so it is extra useful that they can share how they work, to ensure equal practice.

Additionally, sometimes we have joint meetings with supervisors and team coordinators if there is information that is important for both groups to receive. We also have joint meeting with the RCT researchers, team coordinators, supervisors and members from National Office. This has worked well.

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 fill out the data forms about supervision and team meetings on their iPad/computer.

  In the data portal, the family 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 data 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 analyze 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 family nurses are generally good 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.

At a joint gathering for all the teams in November 2024, the data advisor presented data on violence in close relationships and the lack of completed data forms. It is understandable that a conversation about violence in close relationships with the clients is not always carried out (for example because the partner is present), but when this happens at several measurement points, it becomes a problem. We will monitor the data and see if this increases the completion of the data form. We also plan to continue talking about data form completion at the 2025 meeting, to ensure that the data forms are completed.

- 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.

  In 2024, the team coordinators have had two one day-meetings together with the data advisor and UFI (who have developed our data portal), with a focus on developing reports for the team coordinators. This should make their job of recording recruitment data easier and make it easier to show data to the team and the Advisory boards. We will continue this work in 2025.

  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

- Updated data for conferences and presentations

- 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 have some work to do to make the data more accessible and easier to use for clinical practice. We want to make it easier for the supervisors to use data in supervision. 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 also want the team coordinators to have access to some data about the team's activities and participants. This can be used by Advisory boards or at meetings with other services.

  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 violence/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	90 % of eligible referrals who are intended to be recruited to NFP are enrolled in the program 30 % of pregnant women are enrolled by 16 weeks' gestation or earlier	receive the first home visit before the 28th week of pregnancy. 30 % of our clients are recruited by 16 weeks' gestation or earlier. This is higher number than in 2023, when only 20 % of the clients were recruited by 16 weeks' gestation or earlier. Some clients are recruited as early as 6 weeks' gestation.
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 • 11 % (N=47) of the active clients in 2024 have changed family nurse permanently/for a longer period in 2024. • Most of the clients changed family nurse because the family nurse either quit the job or went on long-term sick leave	
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 %	

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		Doctor/Clinic: 0 % Digital visit: 3 % Café: 2 % Other: 3 % 26 % of visits where second parent of child is present 2 % 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 • Range: 1 – 18	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
		Infancy: • Average: 19 • Range: 7 – 48 Toddlerhood: • Average: 14 • Range: 7 - 22	
	a) Length of visits by phase country benchmarks are: • Pregnancy phase: • Infancy phase: • Toddler phase:	• Length of visits by phase (average and range): Pregnancy phase: • Average: 76 minutes. • Range: 15 – 180 minutes. Infancy phase: • Average: 76 minutes. • Range: 10 – 240 minutes. Toddler phase: • Average: 77 minutes. • Range: 15 – 240 minutes.	We are working on reducing the length of the home visits, now that the case load is getting larger. In 2023 the average length of visit was 83 minutes and in 2024 it is 76 minutes.
	b) Client attrition by program phase country benchmarks are: _____% attrition in Pregnancy phase _____% attrition in Infancy phase _____% attrition in Toddler phase	Client attrition by phase: • 11 clients left the program in pregnancy phase in 2024. • 35 clients left the program in infancy phase in 2024 • 20 clients left the program in toddler phase in 2024	See Table 2 and 3 in Appendix 1 for reasons for client attrition and attrition by phase.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		• In addition, 72 clients graduated the program in 2024.	
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 (e.g. standardized job description); National Office Countries may also want to analyse 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	All the teams have a mix of midwives and public health nurses. 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/ case conference and % completion of education sessions	100 % (N=7) completed foundation and infancy training 100 % (N=6) of the new family nurses have completed NBO training. 100 % (N=7) of the new family nurses 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	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
each family, and apportioning time appropriately across 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).	44 % of 4-monthly Accompanied Home Visits completed	The teams completed 39 accompanied home visits in 2024. 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 57 % (N=701) of reflective supervision sessions conducted	
13. NFP teams, implementing agencies, and national units collect/and utilize	No benchmark. Monitored/assured by:	Progress: Our data collection solution works well, and the teams are skilled at	

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.		gathering data. We are constantly working to achieve better utilization of data in clinical practice, including 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):	100 % of Advisory Boards or equivalents _____% attendance at Advisory Boards	100% of the planned Advisory Boards has been held in relation to what was expected 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 %	32 %	14 – 20 %	23 %	10 – 15 %	22 %
Maternal Role (My Child and Me)	23 – 25 %	30 %	45 – 50 %	47 %	40 – 45 %	42 %
Environmental Health (My Home)	15 – 22 %	24 %	17 – 25 %	18 %	17 – 25 %	20 %

My Family & Friends (Family & Friends)						
Life Course Development (My Life)	10 – 15 %	14 %	10 – 15 %	11 %	18 – 20 %	16 %

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):

We have made revisions and adaptations to suit the Norwegian context during the last 3-4 years. 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.

Feedback from the family nurses and supervisors is that this work still is challenging to some point. They are still in a learning process about how to use these documents and materials. We encourage them to deepen and discuss this during the conferences.

The supervisor reports that there is an increasing use and focus on the goalsetting work in supervision with the family nurses. They experience that the work with the clients gets more structured when they use the materials as intended.

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 overall continue to deliver 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 – 2023)	**Current Period (n/%)** (2024)
Age (range and mean)	Range: 15 – 44 Mean: 27.6	Range: 16 – 42 Mean: 28.0 See table 4 in Appendix 1.
Race/ethnicity distribution	72 % (N=415) of clients are Norwegian/Scandinavian. 28 % (N=162) of clients have another ethnicity than Norwegian/Scandinavian.	76 % (N=84) of clients are Norwegian. 24 % (N=27) of clients have another ethnicity than Norwegian. See table 5 in Appendix 1.
Income (please state how this is defined) The annual median salary in Norway in 2023 was around 608 000 NOK (USD 54,000).	78 % (N=439) of clients had an annual income of less than USD 53,000. 11 % (N=63) of clients had an annual income above USD 53,000. 11 % (N=59) of clients didn't want to/couldn't answer this question.	73 % (N=77) of clients had an annual income of less than USD 53,000. 21 % (N=22) of clients had an annual income above USD 53,000. 7 % (N=7) 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): 1 % (N=8)	Residential care (treatment center, maternity home): 2 % (N=2)
Educational Achievement	Primary school: 25 % (N= 142) High school: 32 % (N= 184) Vocational school: 4 % (N= 21) One-year program at university or college: 3 % (N= 19) Bachelors' degree: 20 % (N= 112) Masters' degree: 13 % (N= 75) PHD: 1 % (N= 4) Other: 2 % (N=14)	Primary school: 14 % (N= 15) High school: 38 % (N= 41) Vocational school: 8 % (N= 9) One-year program at university or college: 4 % (N= 4) Bachelors' degree: 18 % (N=19) Masters' degree: 15 % (N= 16) PHD: 2 % (N= 2) Other: 1 % (N= 1)
Employment status	56 % (N= 319) of clients were in employment.	62 % (N=66) 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: 9 % (N= 52) Residential Care: 10 % (N= 57) (as a child)	Foster Parents: 11 % (N= 12) Residential Care: 7 % (N= 7) (as a child)
Obesity (BMI of 30 or more)	13 % (N=75)	21 % (N=20)
Severe Obesity (BMI of 40 or more)	2 % (N=13)	3 % (N=3)
Underweight (BMI of 18.5 or less)	8 % (N=44)	7 % (N=7)
Heart Disease	4 % (N=20)	4 % (N=4)
Hypertension	1 % (N=7)	5 % (N=5)
Diabetes – T1	1 % (N=3)	0 % (N=0)
Diabetes – T2	1 % (N=5)	2 % (N=2)
Kidney disease	1 % (N=6)	2 % (N=2)

Epilepsy	2 % (N=13)	1 % (N=1)
Sickle cell Disease	0 % (N=1)	0 % (N=0)
Chronic Gastrointestinal disease	9 % (N=46)	7 % (N=6)
Asthma/other chronic pulmonary disease	17 % (N=87)	22 % (N=20)
Chronic Urinary Tract Infections	7 % (N=38)	7 % (N=6)
Chronic Vaginal Infections (e.g., yeast infections)	6 % (N=33)	8 % (N=7)
Sexually Transmitted Infections	20 % (N=103)	27 % (N=25)
Substance Use Disorder	13 % (N=71)	15 % (N=14)
Mental Illness: Anxiety	61 % (N=321)	77 % (N=70)
Mental Illness: Depression	62 % (N=325)	75 % (N=68)
Eating Disorder	24 % (N=124)	31 % (N=28)
ADHD (ADHD was added to the list in 2020, so we do not have data from the years before this)	11 % (N=57)	30 % (N=27)
Learning difficulties	16 % (N=82)	24 % (N=22)
Behavioral problems	9 % (N=48)	7 % (N=6)
Other (please define) PTSD (PTSD was added to the list in 2024, so we do not have data from the years before this)		16 % (N=15)

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 2024 are even higher than before (77 % anxiety and 75 % 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 31 % of the new clients in 2024 are currently or have previously experienced eating disorder.

We have many clients with higher education (40% in 2024), while 62% 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 6 in Appendix 1 shows inclusion criteria for clients enrolled and women who declined participation in 2024. The 13 potential clients who declined participation had an average of 4.3 inclusion criteria. The clients who enrolled had in comparison an average of 4.3 inclusion criteria. There are a couple of notable differences in the two groups. The women who decline participation are more likely to be young (31 % vs. 16 %), have persistent low income/difficult economy (62 % vs. 40 %) and not be in work, education and have a low level of education (54 % vs. 32 %). They are less likely to have been in contact with child welfare in their upbringing (8 % vs. 41 %), have little social support (23 % vs. 48 %) and have mental difficulties (54 % vs. 88 %).

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 = 615 20 % moderate anxiety 14 % severe anxiety	N = 371 19 % moderate anxiety 8 % severe anxiety	N = 543 19 % moderate anxiety 9 % severe anxiety	N = 295 16 % moderate anxiety 10 % severe anxiety	N = 232 19 % moderate anxiety 6 % severe anxiety
Depression, (n, % moderate + clinical range) Patient Health Questionnaire-9 (PHQ-9)	N = 620 29 % moderate depression 16 % moderately severe depression 4 % severe depression	N = 371 30 % moderate depression 11 % moderately severe depression 2 % severe depression	N = 546 24 % moderate depression 9 % moderately severe depression 2 % severe depression	N = 295 23 % moderate depression 8 % moderately severe depression 4 % severe depression	N = 231 19 % moderate depression 7 % moderately severe depression 6 % severe depression
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours)	19 % (N=130) of clients have been	10 % (N=33) of clients have been		25 % (N=65) of clients have been	

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.	smoking in the pregnancy, including before they found out that they were pregnant. 3 % (N=16) of clients smoke daily. 1 % (N=5) of clients smoke sometimes. 96 % (N=461) of clients are not smoking.	smoking in their pregnancy. 2 % (N=7) of clients smoke daily. 0 % (N=1) of clients smoke sometimes. 97 % (N=273) of clients are not smoking.		smoking since their baby was born. 5 % (N=13) of clients smoke daily. 6 % (N=16) of clients smoke sometimes. 88 % (N=222) of clients are not smoking.	5 % (N=9) of clients smoke daily. 5 % (N=7) of clients smoke sometimes. 90 % (N=144) of clients are not smoking.
Snus use (A popular tobacco product in Norway)	28 % (N=189) of clients have been using snus in pregnancy, including before they found out that they were pregnant. 8 % (N=40) of clients use snus daily. 4 % (N=18) of clients use snus sometimes. 88 % (N=424) of clients are not using snus.	21 % (N=71) of clients have been using snus in pregnancy 8 % (N=23) of clients use snus daily. 4 % (N=11) of clients use snus sometimes. 88 % (N=246) of clients are not using snus.		24 % (N=59) of clients use snus daily. 5 % (N=12) of clients use snus sometimes. 72 % (N=180) of clients are not using snus.	22 % (N=36) of clients use snus daily. 3 % (N=6) of clients use snus sometimes. 74 % (N=128) of clients are not using snus.

Alcohol, (n, % during pregnancy, units/last 14 days) Same changes in the data form as mentioned above.	37 % (N=254) of clients have been drinking during pregnancy, including before they found out that they were pregnant. 0 % (N=2) of clients are currently drinking sometimes. 100 % (N=479) of clients are not currently drinking alcohol.	100 % (N=281) of clients are not currently drinking alcohol.		52 % (N=135) of clients are currently drinking sometimes. 48 % (N=123) of clients are not currently drinking alcohol.	49 % (N=86) of clients are currently drinking sometimes. 51 % (N=91) 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=33) of clients have been using marijuana during the pregnancy, including before they found out that they were pregnant. 0% (N=1) are using marijuana four or more times a week 100 % (N=458) of clients are not using marijuana.	100 % (N=284) of clients are not using marijuana.		1 % (N=2) are using marijuana once a month or less frequently 99 % (N=253) of clients are not using marijuana.	1 % (N=2) are using marijuana once a month or less frequently 99 % (N=176) of clients are not using marijuana.

Cocaine, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	2 % (N=11) of clients have been using cocaine during the pregnancy, including before they found out that they were pregnant. 100 % (N=478) of clients are not using cocaine.	100 % (N=279) of clients are not using cocaine.		100 % (N=251) of clients are not using cocaine.	100 % (N=170) of clients are not using cocaine.
Other street drugs, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	1 % (N=10) of clients have been using other street drugs during the pregnancy, including before they found out that they were pregnant. 0 % (N=1) of clients are using other street drugs. 100 % (N=477) of clients are not using any other street drugs.	100 % (N=280) of clients are not using any other street drugs.		100 % (N=257) of clients are not using any other street drugs.	100 % (N=171) of clients are not 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	Never: 15 % (N=71)	Never: 15 % (N=43)		Never: 15 % (N=40)	Never: 12 % (N=22)

How often are you so physically active that you become short of breath or sweaty?	Less than once per week: 18 % (N=89) 1 time per week: 14 % (N=68) 2 times per week: 20 % (N=95) 3-4 times per week: 19 % (N=91) 5 times per week or more: 15 % (N=71)	Less than once per week: 16 % (N=45) 1 time per week: 14 % (N=39) 2 times per week: 15 % (N=43) 3-4 times per week: 20 % (N=56) 5 times per week or more: 20 % (N=58)		Less than once per week: 16 % (N=41) 1 time per week: 11 % (N=30) 2 times per week: 19 % (N=49) 3-4 times per week: 25 % (N=67) 5 times per week or more: 14 % (N=37)	Less than once per week: 16 % (N=29) 1 time per week: 13 % (N=23) 2 times per week: 25 % (N=45) 3-4 times per week: 21 % (N=38) 5 times per week or more: 14 % (N=25)
Mastery, (n, mean) Low Mastery = 19 or under. Not Low Mastery = 20 or more.	Intake: N = 648 Mean = 21.2 Low mastery: 32 % (N= 208)	6 months: N = 416 Mean = 21.9 Low mastery: 24 % (N= 100)	12 months: N = 345 Mean = 21.6 Low mastery: 26 % (N= 90)	18 months: N = 242 Mean = 21.6 Low mastery: 24 % (N= 58)	24 months: N = 190 Mean = 22.0 Low mastery: 23 % (N= 43)
IPV disclosure, (n, %) At the end of 2023, we changed the questions from partner violence to violence in close relationships. We also began collecting data on the participants' experiences of violence earlier in life, either in childhood, in adulthood (but not ongoing violence) or both.	**Ongoing violence:** Ongoing partner violence/violence in close relationships was discovered in 25% (N=127) of the participants. **When the violence is revealed:** 47% of the violence is discovered during the pregnancy phase. 36% of the violence is discovered in the infant phase. 17% of the violence is discovered in the toddler phase. **Violence earlier in life:** It has been revealed that 56% (N=98) of the participants have experienced violence earlier in their lives.				

	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	50 % (N=218)	54 % (N=188)	46 % (N=114)	52 % (N=103)	
Subsequent pregnancies, (n, %)	3% (N=13)	10% (N=36)	20% (N=50)	27% (N=52)	
Breast Feeding, (n, %) 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?"	**First postpartum visit:** Breastfeeding: 93 % (N=388) have breastfeed their baby. Currently feeding their baby: 60 % (N=249) are exclusively breastfeeding. 28 % (N=119) of clients breastfeed non-exclusively. 12 % (N=50) of clients are not breastfeeding.	**6 months:** 36 % (N=142) of clients are exclusively breastfeeding. 23 % (N=89) of clients breastfeed non-exclusively. 41 % (N=161) of clients are not breastfeeding.	**12 months:** 41 % (N=120) of clients breastfeed non-exclusively. 59 % (N=174) of clients are not breastfeeding.	**18 months:** 23 % (N=52) of clients breastfeed non-exclusively. 77 % (N=173) of clients are not breastfeeding.	**24 months:** 9 % (N=13) of clients breastfeed non-exclusively. 91 % (N=135) of clients are not breastfeeding.
Involvement in Education, (n, %)	21 % (N= 91)	25 % (N=85)	22 % (N=53)	27 % (N=52)	
Employed, (n, %)	53 % (N= 203)	51 % (N=167)	57 % (N=131)	52 % (N=99)	
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:** 79 % (N=231) of clients receive Marte Meo video guidance Reasons why the rest of the clients does not receive video guidance from NFP: 2 % (N=7) of clients receive video guidance by another service 12 % (N=35) of clients does not want to be filmed 2 % (N=5) of clients where video guidance is not possible due to practical issues 4 % (N=13) of clients does not receive video guidance of other reasons	**12 months:** 44 % (N=80) of clients receive Marte Meo video guidance Reasons why the rest of the clients does not receive video guidance from NFP: 3 % (N=6) of clients receive video guidance by another service 20 % (N=37) of clients does not want to be filmed 1 % (N=2) of clients where video guidance is not possible due to practical issues 31 % (N=56) of clients does not receive video guidance of other reasons	**20 months:** 33 % (N=28) of clients receive Marte Meo video guidance Reasons why the rest of the clients does not receive video guidance from NFP: 2 % (N=2) of clients receive video guidance by another service 29 % (N=25) of clients does not want to be filmed 5 % (N=4) of clients where video guidance is not possible due to practical issues 31 % (N=26) of clients does not receive video guidance of other reasons		
Father's involvement in care of child, (n, %)	He does most/all of the care: 2 % (N=8)	He does most/all of the care: 3 % (N= 11)	He does most/all of the care: 4 % (N=10)	He does most/all of the care: 4 % (N=7)	

During the past three months, how often did the baby's biological father spend time taking care of and/or playing with the baby?	Every day: 59 % (N=256) 3-6 times a week: 10 % (N=44) Once or twice a week: 6 % (N=25) 1-3 times a month: 2 % (N=10) Less than once a month: 4 % (N=18) He has not spent time caring for or interacting with the baby: 16 % (N=70)	Every day: 57 % (N=198) 3-6 times a week: 7 % (N=26) Once or twice a week: 7 % (N=24) 1-3 times a month: 4 % (N= 13) Less than once a month: 4 % (N= 13) He has not spent time caring for or interacting with the baby: 18 % (N=63)	Every day: 52 % (N=129) 3-6 times a week: 9 % (N=23) Once or twice a week: 9 % (N=22) 1-3 times a month: 2 % (N=6) Less than once a month: 5 % (N=12) He has not spent time caring for or interacting with the baby: 18 % (N=44)	Every day: 49 % (N=94) 3-6 times a week: 9 % (N=17) Once or twice a week: 10 % (N=20) 1-3 times a month: 4 % (N= 8) Less than once a month: 5 % (N= 10) He has not spent time caring for or interacting with the baby: 19 % (N=36)	
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?

88 % 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 16-20 % for moderate anxiety and 6-14 % 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 19-29 % of participants experiencing moderate depression, 7-16 % with moderate to severe depression, and 2-6 % 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 14 % at intake to 6 % at completion). Similarly, we see that moderate depression and moderately severe depression decrease from intake to completion. This is encouraging. However, it is unrealistic to believe that participation in NFP will lead to the disappearance of anxiety and depression. Our goal is to help clients learn to manage their depression and 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 21.2 at intake to 22.0 when the child is two years old. We notice that the proportion of clients with "Low Mastery" decreases from 32% at intake to 23% 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 that they have positive experiences that 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 37% 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, 79% of clients receive video guidance. We see a gradual decrease in the use of video guidance as the child reaches 12 and 18-20 months, with 44% at 12 months and 33% at 20 months, respectively. This could be about parents' increasing confidence in their parenting role, and not needing the close follow-up that is offered through video guidance. It could also involve the child attending kindergarten, as many of the home visits take place without the child being present.

Regarding father's involvement in child care, it's worth noting the following: Based on the data, we see that between 49-59% of fathers are involved in daily care for the child, which is positive and encouraging. On the other hand, we see that 16-19% 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)	4	0,7 %
Moderate to late preterm (32-37 weeks' gestation)[1]	41	7 %
Low birthweight (please define for your context) Low birthweight: below 2500 g	29	6 %
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: 98 % (N=440) Not up to date: 2 % (N=8) Does not want to vaccinate the child: 0 % (N=2)	Up to date: 98 % (N= 338) Not up to date: 1 % (N=3) Does not want to vaccinate the child: 1 % (N=5)	Up to date: 98 % (N=255) Not up to date: 0 % (N=1) Does not want to vaccinate the child: 2 % (N=5)	Up to date: 99 % (N=192) Not up to date: 1 % (N=2) Does not want to vaccinate the child: 0 % (N=0)
Hospitalization for Injuries	0 % (N=1)	1 % (N=2)	0 % (N=1)	2 % (N=2)
ASQ scores requiring monitoring (grey zone)	Communication: 1 % (N=5) Gross Motor: 2 % (N=9) Fine Motor: 5 % (N=21) Problem Solving: 3 % (N=11) Personal Social: 1 % (N=4)	Communication: 3 % (N=9) Gross Motor: 3 % (N=10) Fine Motor: 3 % (N=9) Problem Solving: 7 % (N=22) Personal Social: 1 % (N=4)	Communication: 5 % (N=12) Gross Motor: 4 % (N=10) Fine Motor: 2 % (N=5) Problem Solving: 5 % (N=12) Personal Social: 3 % (N=8)	Communication: 9 % (N=12) Gross Motor: 4 % (N=7) Fine Motor: 5 % (N=8) Problem Solving: 6 % (N=10) Personal Social: 3 % (N=5)
ASQ scores requiring further assessment/referral				
ASQ-SE scores requiring monitoring (grey zone)	Social Emotional: 2 % (N=8)	Social Emotional: 1 % (N=3)	Social Emotional: 1 % (N=2)	Social Emotional: 3 % (N=6)
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	9 % (N=40) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 3 % (N=12) of clients were referred to the Child	7 % (N=25) of clients had been referred to the Child Welfare Services by other than the Family Nurse. 2 % (N=6) of clients were referred to the Child	9 % (N=23) of clients had been referred to the Child Welfare Services by other than the Family Nurse.	5 % (N=10) of clients had been referred to the Child Welfare Services by other than the Family Nurse.

months regarding suspected abuse or neglect?	Welfare Services by the Family Nurse.	Welfare Services by the Family Nurse.	2 % (N=4) of clients were referred to the Child Welfare Services by the Family Nurse.	3 % (N=5) of clients were referred to the Child Welfare Services by the Family Nurse.
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?	16 % (N=80) of clients had been referred to the Child Welfare Services at some point during the program. This includes referrals made by the family nurse and others.			
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): 99 % (N=306) At home with other family members: 5 % (N=16) If kindergarten, full-time or part-time: Full-time: N/A Part-time: N/A	Kindergarten: 41 % (N=107) Family kindergarten: 0 % (N=0) Childminder: 1 % (N=3) At home with parent(s): 53 % (N=139) At home with other family members: 4 % (N=20) If kindergarten, full-time or part-time: Full-time: 88 % (N=100) Part-time: 12 % (N=14)	Kindergarten: 82 % (N=156) Family kindergarten: 1 % (N=1) Childminder: 1 % (N=2) At home with parent(s): 17 % (N=33) At home with other family members: 4 % (N=7) If kindergarten, full-time or part-time: Full-time: 90 % (N=148) Part-time: 10 % (N=17)	Kindergarten: 91 % (N=132) Family kindergarten: 1 % (N=1) Childminder: 0 % (N=0) At home with parent(s): 8 % (N=11) At home with other family members: 2 % (N=3) If kindergarten, full-time or part-time: Full-time: 97 % (N=128) Part-time: 3 % (N=4)

Please comment below on your child health/development data

Referrals to Child Welfare Services:

The percentage of clients referred to Child Welfare Services seems relatively stable across different age groups.
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.

ASQ: In examining the ASQ data, we note only minor differences when compared to the figures from earlier years. 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. Here the percentages are identical at both 6 and 24 months.
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.

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 41% attending kindergarten at the age of 12 months. Many children start in the months after their first birthday, so by 18 months, we see that the percentage has increased to 82%. By the age of 2, the percentage of children attending kindergarten is 91%, which is like 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. In November 2024 the National office commenced collecting feedback from clients, with one of our special advisors interviewing mothers, recruited by the family nurses. There are also plans for interviewing some family nurses and some of our collaboration partners in 2025. With the information we

gather in this project, we aim to better understand what distinguishes NFP in Norway from existing services and identify the success factors for achieving lasting improvements for the participants. We intend to publish our findings in, for example, an article or an op-ed. By doing so, we hope to raise awareness of the program among municipal leaders and politicians, seeking their support as the study nears its conclusion.

Some of the feedback will be presented below:

Feedback from a client (November 2024)

In an interview with a mother that has just completed the program, the mother explains how she felt when she was referred to the program by the Midwife at the health station. "I really felt that it was a feeling of being seen". "It was a feeling that the community saw me". "In a way, you are invested in".

When asked of her thoughts of being part of the program, she says: "I think a lot about my mother, you know, that maybe I could have had a better childhood if she had the same help". She explains how she feels very lucky to have participated in the program: "Just think of my luck. It was lucky that I moved to Norway, and that I was living in Bergen, and that it was a trial of the program when I was pregnant".

Thinking of the generational trauma in her family, she said "I am the one [in the family] that has managed to break the pattern".

When interviewing another client in November 2024, this was her response to the question of how she feels now, compared to when she started the program:

"I am very surprised at how well I am actually doing. And I know that I wouldn't be doing so well if I hadn't been part of NFP and if I hadn't had [family nurse] with me all the way, I wouldn't be where I am now. And I know that. So it's like… I am so grateful for how far I've come. I can see it in myself, where I was before and where I am now. It's like… I wouldn't be here without this program."

The same client has this to say about her progress during the program: "My lifestyle change has just been so much better. It's not necessarily all the forms and information, but the whole process… I've just felt taken care of. I've felt that I've been taken care of, but I've done the work myself."

The same client explains her thoughts concerning the "generational patterns" in her life:

"Actually, the [family nurse] and I talked about this not too long ago, that I am definitely someone who has broken away from this pattern and, in a way, ended that generational upbringing. Absolutely, I see that the way I was raised is not how I want my daughter to be raised. I never want her to feel the way I did when I was growing up. And it's like… my biggest goal is to make sure she doesn't feel the way I did."

"I feel very happy. I get very moved by it too, that I… I can see it myself, that I don't treat her the same way. And when I look at my daughter, I think, 'How could my mom treat me that way?' I could never do that to my child, but it's because that's how she was raised, and she thinks that's the right way. But I see now that it's not right at all. And I just see that it's so wonderful that I have the opportunity to stop it for her."

As the family nurses filmed themselves providing video feedback, we are able to capture clients' comments during the feedback situation. We have selected some of it here:

1. The family nurse and the client are watching a clip where the mother waits for her four-month-old child to take an initiative, which is the first step in the Marte Meo Learning Set:

Mother: I think it's important that she doesn't get interrupted when she finds something exciting and interesting. This is what you and I have talked about—that she should feel that what she's focused on matters and that we're not overpowering her or taking over.
Family nurse: Yes.
Mother: And we've been trying to practice that. I actually notice it now when other people interact with her. They completely take over, you know.
Family nurse: Yes, they take over in a way.
Mother: Exactly. They say, "Look at me, look at me," and she's not really interested in that. It's part of her exploration, after all.
Family nurse: It absolutely is.
Mother: And if we interrupt too much, she probably feels like what she's doing isn't that important. And that's a bit hard to watch.
Family nurse: What you're saying is so important. That feeling and experience she gets when she sees that what she's doing is fun, exciting, and interesting to her mom—it gives such an incredible boost to her self-esteem and confidence moving forward. It's great that you've thought about this.
Mother: Yes.

2. The family nurse and the client are watching a clip of the 17-month-old playing on the floor with his mother. The child is holding a book in his hand:

Family nurse: Let's watch the clip. I want you to pay attention, because he puts the book down first— let's see what happens. He's sort of moving away, maybe.
They watch a few seconds of the clip.
Family nurse: Did you see that?
Mother: Yes, he's actually about to walk away, but when I said, "The book is so nice," he turned around.
Family nurse: Exactly. When you show engagement in what he's interested in, you help him stay focused a little longer.
Mother: Yes.
Family nurse: Actually, it was really nice that you brought him back, because helping him focus on the same thing for a while is important. Now that he's older, it's about you choosing which things to follow and which not to follow. It's your engagement with the book that helps him keep his attention on it longer.

Mother: Yes, that was really fun to see.
Family nurse: It's kind of like, I don't know how he'll be when he's older, but helping kids stay engaged with something for a while and not just jumping from one thing to another all the time is really valuable. We live in a world that moves so fast.
Mother: Yes, it's important that things don't always have to be happening constantly.
Family nurse: That's something you can be mindful of and keep doing more of, really.
Mother: Yes, absolutely. That's very important. I can see that. And that he gets that recognition and that I'm looking at him. That's probably the most important thing—that he notices that. It's nice. These films are actually quite useful.
Family nurse: That's great. They're definitely a good learning tool.
Mother: Yes, absolutely.

After the reviewing, one mother said: "I have learned a lot through using video. You learn so much from noticing those small details and understanding how to work with them. Going through this process of reviewing videos of our interactions has been incredibly valuable to me."

3. Another mother said this:

Mother: I'm so glad I have the opportunity to learn like this and to view our interaction from a different angle.
Family nurse: Yes, it's like a bird's-eye view—you get to observe it from the outside, in a way.
Mother: Yes, and in general too. Just think of all I could have missed. It's so insightful, just watching a video like this, being able to see and talk about it.
Family nurse: But it's all in you. It's your positive interaction with your daughter.
Mother: Yes, I do become more aware of it.
Family nurse: So, if there's one thing to learn from this, it's that this is beautiful, and you have something within you that helps you sense what your child needs. And she senses that—she feels that "Mom understands me." And imagine growing up with that feeling—that "Mom understands me."
Mother: Yes, that's true.

It is interesting to discover how parents become focused on small details in the interaction and to provide them with an understanding of how small changes can contribute to influence and better understand child development both now and in the long term.

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	1	Extremely preterm (less than 25 weeks' gestation). The child was born with deformities and was not viable.
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.
- Quarterly reporting on program status to the Ministry of Children-, Youth- and Families.

- Goals and Objectives for CQI program during the reporting period:
- 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 sites.

- Outcomes of CQI program for the reporting period
- We have further developed the internal website. We will continue this in 2025.
- The development of education curricula and material is ongoing.
- Guidelines and framework for digital home visits has been implemented, and 'How to carry out digital home visits' was the topic of our first gathering in January 2024. We then presented our revised Guidelines and framework for digital home visits.
- We conducted a structured evaluation of the flow cart and guidelines related to Domestic violence, which were overall positive.
- We have not yet conducted a structured evaluation of the Marte Meo Learning Set, but the feedback from family nurses has been mostly positive. This also applies to the development of

a standardized training and certification program for video guidance in NFP, which we started in October 2024.

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

We acknowledge 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. To ensure proper education for newly hired family nurses, we have developed a clear process and structure. It has been challenging to determine the best approach, especially considering that some family nurses are employed for shorter periods. Additionally, some former family nurses have been absent due to illness or sick leave, which has prevented them from completing their full training. We have decided to include all new nurses in a structured program that spans three weeks (foundation, infant, and toddler training), as outlined in the program. Regardless of their employment duration, all family nurses will be part of this structure. In cases where a family nurse has not completed her training with her cohort, she will join a new cohort upon her return. This means that we will plan and implement one foundation week, one infant week, and one toddler week each year.

- Goals for CQI in next year:
- Carry out evaluation about guidelines and framework for digital home visits
- Develop digital/online pre-learning for new employees (Canvas)
- Develop “packages” for deepening in different topics and areas of the program to be used in the teams.
- Support the supervisors in this work. Make an annual wheel to help the structure of this learning. And ensure that this is conducted equally in the different teams.
- We aim to develop various training packages which ensure consistent basic competence for all family nurses. The goal is for this development to take place within the teams. Examples of topics in the training packages include domestic violence and interaction.
- We aim to conduct a structured evaluation of the Marte Meo Learning Set. This also includes evaluation of the ongoing group session days and work towards certification as a Marte Meo trainer.
- Further develop reports in the NFP portal to ensure the use of data in clinical practice.
- Enhance reporting to and from the NFP sites.
- More focus on completing the data forms and the importance of the data. We will do this at gatherings for all family nurses and at team meetings.

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 been using Marte Meo Video Guidance since 2016. Video guidance is offered to all families in NFP, with the client and her child as the primary participants. We also provide video guidance to fathers upon request.
In collaboration with Maria Aarts, we have developed the "Marte Meo Learning Set" specifically for use in NFP. This Learning Set is tailored to the needs of families in NFP, and family nurses receive training, supervision, and certification from the National Office.

Domestic Violence:
During 2024, the National Office cooperated with Henning Mohaupt to develop the evaluation of the domestic violence flout cart and guidelines. And preparing for the full day refreshing gathering in November.

Canvas
During 2024 because of the discussion about how to conduct and structure the education for newly employed nurses we have developed a digital pre-learning and foundation platform called Canvas. This is meant for new nurses from the time they are hired to the first education/foundation week. It gives them an opportunity to start the process of becoming a family nurse and understand the foundation of the program. It will also make them more ready to participate in the first week of education (foundation). This will be launched in January 2025.

- 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 as the family nurses do. It serves as a kind of quality check.
Parents find the video feedback useful because it is concrete and directly related to their daily life.
Our family nurses will be certified as Marte Meo trainers in the coming years.

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 the Norwegian legislation, which helps both the family nurses, and the child welfare service to understand the purpose of program. We conducted an evaluation among the family nurses in September. This was overall positive. The materials and guidelines are useful, and they feel more confident in addressing the topic.

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 is accessible.

Brief outline of research methodology:

Reference is made to mentioned study protocol.

Details of progress to date:

The recruitment to the study started beginning of June 2023. As of January 1st, 2025, 402 participants have been recruited for the study. Randomised to:
Intervention group ("Sammen på vei"): 194 participants
Control group: The remainder, implying 208 participants.

Even if the recruitment to the study has been picking up towards the end of the year. The recruitment process needs constant focus and AFI has done a very solid job in being pro-active and to find ways to involve stakeholders and gate keepers in the 5 sites like municipal services and local leaders by being present at the local advisory board meetings and by inviting them to contact AFI if they have questions to the study. AFI has also put in place several measures to make the NFP Teams able to best play their role in the recruitment process. The close collaboration between AFI and the National Office has been paramount in the recruitment to the study.

AFIs assessment of progress to date is:

“The goal is to recruit 700 women. After extending the recruitment period from two to three years, we are now largely on track with our recruitment efforts. It is an ongoing process that requires continuous effort on multiple fronts. We organize workshops for potential referrers, hold meetings with midwives and public health nurses in municipalities, and engage with municipal leaders in local advisory boards. Additionally, we distribute flyers and posters. We are also active on social media, running campaigns to reach women directly. Furthermore, we are planning newsletters targeted at general practitioner clinics. We anticipate maintaining most of these efforts until the recruitment period concludes.

A challenge in the Norwegian study is that we need consent from all parents with legal parental responsibility to access data about the child. Currently, we are missing consent from 25% of co-parents (fathers). This is problematic because it means we may not reach the goal of including 700 children in the study but rather just over 500. However, we are monitoring cases where co-parents lose legal parental responsibility. In such instances, we can rely solely on the mother's consent. Further, we benefit from the extended recruitment period and the fact that we are largely on track in terms of recruitment progress. If the current trend continues into June 2025, we may be able to exceed 700 women enrolled in the study, which could result in closer to 600 children included as well.”

AFI has also benefitted greatly from a lot of sharing from Canada and their experience conducting their RCT. The Directorates role as commissioner of the study has been to overlook the progress and to enable the study to be completed in a way that can give us knowledge about the effects of the program, ref. expansion of one year for phase 3 and inclusion of an additional municipality. The Directorate has also shared with AFI new research of relevance from the NFP global family or from other external research actors.
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:

- 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 family 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 regular meetings and cooperation with the local leaders and local advisory boards.
- The National Office will develop standardized training and certification for the Marte Meo Learning Set for NFP, in close collaboration with Maria Aarts.
- The National Office will explore opportunities 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.

Progress against those objectives

RBUP:

Overall, we have achieved our planned objectives for 2024.

Plan for team-based learning. We want to develop this in collaboration with our 5 supervisors in 2025.

Bufdir:
We have full-filled the three objectives which were set for 2024.

Reflections on our progress:

RBUP:
Some of our planned objectives are ongoing projects, which we will continue in 2025.

Bufdir:
In course of 2024 we have come to a place in the program cycle of Sammen på vei where we as a Directorate have a more withdrawn role in the oversight of the program. This is probably due to good routines and the National Office which has become increasingly professional with an explicit planning cycle and set objectives. We still have the weekly dialogue between the Directorate and the Clinical Lead. But the issues to be solved at the level of the Directorate is far less demanding than before when we had to deal with complex organisational and legal issues, protection of personal data (DPIAs), unsecure funding, limited awareness of the program among important gate keepers etc.

NEXT YEAR:

Our planned objectives for next year:

- Four experience gatherings for all employees in NFP Norway to ensure program delivery
- One toddler training week for the 2024 cohort (family nurses who started in 2024) and foundation and infancy training weeks for the 2025 cohort
- One gathering with the psychologists associated with each team as professional support
- Two gatherings with child welfare contacts associated with each team as professional support
- An annual meeting with municipal leaders in each site (a total of 5)
- Four local advisory board meetings in each site (a total of 20)
- Six joint Marte Meo guidance sessions per team (a total of 30). Conducted locally with a facilitator from the National Office
- Six team leader/supervisor gatherings
- To ensure sustainability over time, we will develop training to become Marte Meo supervisor for two family nurses in each team. The plan is to make them confident in providing video guidance within their team. The responsibility for ensuring the necessary training, follow-up, and supervision will lie with the National Office. We will develop this in close collaboration with Maria Aarts.

Priority tasks for 2025:

- Further development and quality assurance of program content
- Collect experiences and produce articles about the implementation of NFP in Norway
- Continue the development of an interaction assessment tool
- Certify family nurses to become Marte Meo trainers
- Develop a standardized training and certification to become Marte Meo supervisor within NFP

- Implementation and further development of digital training materials on Canvas
- Ensure the efficient operation and further development of digital data collection
- Further develop and maintain the NFP Norway website (both public and internal)
- Continue close collaboration with researchers from AFI linked to the RCT study
- Operate and further develop the digital portal for data collection and data display, including guidance on how to use the data in clinical practice and continuous program development
- Ensure a good process regarding the expansion and changes in the Oslo team

Measures planned for evaluating our success:

RBUP:

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

Bufdir:

- Continue to provide strategic oversight of the program, joint results framework, risk assessment and risk management.
- Manage and follow-up AFI on the RCT
- Explore opportunities to have Sammen på vei integrated as part of a wider welfare strategy aiming at early intervention and investment in the early years of a child's life. This to prevent adverse child development and care situation, but also in order to give every child the best possible opportunities for his/her life trajectory.

Any plans/requests for program expansion?

N/A.

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: ANNUAL REPORT FROM UCD

(To be completed by UCD following meeting to review annual report)

Brief summary of services/support provided by UCD over the last year:

Identified strengths of program:

From the recent Annual review, it is clear that the quality of implementation, whilst expanding in Oslo, remains at an extremely high level.
The expansion program has been carefully thought through and the opportunity for the new teams to work with each other to ensure continuity is commendable.

The sustained Leadership provided by both Clinical Lead and Senior Adviser to The Norwegian Directorate for Children, Youth and Family Affairs has ensured that teams are supported in a sensitive and timely way. The relationship forged between the National Office, RCT team and local principalities is a testimony to the dedication and investment made by the Clinical Lead, Senior Adviser, and extended Leadership team.

We are keen to hear more about the work undertaken around violence in close relationships and how Marte Meo is being contextualised in NFP implementation in Norway. There will be opportunities through the Clinical and Education forum for the International community to hear and learn from you on these key areas. We look forwards to this.

Areas for further work:

We are concerned about the level of need represented in those recruited for the RCT. While the report presents data on specific vulnerabilities identified in study participants, we urge you to examine the cross-classification of needs represented in this sample, so you can consider sharpening your recruitment criteria going forward. Specifically, we urge you to prepare a table that shows every measured vulnerability and the degree to which the vulnerabilities are present simultaneously for each study participant/enrollee in the study/program, using data displayed in Appendix Table 1. This will be a 10x10 cross-classification matrix. We are working on a review of the randomized clinical trials of the program that shows persuasively that the benefits are most pronounced where the needs are greatest. This is critical for the replication of the program and the research.

Agreed upon priorities for coming year:

On-going Consultancy support as requested with license holder and 1:1 International Consultancy with Clinical Lead (Tine) as requested.

Norway team to connect with David regarding discussion of cross classification of participant vulnerabilities.

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

Table 1: Inclusion criteria for all clients enrolled in 2024 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	87 %	80 %	91 %	97 %	67 %	**86 %**
Contact with child welfare in your own upbringing	53 %	24 %	41 %	42 %	50 %	**41 %**
Little social support in family and network	47 %	68 %	41 %	42 %	39 %	**48 %**
Persistent or serious conflicts with partner or others	53 %	40 %	36 %	52 %	50 %	**46 %**
Difficulties in utilizing relevant services being offered	13 %	8 %	23 %	15 %	11 %	**14 %**
Not in work, education, and a low level of education	53 %	16 %	50 %	21 %	33 %	**32 %**
Persistent low income/difficult economy	67 %	24 %	59 %	27 %	39 %	**40 %**
Mental difficulties	93 %	84 %	95 %	91 %	78 %	**88 %**
Drug problems	33 %	4 %	23 %	18 %	33 %	**20 %**
Young of age	33 %	4 %	18 %	18 %	11 %	**16 %**

Table 2: Reasons for client attrition in 2024 by phase.

	Pregnancy	Infancy	Toddler
Child is no longer in mother's custody		2	1
Client has moved out of NFP-area	1	9	2
Dissatisfied with program		1	
Infant death	1		
Lost to follow-up		3	2
Miscarriage/still birth	1		
Needs being met through other services/programs	1	1	
No time for visits	1	4	3
Perceives she has received what she needs from the program		5	2
Perceives that she has sufficient knowledge or support	2	1	3
Refused new NFP nurse		3	2
Refused NFP following report to Child Welfare Services		3	3
Other	4	3	1
Total	**11**	**35**	**20**

Table 3: Percentage of clients who have completed each phase/sub-phase or left the program in each phase/sub-phase. Data from 2016-2024.

	Completed	Left program
Pregnancy phase	95 %	5 %
Infancy 0-6 months	83 %	17 %
Infancy 6-12 months	71 %	29 %
Toddler 12-18 months	59 %	41 %
Graduated program	50 %	50 %

Table 4: Age (mean and range) for clients enrolled in 2024 by team and total

	Rogaland	Oslo	Agder	Trøndelag	Vestland	Total
Mean	25.6	31.0	25.7	28.6	27.5	28.6
Range	16 – 39	22 – 39	19 – 33	18 – 40	18 – 42	16 – 42

Table 5: Ethnicity for clients enrolled in 2024 by team and total

	Rogaland	Oslo	Agder	Trøndelag	Vestland	Total
Norwegian	80 %	69 %	68 %	81 %	81 %	76 %
Other	20 %	31 %	32 %	19 %	19 %	24 %

Table 6: Inclusion criteria for clients enrolled in 2024 and clients who declined participation in 2024. % of all clients/potential with this criterion

	Enrolled in 2024	Declined participation in 2024
Perceived neglect, violence/abuse or bullying	86 %	85 %
Contact with child welfare in your own upbringing	41 %	8 %
Little social support in family and network	48 %	23 %
Persistent or serious conflicts with partner or others	46 %	54 %
Difficulties in utilizing relevant services being offered	14 %	15 %
Not in work, education, and a low level of education	32 %	54 %
Persistent low income/difficult economy	40 %	62 %
Mental difficulties	88 %	54 %
Drug problems	20 %	15 %
Young of age	16 %	31 %

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