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 TWO ANNUAL REPORT

Phase Two: Feasibility and Acceptability through Pilot Testing and Evaluation.

Phase Two involves conducting a pilot test of the adapted NFP program with the projected number of sites and/or clients specified in the licensing agreement. The pilot includes testing the feasibility of referral pathways, data collection measures/sources, program materials, nurse recruitment, nurse education, and any other relevant measures. The pilot will determine acceptability of the program for the mothers, families, community partners, nurses, implementing agencies, and any other relevant partners. The results of this work will inform what additional adaptations may be needed to ensure the feasibility and acceptability of the NFP program within local contexts. At the end of this phase, the country develops its NFP information system or adapts its existing system to accommodate NFP data requirements. Continued recruitment of clients in existing pilot sites, or expansion to further sites for continued learning regarding required adaptations, may be approved if requested.

Purpose of annual report:
As part of the license agreement with the University of Colorado, each country is required to prepare and submit an annual report. Through the annual report, data are reported, analyzed and reviewed, to guide discussion of the country's implementation successes and challenges, as well as emergent outcome variations. The annual report forms the basis of the Prevention Research Centre, University of Colorado's (UCD) annual review of NFP implementation and fidelity in licensed partner countries and for discussing quality improvement plans. 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 Dr David Olds, Ben Jutson and the country's International Consultant at least three weeks prior to the Annual Review meeting. 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): 1/1-2020 to 21/12-2020

Report completed by: RBUP and Bufdir

Date submitted: 21/12-2020

The size of our program:

	Number	**Total**
Fulltime NFP Nurses	**8**	**8**
Part time NFP Nurses		
Fulltime NFP Supervisors	**2**	**2**
Part time NFP Supervisors		
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)		
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable) Administrators	**2**	**2 (2x80%)**
Total	**12**	**12**

- We have 2 teams (supervisor-led groups of NFP Nurses)

- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:5, the administrators are included.

- Current number of implementing agencies/sites delivering NFP: 2
- Current number of NFP teams: 2

- 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:

We continue to receive much positive feedback from participants, collaborators and NFP nurses. The referred families are mostly well eligible for the program. In Oslo we experience that more leaders outside of the NFP program and in other townships are more aware about the program and its content. There have been changes of 1 (one) family nurse in the team in South West, whom left in February 2020 and a new family nurse began in April to replace her. The referral pace has been a bit slow. We think that it might be due to change of personnel, as well as, no experienced predictability of the program's future until the national budget came in October. An additional reason has probably been the situation with Covid-19 whereby society has functioned somewhat different than usual and there has been anxiety amongst people and services to initiate contact.

In May a meeting was conducted with central and local politician from one political party (FRP) in one of the South West sites. One client, the supervisor, a member from the local advisory board (the leader from the

child protection service) and the Clinical Lead joined the meeting. The background for the meeting was the party's request to learn more about the experiences with NFP during the pilot phase (phase 2). The meeting went well since the politicians had very good questions, especially to the client who generously shared her experiences. The local child welfare leader was very convincing in sharing his experiences with close interdisciplinary collaboration with the program.

Both NFP teams are still employed by RBUP, but the plan is to have both teams transferred before March 2021. There has been different challenges for the local sites to prepare for the transition and they have been particularly pre-occupied by the financial aspects and predictability regarding the program's continued political focus by the national government. Even if they have been drawn to the fact that there is a very explicit long-term political commitment to the program by the national authorities, the local authorities continue to be preoccupied of "secure" budgets at the national level for only a year at the time. This is a bit strange since this is valid for all support that the local authorities receive from the state. However, we are confident that this issue is being solved in course of the three first months of 2021.

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

License holder name: Directorate for Children, Youth and Family Affairs.
Role and Organisation: Official directorate reporting to the Ministry of Children and Family Affairs. In charge of the up-bringing sector and to facilitate a safe upbringing for children, as well as leading the child protection services at national level and providing certain specialized services for local authorities targeted at particular vulnerable children and their families. In relation to the NFP Program in Norway the Directorate is the license holder and the Directorate is responsible vis a vis the Ministry of Children and Family affairs to test NFP in Norway. 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 State.

Description of our National implementing capacity and roles:

- Clinical Leadership:

Norway's Clinical Lead draws on her clinical background as a midwife from two different municipalities when planning clinical adaptations, implementation support to sites and training of the NFP teams. During many years she contributed to the training of midwives at the Institute of Nursing at Oslo Metropolitan University. She also has a history of engagement in the Midwives' Association.
The Senior Advisor has her clinical background from child welfare and has ample experience from work with vulnerable pregnant women, children and families. Her skills and knowledge about dyadic assessment and tools, especially about Emotional Availability Scales (EAS) and video feedback of Infant-Parent Interaction, has been particularly beneficial in the process of developing the DANCE (Dyadic Assessment of Naturalistic Caregiver child Experiences) "substitute." The Network of Infant and Toddler Mental Health at RBUP, offers technical and clinical support to the Clinical Lead and Senior Advisor, and facilitates expert discussions and guidance throughout the country.

- Data analysis, reporting and evaluation:

We have a clever research coordinator who works full time and is responsible for overseeing the data collection and data input process, analyzing the data and making the data reports. The research coordinator at RBUP manages the data system and develops monthly data reports. The research coordinator has regular meetings with each supervisor to hand over data reports and discuss data findings.

The administrators/team secretaries in both sites are trained in data input and data quality, and reports are being run on a regular basis. The family nurses collect data on paper forms, and the administrators handle the data system input/plotting into SPSS.

- Service development/site support:

Implementation partner RBUP has plentiful experience in piloting new programs and methodology and offers implementation research support as part of the testing of new interventions. The Clinical Lead and Senior Advisor at the National NFP Office at RBUP offer daily support to the sites. The Clinical Lead is staff manager for both NFP teams.

- Quality improvement:

During this year, everyone in the NFP national office has taken responsibility to contribute towards quality improvement. Further quality improvement It has been partly affected by unpredictability about the programs future, especially in the first half of the year. In cooperation with the supervisors, we decided which area that seemed most important/useful to develop and improve. We usually collect experiences from the teams about the areas/moments they consider as most prominent we to improve during our joined gatherings. Afterwards this is being followed-up and worked on at the national office before we share it with the teams for final adjustments.

- NFP Educators:

Kristin Lund, Senior Advisor and Tine Gammelgaard Aaseruud, Clinical Lead, have held the education during this year. Marte Dalane-Hval, Research Coordinator, has supported the training when needed.

- Other (please describe)

In November, Karianne Hammerstrøm Nilsen, joined our national NFP team as project manager. We are very pleased to have her in the team. Karianne is very skilled and have relevant experience for the program, which is very important for us now as we are moving into phase 3, as well as in the future when we have expanded our reach.

Description of our local and national NFP funding arrangements:

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

Current policy/government support for NFP:

It was a major break through when it was decided in October 2020 by the national government to scale up the program for the period of 2021-2027 and conduct effect evaluation of the program as from 2022- 2027.

How our NFP supervisor and nurse education is organized:

Our nurse education program consists of three training modules, including program content as well as program delivery during the three phases of Foundation/Pregnancy, Infancy and Toddlerhood. As mentioned, the Clinical Lead and the Senior Advisor have held the Infancy training this year, whereas the Foundation training was in Scotland as NFP Scotland has been forthcoming in letting us send our new nurses to their trainings. We find it useful that the Foundation week is held within a bigger NFP community than what we can offer here in Norway as per today. In addition to the same education as the nurses, the supervisor

education consists of three additional days with focus on the Supervisor roles (supervisor, team-leader, working with stakeholders, nurse, teacher) and the content of these roles.

The education curricula for the nurses are described further in Part two, “NFP Education”, page 7.

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

Continued work has been invested in bringing the health sector at national level on board in the program given defined areas where collaboration is needed: 1) Where and how to organize the program (health sector versus child protection services or in collaboration between the sectors) 2) Health sectors interest in the NFP- effect evaluation 3) Digitalization of data handling system and 4) Legal basis for the program – possibility to be covered by the health laws.

Other relevant/important information regarding our NFP program:

In course of the year there has been increased support by various units and departments within the Directorate to help assess and solve various aspect of the program. 2020 has been a particular demanding year at various levels for both the National unit and for the Directorate. This is particulary true for this autumn.

PART TWO: PROGRAM IMPLEMENTATION

Clients

# of NFP clients participating in the program over the last year: 142

- Current clients: Pregnancy phase (%): 21 % (N=18)
- Current clients: Infancy phase (%): 52 % (N=45)
- Current clients: Toddler phase (%): 28 % (N=24)

% of those eligible clients offered the program who have enrolled over the last year: 84 %

- Within this year the % of eligible women referred/ notified who were successfully enrolled onto the program was 84 %

  - Our reflections on this figure (including any consideration of an appropriate national benchmark):

We believe that the process in recruitment, where the nurses have initial exploratory conversations together with the potential client, influences the % enrolled in the program. In the exploratory conversations (a minimum of two) the potential client receives information about the program and the nurse gets information about the client and her circumstances. The client gets time to think it over and is given the possibility to discuss participation with her partner/family e.g., and she is also offered additional conversations with the nurse if need be. They mainly meet face to face. It is our perception that when the client gets adapted information and feels respected it seems more likely for an eligible participants to approve to be enrolled in the programme.

Engagement of fathers/partners/other family members

- % of home visits, where father/partner is present: 21 %

- % of home visits, where other family members are present: 2 %

- How we engage fathers/partners/other family members in our program:

Engaging fathers/partners/others in the program is a priority. In the exploratory phase, the nurses encourage the clients to involve the fathers/partners/others in the program. It is always discussed with the client, to be respectful of her experience and wishes.

- Our reflections on father/partners/other family members engagement:

In 2019, fathers/partners were present during 25 % of the home visits. Covid-19 might have made it more difficult for fathers to be present since more visits take place other places than in the client's home, e.g. outside walking or digitally.

Nursing Workforce

Average nurse caseload:

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	8	2	2	12
# of staff who left during reporting period	1			1
% annual turnover	12.5 %	0 %	0 %	8.3 %
# of replacement staff hired during reporting period	1			1
# of staff at end of reporting period:	8	2	2	12
# of vacant positions				

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

In February, the nurse who left NFP became the leader for the Midwives in the municipality. She is now in the local advisory board (AB) and uses her experiences from her time in the team in a supportive and clever way. We had a highly qualified applicant for the vacant position.

In Oslo there will be a change in the members of the team, since the supervisor of the last 4 years will be hired at the national office as from 1st of January. This is part of the preparations to scale up the National office in view of phase 3 which we will be moving into as from 2021. One of the family nurses in the team will be the new Supervisor and therefore we have hired a new family nurse in the team. There were 9 highly qualified applicants for the position which clearly shows an interest in the program among relevant professionals. This is positive as we will have to hire a considerable number of new nurses when moving into phase 3 of the program.

- Successes/challenges with NFP nurse/supervisor recruitment:

There is an increasing number of actors and institutions who seems to be interested in the program, especially at the level of local authorities. It seems like the program is beginning to get quite known. In addition to the increase in qualified applicants we have had nurses contacting us, outside of hiring processes, to ask for vacancies in the NFP teams

- Any plans to address workforce issues:

We plan to hire the supervisors first in the new sites, and to have them join the program in order for them to take part in the hiring processes for the nurses and administrators.

NFP education

- Briefly describe your NFP education curricula
  - **NFP training modules.** All the nurses have completed the foundation week in Scotland. The education curricula for infancy and toddlerhood ais delivered by the National office in Norway.
  - **Newborn Behavioral Observation training (NBO)**. This involves five theoretical days over a period of 6 months. Nurses are expected to practice under supervision to become NBO-observers.
  - **Video Home Training (Marte Meo).** This is an education curricula process over 1-2 years, with supervision and continuous follow-up in video guidance. This is done for each nurse in each individual NFP-family.
  - **PIPE training and maintenance.** There are two days of basic training, and regular maintenance days for each of the teams and with the teams all together.

- **Motivational Interviewing (MI).** There is one day of basic training, and regularly follow up sessions including case studies when the teams are all together.
- **Intimate Partner Violence (IPV)**. There are two separate days of basic training.

- Changes to NFP education since the last report

We have not made any changes to the NFP education curricula this year, given the insecurity about the future of the program in Norway. Now that we know that the program is moving into phase 3, we have started to evaluate the NFP education curricula to make it adaptable to a larger context. Due to the Covid-19 situation the education and follow-up with the nurses have been done both through live and in digital network meetings. Supervision in home video training, both individual supervision and supervision in groups, has been conducted using Teams. In addition, we have arranged network meetings with a variety of topics, such as «When the child starts in Kindergarten», «How to keep up the focus on the child during Covid-19», «Attachment theory», «How to use the Circle of Security in NFP».

- Successes/challenges with delivery of core NFP nurse/supervisor education:

Successes: We have made our own experiences and know NFP well after several years of testing the program in phase 2. The training is based on these experiences and the adaptations we have made to Norway gives the training a better coherence and quality than we could offer earlier. This applies to both NFP nurse and supervisor education.
Challenges: It is a challenge that there is much to learn about being a family nurse and supervisor in NFP, in addition to the three NFP training modules. We have noticed the need for reducing the content of the program which includes the mother-child intervention. We will try to do it without compromising on the quality. The fact that we have hired a new nurses along the way, has contributed to us having held trainings with only two nurses at a time. In small education groups, we may lose some of the group feeling and the quality of being able to learn from the rest of the group.

- Successes/challenges with ongoing (integration) NFP nurse/supervisor education:

Successes: Today we deliver a more focused training, being adapted to the challenges we have in Norway.
Challenges: It is a challenge that our program is rather comprehensive, as we have replaced DANCE with assessments that are commonly in use in Norway. Our nurses are being trained in Newborn Behavioral Observation (NBO) and video home training (Marte Meo), which are two comprehensive educations.

- Successes/challenges with delivery of NFP induction, education and CPD for associated team members (Family Partnership Worker/Mediator)

We do not have FP workers/mediators.

Reflective Supervision

- Successes/challenges with NFP nurse reflective supervision:

The nurse reflective supervision is going well, and the reflection supervision documents are being more frequently used. The same applies to the use of the STAR document. The SV joining in on home visits are still difficult for the teams to get arrange for as often as wished for.

- Successes/challenges with reflective supervision to our supervisors:

There is still less reflective supervision and more supportive and cooperative work to handle the unpredictability and, as of now, preparatory work for transition to local engagement. Now that

both Supervisors has experience in being Family nurses themselves it might be more natural to make use of reflective supervision.

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

Not relevant.

NFP Information System

- High level description of our NFP information/ data analytical system, including how data are entered by nurses or others:

The nurses collect the data on paper data forms and the administrators/team secretaries plot the data into the SPSS data program, developed for NFP data management by our research team.

- Commentary on data completeness and/ or accuracy:

Since the data forms are filled out on paper and then manually plotted into SPSS, we do experience some mistakes and missing data forms. The research coordinator does a lot of quality assurance to improve the data quality.

In June we started using our updated and adjusted data forms. The feedback from our nurses has been that the forms are easier to fill out and more adjusted to our setting.

When our new digital data collection system is up and running next year, we hope that there will be fewer mistakes and missing data.

- Reports that are generated, how often, and for whom:

The research coordinator makes data reports for the supervisors, focusing on different data forms and various subjects. We usually do this monthly, but less often this year due to Covid-19 and health issues.

The supervisors use the data in individual supervision and in team meetings. We also have data-report meetings with the teams, where we discuss findings and how data can be useful in their clinical practice.

The research coordinator makes reports for the Advisory Boards in each site. Reports and data are also provided for Bufdir upon request.

- Our reflections on our information/ data analytical system - what we need to do to improve functionality, usefulness and quality:

We have started developing a digital data collection system. At RBUP there is a "research support"-team, who helps researchers in different projects with digital data collection. Marte, the research coordinator in NFP, is working closely with this team and have started developing a digital data collection system. The NFP teams (family nurses, supervisors and team secretaries) will also be involved in the process, so that the data collection system will be as good as possible to serve the different needs. It is important to use all the experiences we have gained over the last four years.

We think it is a good choice to use the research support-team at RBUP. It is easy to collaborate closely with them and we can continue to develop the system in the years to come.

Description of our implementing agencies/sites:

High level description of our implementing agencies/sites:

- Oslo municipality (in which two districts function as a joint site) adopted its municipality strategy “Smart, Safe, Green. Oslo towards 2030” in 2015, with its introduction chapter focusing on child and youth participation. Target area 2 under “Safe” deals with high quality services and target area 3 deals with equal rights to a beneficial and active life. Early intervention towards families in need is mentioned.
- Sandnes municipality, the host municipality within the three municipalities joint site in the South West, has its own municipal child and youth council. Its municipality strategy “Sandnes - front and centre of the future” was developed with the participation of children and youth and contains a section on public health specifically mentioning prevention of persisting social inequalities in health. Two out of the three municipalities in the south western site have received central government seed funding to develop more coordinated efforts of early identification and intervention aimed at parents to children 0-6 suffering from mental illness or substance abuse (including in pregnancy) and consider NFP to fit well in with these interventions being a program operating on the families home arena.

- Current number of implementing agencies/sites delivering NFP: 2

- Reflections on our successes/challenges with delivery of NFP through our implementing agencies/sites:
- There has been consistent engagement from the leader of the AB and the leader from the other district, in Oslo. At the same time there has been delays in decisions and planning for the future transition, due to unpredictability and difficulties in getting in touch with the city council department. The focus in the Oslo site has mostly been on meetings between RBUP and administrative leaders to discuss the arrangements for the transition of the teams to become locally employed. We believe that lack of predictability in whether or not there would be a future for the program has influenced the fewer meetings in the local AB. In Oslo there has been an AB meeting in January with focus on evaluation and debate about the role of the AB and the needs for the future phase. The continuation of the AB group was supported, but there is a need to redefine who would be the persons who will be appropriate for the process with transition to local employment. This process has been postponed due to Covid-19 and that the decision about moving the program into phase 3 only became official with the announcement of the national budget for 2021 in the beginning of October. There has been another meeting recently, but before the city council department had decided to part of phase 3. This is now secured and is something that we are very happy about.
- In the South West the contact between local AB members and the municipality's decision-making leaders has been challenging and there seemed to be a distance between the two levels. The local leaders highlight that the AB’s place in the municipalities' local structure for information and decisionmaking is not working well enough. They also mention that other intervention programs do not have a local AB and somehow put a question mark with the set up. The meetings with the local AB have nevertheless been held on a regular basis and there is always a good atmosphere with high level of engagement. Both the supervisor and the clinical leader believe that it is a unique meeting place to share experiences and knowledge about the

program with the local leaders and it has repeatedly been particularly useful when either recruitment or collaborative relationships have been challenging for the team. We do agree in the issues raised by local administrative leaders and difficulties in getting effective decision making pathways into place. We have therefor cooperated with the Directorate to start a process with local administrative leaders to work on this to find good solutions.

- We are looking forward to collecting experience when the teams will be locally employed. One might expect that local leaders and others who will be close to the NFP team, will take a higher degree of responsibility for the team, the program and how the recruitment and cooperation works. The experiences with the local AB highlight the importance of working closely with the sites to develop a sustainable organization of the AB and develop an effective way of information-flow to the right decisionmakers. It seems particularly important to look at the implications of having several municipalities in one site as this is more demanding to handle. The two councils have 18 and 19 members, respectively.
- There are now two former program participants in the two local ABs, which we experience to be beneficial for the meetings. The cooperation with different services, but especially the child welfare is increasingly good, and we notice the importance of the regular contact and collaboration.

Program adaptation

- Brief description of our program adaptation processes:
- We conduct our adaption processes by starting to collect the nurses and supervisors' experiences and reflections. We then work thoroughly at the NO with the input received before we present a first draft to get feedback to guide us (this is usually a repeating process). We also present adaptation to the local AB and ask for their opinion.

- Adaptations undertaken during this reporting period and outcomes (successes and challenges) of these:
- This year we have
  - improved the data forms by a thorough process using our experiences to make the forms more accurate for Norway.
  - improved the eligibility criteria's and the exploring phase, to be as specific as possible in the recruitment process.
  - Developed the way of using STAR in clinical practice.
  - Adjusted Dyadic Intervention tools
  - Developed the job-descriptions for the team members in NFP Norway

- Adaptations planned for next 12 months
  - Improve guidelines and facilitators
  - Improve education curricula and plan the education for the new team-members in September
  - Improve interventions (Dyadic assessment, IPV, MI, etc.)
  - Improve the functionality and appropriateness of the local AB
  - Develop two days of extensive introduction of the program for local leaders in new sites

- Reflections on successes and challenges with our adaptation approach:

We always include our family nurses and supervisors in the process of proposing changes and necessary adjustments in program delivery. Their input is valuable, because they know the families and the challenges out there, more than anyone. Through this approach everyone feel ownership of changes and adjustments, and it makes the adaptation approach user-friendly and accurate. This comprehensive involvement of everyone is possible when we are as few as we are today. Quality improvement like this takes time, but it pays off in the long run.

Video home training has been more flexible than it used to be. We offer video home training from the child is three months old, and for the next three to eight home visits. This year, we have been more flexible, so if the family want more video guidance after this first period, the family nurses are free to offer it if they find it appropriate. Earlier we had scheduled time for when to do the video home training, now it is more flexible and adapted to the family's' needs. We use video home training as one of many tools to promote the interaction between parents and children. PIPE is offered similarly, based on the family's wishes, and not at set times / at set home visits. We have good experiences with delivering the program like this.

Any other relevant information:

We completed a zoom meeting and cooperation regarding Interaction tools with Nancy Donelan-McCall, PhD, Associate Professor, University of Colorado Denver a year ago. During the year we have collaborated with the DANCE team, most recently by having the senior advisor and one of the supervisors to complete six weeks of online training in Dance. We gathered experiences to draw on in our work to adapt and adjust the interaction intervention here in Norway.

We realize that it may be too extensive to require full certification in NBO and Marte Meo, as we triple the number of families in the program when moving into phase 3. We are considering whether we can simplify these two interventions, without significantly deteriorating the quality. In this matter, the experiences with DANCE will be very useful, to make sure that we offer the same quality of intervention to our families that families in other countries receive.

When it comes to Emotional Availability (EA) scales to assess the interaction at different times, this is a procedure that the family nurses have found valuable. The problem / challenge is that it is a time-consuming instrument, and there are few certified coders for this comprehensive work. We are therefore on the search for assessment tools that can be compared with EA, without being as comprehensive. The four EA coders associated with NFP today will participate in training in a well-known assessment tool called Coding Interactive Behavior (CIB) measure February 2021. Both training and coding take less time, and are not as comprehensive as EA. The system can be used in the process of intervention and serve as guidance for the nurses (like EA), and it is also a scientific tool (like EA). We hope that CIB can be a qualitative replacement for EA.

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

Please complete the table below to identify how the CMEs are being monitored/assured, 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 as necessary.

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	
3. Client meets socioeconomic disadvantage criteria at intake	The eligibility criteria for inclusion in the program in our country are: At least one of the following: - Experience with violence/abuse - Early life challenges - Lack of social support and/or conflict in the relationship between the expectant parents - Mental problems - No work and/or not in education and low level of education	100 % clients enrolled who meet the country's eligibility criteria See Table 1 in Appendix 1 for more details.	We have focused on adapting and refining our eligibility criteria this year. The NFP teams have been deeply involved in this process and we think we have found some very good and even more relevant criteria. We will start using our new eligibility criteria soon.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	This includes the socio-economic criteria of: The clients may have socio-economic criteria, but it is not necessary. Application of these criteria are assured and monitored by: Family Nurses		
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no 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	89 % of NFP clients receive their first home visit no later than the 28th week of pregnancy 84 % of eligible referrals who are intended to be recruited to NFP are enrolled in the program 33 % of pregnant women are enrolled by 16 weeks' gestation or earlier	All clients were recruited by the 28th week of pregnancy, but 11 % (N=5) received their first home visit later than the 28th week of pregnancy. They were recruited late (one in week 25 and the rest in week 28). Next year, we will focus more on recruiting clients earlier, so that all clients will receive their first home visit by the 28th week of pregnancy.
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned a single NFP nurse.	100 % clients are assigned a single NFP nurse	
6. Client is visited face-to-face in the home, or occasionally in another setting (mutually	Current National benchmark is: ____% visits take place in the home We haven't jet set up benchmarks for this CME	58 % of visits take place in the home % breakdown of where visits are being conducted other than in the client's home:	In 2019 79 % of visits took place in the home and in 2020 the same number was 58 %. This is mainly because of Covid-19.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
determined by the NFP nurse and client), when this is not possible.		Family/Friend's Home: 1 % Public Health Office: 1 % NFP-Office: 10 % Doctor/Clinic: 0 % Telehealth (phone): 10 % Telehealth (video): 9 % Café: 1 % Meeting outside/walking: 5 % Other: 4 %	Our family nurses have found alternative ways to meet the clients, both in person and digital. They have had several visits outside their client's homes (e.g. at a playground) or they have been walking.
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.	Current National benchmarks for: a) Program visit dosage patterns in relation to client strengths and risks benchmarks are:	• _____% 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: 8. Range: 1 – 26. • Infancy: 19. Range: 8 – 35. • Toddlerhood: 13. Range: 2 – 35. • Length of visits by phase (average and range):	We do not collect data on how many clients are visited on standard or alternate visit schedule. Instead we have presented data on average number of completed visits for clients who have completed each phase. We are planning on developing a summary for each phase, that the family nurse complete after each phase. The summary will ask about the number of completed visits in the phase and why the client have received fewer/more visits than the standard.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	b) Length of visits by phase country benchmarks are: • Pregnancy phase: • Infancy phase: • Toddler phase: Not developed jet c) Client attrition by program phase country benchmarks are: _____% attrition in Pregnancy phase _____% attrition in Infancy phase _____% attrition in Toddler phase We have not developed benchmarks on this. Need more experience.	• Pregnancy phase: Average: 79 minutes. Range: 10 – 150 minutes. • Infancy phase: Average: 77 minutes. Range: 5 – 180 minutes. • Toddler phase: Average: 77 minutes. Range: 10 – 225 minutes. <u>Client attrition by phase and reasons:</u> 0 % attrition in Pregnancy phase 0 clients left the program in pregnancy phase in 2020. 12 % attrition in Infancy phase (of the 142 clients active this year) 12 clients left the program in infancy phase in 2020: • 5 clients moved to an area where NFP is not available • 1 client refused new family nurse • 1 client refused NFP following report to Child Protective Services • 2 clients perceived that they had received what they needed from the program • 3 clients perceived that they had sufficient knowledge or support 6 % attrition in Toddler phase (of the 142 clients active this year)	

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		8 clients left the program in toddler phase in 2020: • 2 clients moved to an area where NFP is not available • 3 clients refused new family nurse • 2 clients refused NFP following report to Child Protective Services • 1 client left the program of other reason	
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): Clinical Lead Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc.	100 % NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree	In Norway all NFP-nurses are registered nurses with additional training and recognition as public health nurses or midwives.
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 100 % of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	100 % of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities 94 % completion of team meetings, 97 % completion of case conference and 100 % completion of education sessions	In Norway we have several public holidays and 5 weeks of holiday per year. We updated the supervision data forms late 2019. We added an alternative for "not planned due to holiday etc." under the question "Was the meeting cancelled?" The numbers to the left show a 93 % completion of team meetings.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			This does not include when a team meeting was not planned due to holidays etc.
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	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*.
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).	30 % of 4-monthly Accompanied Home Visits completed	It has been challenging to do Accompanied Home Visits this year due to Covid-19.
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team	100% of NFP teams have an assigned NFP Supervisor	100 % of NFP teams have an assigned NFP Supervisor	One of the supervisors was on sick leave for a longer period this year.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
and provides nurses with regular clinical and reflective supervision	100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurses).	75 % of reflective supervision sessions conducted	The other main reason for cancelling reflective supervision sessions was planning conflicts.
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.	No benchmark. Monitored/assured by:	Progress:	Please be referred to the part about NFP Information System earlier in the report.
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 Monitored/assured by (including other measures used to assure high quality implementation):	_____% of Advisory Boards or equivalents _____% attendance at Advisory Boards	We have not been collecting data on this CME. We hope to be able to develop the AB when the team has been transferred to local engagement. The one AB managed to have the AB meetings 4 times a year and they are prepared by a working group beforehand. There are

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			always more than half of the members present in the meetings The other AB has had two meetings this year and one of them was on a digital platform. Here, also more than half of the members are present at the meetings. Together with the members of the local AB we plan to continue the developmental work for a better and more appropriate function for the AB in each site.

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

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35 – 40 %	31 %	14 – 20 %	20 %	10 – 15 %	17 %
Maternal Role (My Child and Me)	23 – 25 %	29 %	45 – 50 %	48 %	40 – 45 %	41 %
Environmental Health (My Home)	5 – 7 %	11 %	7 – 10 %	9 %	7 – 10 %	10 %
My Family & Friends (Family & Friends)	10 – 15 %	18 %	10 – 15 %	16 %	10 – 15 %	17 %
Life Course Development (My Life)	10 – 15 %	16 %	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):
In infancy and toddler phases, our domain coverage is mostly within the benchmarks. In pregnancy phase, the personal health-average is below the benchmark and the rest of the domains are above the benchmarks. We think this is because the clients also get pregnancy follow-ups from the universal services, and that they focus more on personal health there.
We are pleased that, even in 2020 with Covid-19, our nurses seem to have delivered program content and covered all the domains in a good way.

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 also explain any missing data or analyses as necessary.

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%) (2016 – 2019)**	**Current Period (n/%) (2020)**
Age (range and mean)	Range: 16 – 42. Mean: 27.0.	Range: 19 – 42. Mean: 27.1.
Race/ethnicity distribution	62 % (N= 117) of clients are Norwegian/Scandinavian. 38 % (N= 72) of clients have another ethnicity than Norwegian/Scandinavian.	72 % (N= 36) of clients are Norwegian/Scandinavian. 28 % (N= 14) of clients have another ethnicity than Norwegian/Scandinavian. (We changed the answer option from Scandinavian to Norwegian in our updated data form in June this year)
Father involvement How often does the client have contact with the baby's biological father (in-person, phone or text)?	Every day: 77 % (N=146) 3-6 times a week: 3 % (N=5) Once or twice a week: 3 % (N=6) 1-3 times a month: 5 % (N=9) Once every few months: 3 % (N=6) Once a year: 1 % (N=2) Less than once a year: 1 % (N=1) Never: 8 % (N=15)	Every day: 78 % (N=39) 3-6 times a week: 0 % (N=0) Once or twice a week: 4 % (N=2) 1-3 times a month: 2 % (N=1) Once every few months: 2 % (N=1) Once a year: 2 % (N=1) Less than once a year: 0 % (N=0) Never: 12 % (N=6)

Income (please state how this is defined) The average gross income in Norway in 2019 was around 60,000 USD.	92 % (N=144) of clients earned less than 60,000 USD. See Table 2 and 3 in Appendix 1 for more details.	90 % (N=38) of clients earned less than 60,000 USD.
Inadequate Housing (please define) • Staying with friend(s) temporarily • 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 • Other arrangement	Staying with friend(s) temporarily: 2 % (N=4) Residential care (treatment center, maternity home): 1 % (N=2) Other arrangement: 1 % (N=2) See Table 4 and 5 in Appendix 1 for more details.	Staying with friend(s) temporarily: 2 % (N=1) Residential care (treatment center, maternity home): 4 % (N=2) Other arrangement: 2 % (N=1)
Educational Achievement	Primary school: 30 % (N= 56) High school: 32 % (N= 60) One-year program at university or college: 6 % (N= 11) Bachelors' degree: 18 % (N= 33) Masters' degree: 12 % (N= 22) PHD: 1 % (N= 2) Other: 1 % (N=2)	Primary school: 30 % (N= 15) High school: 14 % (N= 7) Vocational school: 2 % (N= 1) One-year program at university or college: 8 % (N= 4) Bachelors' degree: 24 % (N= 12) Masters' degree: 16 % (N= 8) PHD: 2 % (N= 1) Other: 4 % (N=2)
Employment	52 % (N= 98) of clients were in employment.	48 % (N= 23) of clients were in employment.
Food Insecurity (please define)	Not Applicable	Not Applicable
Ever in the care of the State (as a child or currently)	Foster Parents: 8 % (N=15) Residential Care: 11 % (N=20) (as a child)	Foster Parents: 6 % (N=3) Residential Care: 10 % (N=5) (as a child)

Obesity (BMI of 30 or more)	7 % (N= 12)	11 % (N= 4)
Severe Obesity (BMI of 40 or more)	1 % (N= 1)	10 % (N= 4)
Underweight (BMI of 18.5 or less)	10 % (N= 19)	13 % (N= 5)
Heart Disease	5 % (N= 9)	0 %
Hypertension	2 % (N= 4)	0 %
Diabetes – T1	2 % (N= 3)	0 %
Diabetes – T2	2 % (N= 3)	0 %
Kidney disease	1 % (N= 1)	2 % (N= 1)
Epilepsy	3 % (N= 6)	0 %
Sickle cell Disease	1 % (N= 1)	0 %
Chronic Gastrointestinal disease	6 % (N= 12)	7 % (N= 3)
Asthma/other chronic pulmonary Disease	12 % (N= 23)	24 % (N= 11)
Chronic Urinary Tract Infections	8 % (N= 16)	13 % (N= 6)
Chronic Vaginal Infections (e.g., yeast infections)	5 % (N= 10)	13 % (N= 6)
Sexually Transmitted Infections	17 % (N= 33)	33 % (N= 15)
Substance Use Disorder	9 % (N= 18)	9 % (N= 4)
Mental Illness: Anxiety	43 % (N= 82)	61 % (N= 28)
Mental Illness: Depression	45 % (N= 86)	54 % (N= 25)
Eating Disorder	14 % (N= 27)	28 % (N= 13)

Please comment below on the vulnerability of your client population, including analysis of STAR (or equivalent) data and reviewing trends over time.
We don't collect data based on STAR.

The number of clients who have anxiety and depression are very high (61 % and 54 % respectively in 2020). In addition, the number of clients who have an eating disorder is also quite high (28 % in 2020). This indicates that our client population is very vulnerable when it comes to mental illnesses.

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 = 187. 16 % moderate anxiety. 9 % severe anxiety.	N = 98. 12 % moderate anxiety. 2 % severe anxiety.	N = 171. 16 % moderate anxiety. 4 % severe anxiety.	N = 66. 9 % moderate anxiety. 2 % severe anxiety.	N = 63. 22 % moderate anxiety. 3 % severe anxiety.
Depression, (n, % moderate + clinical range) Patient Health Questionnaire-9 (PHQ-9)	N = 184. 22 % moderate depression. 16 % moderately severe or severe depression.	N = 99. 22 % moderate depression. 6 % moderately severe or severe depression.	N = 171. 19 % moderate depression. 6 % moderately severe or severe depression.	N = 67. 18 % moderate depression. 6 % moderately severe or severe depression.	N = 64. 16 % moderate depression. 11 % moderately severe or severe depression.
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours) We changed the questions about smoking and drug use in June 2020. We have added the question "Do you smoke now/at the moment"? It will be interesting to see how these numbers change/develop when more data forms are filled out.	26 % (N= 58) of clients have been smoking in the pregnancy, including before they found out that they were pregnant. 5 % (N=1) of clients are smoking daily. 5 % (N=1) of clients are	12 % (N=9) of clients have been smoking in their pregnancy. 7 % (N=1) of clients are smoking daily. 0 % (N=0) of clients are		31 % (N= 23) of clients have been smoking since their baby was born. 17 % (N=1) of clients are smoking daily. 17 % (N=1) of clients are	 0 % (N=0) of clients are smoking daily. 33 % (N=1) of clients are

This data form is now being filled out at four times during the program: pregnancy intake, 36 weeks of pregnancy, 12 months and 18 months.	smoking sometimes. 90 % (N=18) of clients are not currently smoking.	smoking sometimes. 93 % (N=14) of clients are not currently smoking.		smoking sometimes. 67 % (N=4) of clients are not currently smoking.	smoking sometimes. 67 % (N=2) of clients are not currently smoking.
Alcohol, (n, % during pregnancy, units/last 14 days) Same changes in the data form as mentioned above.	48 % (N=113) of clients have been drinking in the pregnancy, including before they found out that they were pregnant. 100 % (N=21) of clients are not currently drinking alcohol.	100 % (N=15) of clients are not currently drinking alcohol.		44 % (N=4) of clients are currently drinking sometimes. 56 % (N=5) of clients are not currently drinking alcohol.	20 % (N=1) of clients are currently drinking sometimes. 80 % (N=4) 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.	6 % (N=12) of clients have been using marijuana in the pregnancy, including before they found out that they were pregnant. 100 % (N=21) of clients are not	100 % (N=17) of clients are not		100 % (N=5) of clients are not	

	currently using marijuana.	currently using marijuana.		currently using marijuana.	
Cocaine, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	1 % (N=3) of clients have been using cocaine in the pregnancy, including before they found out that they were pregnant. 100 % (N=20) of clients are not currently using cocaine.	100 % (N=15) of clients are not currently using cocaine.		100 % (N=5) of clients are not currently using cocaine.	
Other street drugs, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	1 % (N=2) of clients have been using other street drugs in the pregnancy, including before they found out that they were pregnant. 100 % (N=19) of clients are not currently using any other street drugs.	100 % (N=15) of clients are not currently using any other street drugs.		100 % (N=6) of clients are not currently using any other street drugs.	100 % (N=1) of clients are not currently using any other street drugs.

Excessive Weight Gain from baseline BMI - Pregnancy, (n, %)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Mastery, (n, mean) Low Mastery = 19 or under. Not Low Mastery = 20 or more.	Intake: N = 223. Mean = 21.8 27 % (N= 61) of clients have low mastery. 73 % (N=162) of clients have not low mastery.	6 months: N = 123. Mean = 22.7 15 % (N= 19) of clients have low mastery. 85 % (N=104) of clients have not low mastery.	12 months: N = 86. Mean = 22.6 14 % (N= 12) of clients have low mastery. 86 % (N=74) of clients have not low mastery.	18 months: N = 70. Mean = 22.2 19 % (N= 13) of clients have low mastery. 81 % (N=57) of clients have not low mastery.	24 months: N = 57. Mean = 22.4 19 % (N= 11) of clients have low mastery. 81 % (N=46) of clients have not low mastery.
IPV disclosure, (n, %)	Pregnancy: 16 % (N= 9)	Infancy: 22 % (N= 12)	Toddler: 13 % (N= 5)		
	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 • IUD Non-Hormonal	46 % (N= 61) of clients are using at least one reliable birth control. See Table 6 and 7 in Appendix 1 for more details.	55 % (N= 51) of clients are using at least one reliable birth control.	47 % (N= 35) of clients are using at least one reliable birth control.	61 % (N= 38) of clients are using at least one reliable birth control.	
Subsequent pregnancies, (n, %)	4 % (N= 5)	15 % (N= 13)	21 % (N= 15)	31 % (N= 19)	
Involvement in Education, (n, %)	26 % (N= 34)	24 % (N= 21)	24 % (N= 17)	31 % (N= 19)	
Employed, (n, %)	58 % (N= 49)	60 % (N= 42)	67 % (N= 38)	54 % (N= 30)	
Housing needs, (n, %)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	

DANCE (or equivalent), (mean - 2, 9, 15, 22 mos.) Emotional Availability Scales (EAS) - At 6, 12 and 24 months See Table 8 and 9 in Appendix 1 for information about EA Zone Adult Sensitivity and EA Zone Child Responsiveness.	EA Zones – Adult Sensitivity at 6 months: Emotionally available: 59 % (N=58) Complicated: 34 % (N=34) Detached: 7 % (N=7). EA Zones – Child Responsiveness at 6 months: Emotionally available: 66 % (N=67) Complicated: 24 % (N=24) Detached: 8 % (N=8).	EA Zones – Adult Sensitivity at 12 months: Emotionally available: 44 % (N=30) Complicated: 49 % (N=33) Detached: 7 % (N=5). EA Zones – Child Responsiveness at 12 months: Emotionally available: 46 % (N=31) Complicated: 49 % (N=33) Detached: 6 % (N=4).		EA Zones – Adult Sensitivity at 24 months: Emotionally available: 79 % (N=19) Complicated: 17 % (N=4) Detached: 4 % (N=1). EA Zones – Child Responsiveness at 24 months: Emotionally available: 79 % (N=19) Complicated: 17 % (N=4) Detached: 4 % (N=1).	
Father's involvement in care of child, (n, %) During the past three months, how often did the baby's biological father spend time taking care of and/or playing with the baby?	He does most/all of the care: 2 % (N= 2) Every day: 63 % (N= 83) 3-6 times a week: 9 % (N= 12)	He does most/all of the care: 4 % (N= 4) Every day: 64 % (N= 59) 3-6 times a week: 5 % (N= 5)	He does most/all of the care: 0 % (N= 0) Every day: 63 % (N= 46) 3-6 times a week: 14 % (N= 10)	He does most/all of the care: 3 % (N= 2) Every day: 52 % (N= 32) 3-6 times a week: 11 % (N= 7)	

	Once or twice a week: 6 % (N =8) 1-3 times a month: 4 % (N= 5) Less than once a month: 4 % (N= 5) He has not spent time caring for or interacting with the baby: 13 % (N= 17)	Once or twice a week: 4 % (N =4) 1-3 times a month: 2 % (N= 2) Less than once a month: 5 % (N= 5) He has not spent time caring for or interacting with the baby: 14 % (N= 13)	Once or twice a week: 3 % (N =2) 1-3 times a month: 1 % (N= 1) Less than once a month: 10 % (N= 7) He has not spent time caring for or interacting with the baby: 10 % (N= 7)	Once or twice a week: 10 % (N =6) 1-3 times a month: 5 % (N= 3) Less than once a month: 8 % (N= 5) He has not spent time caring for or interacting with the baby: 11 % (N= 7)	
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. The results from both questions are presented here. We also added a question "How are you currently feeding your baby?"	**First postpartum visit:** Exclusive breastfeeding: 57 % (N=99) of clients had breastfed their baby exclusively. Breastfeeding: 100 % (N=22) have breastfed their baby. Currently feeding their baby:	**6 months:** 13 % (N=17) of clients are exclusively breastfeeding. 47 % (N=64) of clients are breastfeeding non-exclusively. 40 % (N=40) of clients are not breastfeeding.	**12 months:** 50 % (N=43) of clients are breastfeeding non-exclusively. 50 % (N=43) of clients are not breastfeeding.	**18 months:** 30 % (N=17) of clients are breastfeeding non-exclusively. 70 % (N=39) of clients are not breastfeeding.	**24 months:** 13 % (N=6) of clients are breastfeeding non-exclusively. 87 % (N=40) of clients are not breastfeeding.

	64 % (N=14) are exclusively breastfeeding. 27 % (N=6) are not exclusively breastfeeding. 9 % (N=2) are currently giving their baby pumped breast milk.				

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 rates achieved in RCT, to equivalent populations etc.)**:**

In which areas is the program having greatest impact on maternal behaviors?

In EA, direct scores are set from 1-7 in 6 different dimensions of the interaction between mother and child, based on a 20-minute video recording in the family's home. Scores below 4 are considered below the limit value. In our figures, we find that there is generally "good enough" interaction in our families (scores from 4 and above). It is important to emphasize that we already have supported these families in NFP since pregnancy. The scores at 6 months of age in EA reflect the qualitative follow-up that has already been given.

It is nevertheless gratifying to see that the interaction between mother and child increases from T1 (6 months) to T3 (24 months). This applies to all sub-scores for both mother and child.

In EA, the mother's sensitivity and the child's response are given great weight in the assessment. EA-Z zones and scores are directly from the sensitivity and responsiveness EA Scale codes. These two scales are considered the primary sources of information. Biringen recommends directly coding the EA-Z whenever possible so that coders can consider additional EA qualities besides sensitivity and responsiveness when assigning scores and zones. In NFP, we do as Biringen recommends.

There are seven mothers who end up in the zone called Detached at T1 (6 months), and this number has dropped to one mother at T3 (24 months). These are uplifting results. Regarding the one mother who gets a low score at the end of the program, we have ensured that further follow-up is close and thorough after ending in NFP.
Number of mothers in the Emotionally Available Zone has increased by 20% from T1 to T3 (from 59% to 79%). The number of mothers in the Complicated zone has dropped to half (from 34% to 17%), and we see a similar sign for the Detached zone (from 7% to 4%).
EA zones for children show that the number of children in the Detached zone has dropped to half from T1 to T3, which we are very satisfied with.

Based on the figures, we can see that the scores at T2 (12 months) are generally lower than at T1 and T3. This can be explained by the fact that we have fixed coders at each age level, and our coder of 12 months have been stricter, especially at the beginning of the coding work. We have adjusted by having regular coding meetings, where we code together and agree on scores. In addition, we have had refresher classes with Zeynep Biringen to ensure greater consensus. This has been helpful.

Which are the areas of challenge?
At intake, 34 % of the clients are neither in education nor in employment. At 24 months, this applies to 32 % of the clients. This is an area that it important to focus on and hopefully improve.

Mental health is also an important area. The percentage of clients with severe anxiety decreases from 9 % to 3 % from intake to 18 months. But at the same time, the percentage of clients with moderate anxiety increases from 16 % to 22 % in the same time frame. When it comes to depression, moderately severe or severe depression decreases from 16 % to 11 % from intake to 18 months. Here, moderate depression also decreases from 22 % to 16 %. But the numbers are still quite high. But it is important to remember that mental problems are the second most common eligibility criterion for our clients. In total, 60 % of the clients recruited to the program, have mental problems as one of the eligibility criteria.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks gestation)	0	0 %
Very preterm (28-32 weeks gestation)	1	0.5 %
Moderate to late preterm (32-37 weeks gestation)	10	5.2 %
Low birthweight (please define for your context) Low birthweight: below 2500 g	16	9.3 %
Large for Gestational Age (LGA) (please define for your context)		
Other (please define)		

Please comment below on your birth data:

The numbers are low, but they seem to be quite close to the national numbers when it comes to preterm births. Generally, there is good follow up in Norway and there are many interventions available for delaying preterm births. When it comes to low birthweight our numbers are a bit above the mean for Norway (4,2%)

Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	99 %	99 %	99 %	100 %
Hospitalization for Injuries	0 %	1 %	0 %	0 %
ASQ scores requiring monitoring (grey zone)	Communication: 1 % (N=2) Gross Motor: 1 % (N=1) Fine Motor: 6 % (N=8) Problem Solving: 4 % (N=5) Personal Social: 2 % (N=3)	Communication: 0 % (N=0) Gross Motor: 0 % (N=0) Fine Motor: 3 % (N=1) Problem Solving: 3 %(N=2) Personal Social: 1 % (N=1)	Communication: 2 % (N=1) Gross Motor: 2 % (N=1) Fine Motor: 2 % (N=1) Problem Solving: 3 % (N=2) Personal Social: 3 % (N=2)	Communication: 6 % (N=3) Gross Motor: 6 % (N=3) Fine Motor: 4 % (N=2) Problem Solving: 6 % (N=3) Personal Social: 4 % (N=2)
ASQ scores requiring further assessment/referral				
ASQ-SE scores requiring monitoring (grey zone)	Social Emotional: 3 % (N=3)	Social Emotional: 0 % (N=0)	Social Emotional: 0 % (N=0)	Social Emotional: 2 % (N=1)
ASQ-SE scores requiring further assessment/referral				
Child Protection (please define for your context) Referrals to Child Protective Services – Concerns regarding suspected abuse or neglect of child	8 % (N=10) of clients had been referred to the Child Welfare Organization by other than the family nurse. 3 % (N=4) of clients had been referred to the Child Welfare Organization by the family nurse.	8 % (N=7) of clients had been referred to the Child Welfare Organization by other than the family nurse. 1 % (N=1) of clients had been referred to the Child Welfare Organization by the family nurse.	14 % (N=9) of clients had been referred to the Child Welfare Organization by other than the family nurse. 3 % (N=2) of clients had been referred to the Child Welfare Organization by the family nurse.	12 % (N=6) of clients had been referred to the Child Welfare Organization by other than the family nurse. 2 % (N=1) of clients had been referred to the Child Welfare Organization by the family nurse.
Child Protection (please define for your context) Referrals to Child Protective Services	7 % (N=9) of clients had been referred to the Child Welfare Organization by other than the family nurse.	10 % (N=9) of clients had been referred to the Child Welfare Organization by other than the family nurse.	16 % (N=10) of clients had been referred to the Child Welfare Organization by other than the family nurse.	14 % (N=8) of clients had been referred to the Child Welfare Organization by other than the family nurse.

– Voluntary support services	4 % (N=5) of clients had been referred to the Child Welfare Organization by the family nurse.	1 % (N=1) of clients had been referred to the Child Welfare Organization by the family nurse.	5 % (N=3) of clients had been referred to the Child Welfare Organization by the family nurse.	2 % (N=1) of clients had been referred to the Child Welfare Organization by the family nurse.

Please comment below on your child health/development data

Referrals to Child Protective Services– Concerns regarding suspected abuse or neglect of child and/or voluntary support services:

The figures are unclear, based on use of early data forms which did not specify new referrals in the last six months. Thus, it is unclear whether the same referral was checked at T1, T2, T3 and T4, or whether they represent new referrals to the Child Protective Services. We have corrected this in the data form we use today, so hopefully the figures will be more reliable next year. If we carefully interpret the figures, we see that the number of referrals to the Child Protective Services decreases from T1 to T4, and this applies both when the family nurse refers and when the referrals come from other than family nurses, and regardless of whether the referrals are regarding suspected abuse or neglect of child or associated with voluntary support services. Based on information from other services and from the family nurses, we can cautiously estimate that participation in NFP has contributed to postponing or avoiding a minimum of two care takeovers per family nurse. Here we have to settle for assumptions, hence this cautious estimate. There are probably even more families who will manage the caring role well by participating in the program.

ASQ:

When we compare our data on ASQ with the Norwegian reference sample, we find more children in the grey zone (ASQ scores requiring monitoring) in our group. This is natural, since our group is extra vulnerable. At RBUP, a comprehensive population study of ASQ has been carried out, where the same 1,500 children have been followed up at the different age levels, and where the parents have received feedback and guidance on the results along the way. This design is similar to NFP, except that in NFP the participants are an extra vulnerable group. We want to compare ASQ data from the population study with NFP data in 2021, when more of our children have turned 24 months. Then we will have a greater basis for comparison.

Our findings on ASQ, shows that the % of children in the grey zone are higher at T4 than in T1 (except for Fine Motor). It is an interesting question whether the intervention in NFP is directly related to the development areas measured in ASQ. For example, there is less focus on Gross Motor than on socio-emotional development during home visits, and we see that in ASQ: SE, which measures socio-emotional development, the scores are even at all 4 measurement times. It would be interesting to compare with results from other NFP countries. It should be emphasized that the Norwegian and American norm data are not similar, we will elaborate on this in more detail when we compare data in 2021.

ASQ and ASQ: SE are considered as screening tools. This means that it is unlikely to be able to capture details that the family nurse is not already aware of, as they follow the family so closely already. ASQ and ADQ: SE work well as conversation tools, but perhaps to a lesser extent to capture details in the child's development.

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. The journal of the Norwegian Nurses' Association presented an interview with a participant in February 2020 (full article in Norwegian: https://sykepleien.no/2020/02/familie-forste-gang-skal-hjelpe-sarbare-forstegangsforeldre?auHash=vcZanRVH8b22-Qz29fQ-bthxA2QSVLerYMVjn2PM9iE) Mona, the participant, described her initial skepticism towards program participation, stating that she felt little trust in the authorities. She worried that focus would be on her shortcomings as a mother, and that she would lose custody of her child. Looking back, however, Mona found that the relationship with her family nurse was positive, supportive and safe, and that the program helped her feel secure as a mother, especially in understanding her child. Furthermore, the support she received helped her in deciding to finish high school, and in following up and receiving support from health and social services. In May 2020, The Regional Center for Child and Adolescent Mental Health - the organization hosting NFP in Norway – published an article concerning NFP in their magazine (full article in Norwegian, pp 39 - 42: https://issuu.com/r-bup/docs/rbup_magasinet_2020/42). The article included an interview with a participant, Camilla, who was going through a difficult time during pregnancy, with no family of her own to support her. Camilla highlighted the benefits of receiving support from one professional who knew her, rather than multiple professionals. This meant that there was no need to reiterate her story and needs to one professional after another. The family nurse involved provided support in preparing Camilla for giving birth, interacted with other relevant professionals, and followed up after birth. The family nurse being available for support after working hours was valuable for Camilla, who also expressed that the family nurse was one of the few people in her life that she did not push away. In August 2020, The Norwegian Ministry of Children and Families produced a video with a NFP participant who was interviewed by the acting Minister of Children and Family Affairs (full video in Norwegian: https://fb.watch/24OpmaIK0k/). Maria, the participant, described her own childhood as problematic, due to an adult close to her having drug and violence-related problems. She feared that her own daughter would suffer like she had. However, her assigned family nurse had supported her in trusting herself as a mother. She stated that the help she received has meant everything to her – and that her daughter may not remember the family nurse when she grows up, but that the NFP support will benefit her for the rest of her life.

- It is proposed that a video will be shared at the annual meeting in January where a family shares their experience about the impact of the program (max. 10 minutes).

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	0	
Maternal death	1	One mother committed suicide this year. The NFP program continued with the baby's father as the primary caretaker. We learned that the data forms about the client is not necessarily suitable for the father. We will look more into developing data forms suitable for similar situations in the future.
Other		

Any other relevant information or other events to report:

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program **Not started this work yet in NFP Norway**
• Briefly describe your system for monitoring implementation quality: • Goals and Objectives for any CQI initiatives undertaken during the reporting period: • Outcomes of any CQI initiatives undertaken during the reporting period • Lessons learned from CQI initiatives and how these will be applied in future: • Goals for CQI in next year:
Program innovations tested and/or implemented this year (this includes both international and local innovations)
• Program innovations tested[1]: • Program innovations implemented: • Findings and next steps:
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 attach a summary of findings in relation to any Additional Approved Model Elements in Appendix 3 to this document

[1] Please attach the materials used for the innovations.

Feasibility & acceptability study:
• Goals: For information regarding the feasibility and acceptability study reference is made to annual report for 2019. • Methods: • Sample: • Progress to-date:
Findings from feasibility & acceptability study to date:
• Key findings from our study • Reflections on our findings/results • Any actions planned based on results
Anything else that would be helpful for the UCD international team to know?

PART FIVE: ACTION PLAN

LAST YEAR:

Our planned priorities and objectives for last year:

1. RBUP planned to transfer the teams from RBUP to employment at the level of the municipality.
2. Refine and develop the data forms and other materials to fit better to the Norwegian context.
3. Develop the educational curriculum for the Norwegian context. Develop dyadic tools to secure better sustainability.
4. Prepare for expansion for 2021 by strengthening the national office (provided that the Ministry is pursuing the program), including the development of a digital data collection system. Send invitation to municipalities to send letter of interest to join the programme.
5. Work on refining the inclusion/exclusion criteria for the program when recruiting participants.

Our research/program evaluation priorities:

Bufdir will enter into a dialogue with the Ministry to identify what the Ministry is expecting/willing to fund and what research design one is to pursue to be able to measure effects of the program in a Norwegian context. The outcome measures have to be selected accordingly.

Progress against those objectives

- The teams have unfortunately not been transferred to local authorities yet, but we hope to have this in place within the first quarter of 2021.
- The data forms have been improved
- The criteria for the recruitment to program has been refined and we start using the refined criteria from 1st January 2021
- The process of developing dyadic tools has been started
- We have begun to strengthen the national office in view of phase 3 and have a plan for it for 2021
- We have just started to cooperate with the research support team at RBUP who will develop the digital data collection system
- Bufdir has secured funding for effect evaluation of the program amounting to 10 mill NOK equivalent to 1,150,000 UCD for the period 2022-2027. Details about preferred design and outcome areas to be pursued by the effect evaluation is left to Bufdir and the research institution who will be selected for the task, as well as dialogue with UCD as license owner.

Reflections on our progress:

Overall we are satisfied with the progress made measured against set objectives for 2020.

NEXT YEAR:

Our planned priorities and objectives for next year:

- RBUP plan to transfer the employment of the teams from RBUP to the municipality level before March 2021
- Develop the digital data collection system
- Develop and adapt the education curriculum for phase 3
- Start implementing work with the new sites
- Develop the website at RPUP regarding NFP and secure better updated information about the program

- Develop and implement introduction/education about the NFP program for relevant sector leaders at the sites.

- Bufdir will be pursuing the planning of the effect evaluation. A bidding process to identify the research institution which will be given the task will be conducted in 2021.

- Bufdir will also be pursing the collaboration needed from the Ministry of Health and the underlying Directorate of Health, for instance in relation to the effect evaluation, as well as regarding discussions about the future organization of the program

- Bufdir will also be pursuing to its maximum the importance of securing the legal basis for the program regarding handling of personal information in the program which has been challenged by the strict interpretation of the GDPR regulations in Norway.

Measures planned for evaluating our success:

- NFP teams all locally engaged!
- Digital data collection system in use from September 2021
- Education curriculum developed for Norway NFP
- National web site on NFP Norway is up and running by the end of the year
- Research institution is identified
- An effective collaboration with the Health sector is in place
- A legal basis for the program has been secured

Any plans/requests for program expansion?

UCD is well aware of the fact that the program as part of phase 3 will be expanding to new program sites. We received many solid and exciting expressions of interest. Based on the review of 26 incoming applications from local authorities composed of 43 municipalities interested to take part in the expansion of the program, we are proposing to expand to three new sites which will include a number of municipalities in order to secure a sufficient recruitment base to the NFP program and for the effect evaluation. The selection of new program sites have a good geographical representation, apart from the northern parts of Norway. Unfortunately we did not receive any qualified applications from these areas. But as a whole we are more than satisfied with the level of interest among municipalities to join the program. With the expansion we hope to be able to recruit 480 new families to the program within mid 2023. As a result of this expansion our license agreement is currently being revised.

FEEDBACK FOR UCD INTERNATIONAL TEAM:

The most helpful things we have received from the International team over the last year have been: Regular meetings with international consultant, regularly CI. Lead meetings, developmentary workgroup on Covid-19, Reflective SV,
PIPE workgroup, DANCE education for senior advisor and supervisor, Mentoring CI. Lead.

Bufdir would like to add that the International website has become increasingly more relevant and an important place to get updated information about tools and resources, as well as sharing of information and guidance on program implementation in the different phases of the program.

Bufdir would also like to appreciate the initiative with the webinar series conducted by Dr. David Olds to share information about effect evaluation of the program across countries. This is an excellent initiative from UCD, in spite of the fact that few of us at the level of the Directorate have been able to attend this autumn due to a very heavy work load.

Our suggestions for how NFP could be developed and improved internationally are: We might be able to come up with something on this in the annual meeting.
This is what we would like from UCD through our Support Services Agreement for next year: Support in undertaking and developing the above mentioned planned activities for 2021. Share relevant material and to put us in contact with persons in NFP or outside of NFP who might know something extra around specific themes where we are looking for input.

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 annual review meeting)

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

- Mentoring and consultation to clinical lead and license holder
- Supporting clinical lead with further program adaptations, preparation of proposals and processes for expansion of National Unit and development of new sites
- Monitoring of license, oversight of fidelity and agreement of quality improvement plans
- COVID-19 project, in which resources and learning has been rapidly shared between countries. Norway is also participating in the working group relating to ongoing use of telehealth in NFP.
- Reflective supervision working group activities re RS documentation and reporting.
- Updating and maintaining the international NFP website, including creating opportunities for accessing international program resources, educational materials, and NFP news updates.
- Access to the international website forum for discussion of issues with leads in other NFP implementing countries
- Development and dissemination of international guidance documents on program content and implementation that draw on the experiences of all NFP implementing countries.
- Sharing and updating the international data collection manual and program guidelines.
- Provision of the international Clinical Leads' Advisory Group meetings.
- Sharing new program innovations developed and researched by PRC and all implementing countries
- Developing new opportunities for international collaboration and networking, such as the data analytic and research-leads forum and the PIPE education group.
- Facilitating the sharing of good practice between countries on particular topics.
- Access to expert consultation re IPV from Dr Susan Jack and learning from other countries adapting and testing the intervention
- Sharing new NFP international research outputs from all countries via the website and through the international research seminars.
- Promoting NFP internationally as an example of a program that ensures high quality replication in all contexts and maintains its international reputation for effectiveness and quality.

Identified strengths of program:

- The high quality of strategic and clinical leadership for the program at national and local levels
- The Governmental commitment to continuing to expand and test the program in the Norwegian context.
- The deep commitment to delivering NFP with excellence throughout the system with strong collaboration developed between the key partners.
- The high quality of the nursing workforce and their levels of commitment and skilfulness
- The inclusion of NFP clients in local program implementation and as advocates for the program
- The commitment to working with the experience of all program partners to further adapt and improve NFP for the Norwegian context.
- The quality of analysis and use of data to inform program progress and areas of challenges, as presented in this report.

- The collaboration with local sites to ensure strong local delivery of the program and the commitment to ongoing development of Local Advisory Boards and their integration into local system

Areas for further work:
We suggest the following:

- Exploring nurses' experiences and approaches to promoting client employment and education by the program end (as suggested by yourselves in the report)
- Exploring clients' motivations for pregnancy planning
- Exploring nurses' experiences and approaches to contraception use in the context of client motivations (as discussed during the annual review meeting)

Agreed upon priorities for country to focus on during the coming year:
In addition to those listed in part five, as a result of the meeting we suggest that consideration is also given to:

- Developing proposals re father data collection and analysis in the program
- Establishing a Norwegian benchmark for client enrolment in the program by weeks of pregnancy. We note that the international benchmark is currently not being met and as the 'exploring phase' of the program is being extended, it is likely to be less attainable in future. There is, of course, a balance between identifying the right women to receive the program and enrolling them sufficiently early in pregnancy to be helped and it may be that large numbers of those enrolled are close to 16 weeks currently. Perhaps further analysis of the range of enrolment by weeks pregnancy would be helpful to begin establishing a benchmark?

Any approved Core Model Element Variances:

None requested

Agreed upon activities that UCD will provide through Support Services Agreement:

- Mentoring and consultation to clinical lead and license holder
- Monitoring of license, oversight of fidelity and agreement of quality improvement plans
- Research guidance
- Consultation on further adaptations and quality improvements
- Visit to Norway by AR; September/October 2021.

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

Table 1: Inclusion criteria for all clients enrolled by year. % of all clients enrolled with this criterion

	Violence		Early life challenges		Lack of social support/ conflicts		Mental problems		No work/education	
Year	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
2016	7	24.1	19	65.5	8	27.6	20	69.0	8	27.6
2017	24	27.9	51	59.3	37	43.0	52	60.5	34	39.5
2018	10	23.8	33	78.6	16	38.1	22	52.4	16	38.1
2019	16	33.3	27	56.3	19	39.6	30	62.5	18	37.5
2020	23	53.5	35	81.4	19	44.2	25	58.1	19	44.2
Total	**80**	**32.3**	**165**	**66.5**	**99**	**39.9**	**149**	**60.1**	**95**	**38.3**

Table 2: Annual income at intake – 2016 - 2019

	N	%
No income	25	14.0
Below 16,000 USD	31	17.3
16,000 to 27,000 USD	29	16.2
27,000 to 38,000 USD	27	15.1
38,000 to 50,000 USD	22	12.3
50,000 to 60,000 USD	10	5.6
60,000 to 72,000 USD	3	1.7
Above 72,000 USD	9	5.0
Does not wish to respond	23	12.8
Total	**179**	**100.0**

Table 3: Annual income at intake – 2020

	N	%
No income	7	14.9
Below 16,000 USD	6	12.8
16,000 to 27,000 USD	9	19.1
27,000 to 38,000 USD	5	10.6
38,000 to 50,000 USD	5	10.6
50,000 to 60,000 USD	6	12.8
60,000 to 72,000 USD	3	6.4
Above 72,000 USD	1	2.1
Does not wish to respond	5	10.6
Total	**47**	**100.0**

Table 4: Clients residence at intake – 2016 - 2019

	N	%
Apartment/House	181	95.3
Foster Home	1	0.5
Staying with friend(s) temporarily	4	2.1
Residence with supervision/follow-up	0	0.0
Student dormitory	0	0.0
Residential care (treatment center, maternity home)	2	1.1
Other arrangement	2	1.1
Total	**190**	**100.0**

Table 5: Clients residence at intake – 2020

	N	%
Apartment/House	45	90.0
Foster Home	0	0.0
Staying with friend(s) temporarily	1	2.0
Residence with supervision/follow-up	1	2.0
Student dormitory	0	0.0
Residential care (treatment center, maternity home)	2	4.0
Other arrangement	1	2.0
Total	**50**	**100.0**

Table 6: Birth Control use at 6, 12, 18 and 24 months

	6 months		12 months		18 months		24 months	
	N	%	N	%	N	%	N	%
Never	51	40.5	31	35.2	33	45.2	20	32.8
Almost never	7	5.6	3	3.4	1	1.4	3	4.9
Some of the time	2	1.6	6	6.8	1	1.4	5	8.2
About half of the time	1	0.8	2	2.3	4	5.5	0	0.0
Most of the time	4	3.2	3	3.4	2	2.7	1	1.6
Every time	61	48.4	43	48.9	32	43.8	32	52.5
Total	**126**	**100.0**	**88**	**100.0**	**73**	**100.0**	**61**	**100.0**

Table 7: Types of Birth Control at 6, 12, 18 and 24 months

	6 months		12 months		18 months		24 months	
	N	%	N	%	N	%	N	%
Condoms	25	30.1	21	34.4	10	24.4	11	26.2
Natural family planning, rhythm method	1	1.2	2	3.3	1	2.4	1	2.4
Withdrawing, pulling out before coming	3	3.6	2	3.3	1	2.4	3	7.1
Birth control pills	9	10.8	9	14.8	7	17.1	8	19.0
Patch	2	2.4	2	3.3	0	0.0	1	2.4
Quarterly birth control injection	3	3.6	2	3.3	1	2.4	2	4.8
Hormonal implant	9	10.8	2	3.3	7	17.1	8	19.0
IUD Hormonal	17	20.5	20	32.8	14	34.1	11	26.2
IUD Non-Hormonal	2	2.4	2	3.3	1	2.4	0	0.0
Emergency contraception	0	0.0	3	4.9	0	0.0	0	0.0
Other	2	2.4	0	0.0	1	2.4	0	0.0

Table 8: EA Zones – Adult Sensitivity

	6 months		12 months		24 months	
	N	%	N	%	N	%
Emotionally available	58	59	30	44	19	79
Complicated	33	34	33	49	4	17
Detached	7	7	5	7	1	4
Total	**98**	**100**	**68**	**100**	**24**	**100**

Table 9: EA Zones – Child Responsiveness

	6 months		12 months		24 months	
	N	%	N	%	N	%
Emotionally available	66	67	31	46	19	79
Complicated	24	24	33	49	4	17
Detached	8	8	4	6	1	4
Total	**98**	**100**	**68**	**100**	**24**	**100**

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