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Nurse-Family Partnership® (NFP) International

Phase Two Annual Report

Phase Two: Feasibility and Acceptability through Pilot Testing and Evaluation
Conduct a pilot test of the adapted Nurse-Family Partnership (NFP) program to inform what additional adaptations may be needed to ensure the feasibility and acceptability of the adapted NFP program.

- Some information may not be applicable in which case note it as N/A
- If you don't have the requested information, you may leave the section blank

PART ONE: PROGRAM OVERVIEW

Name of country: Bulgaria

Dates report covers: March 2019 – February 2020

Report completed by: NFP Bulgaria Team

The size of our program:

	# Who work exclusively in NFP	# Who have additional assignments	**Total**
Fulltime NFP Nurses	**5**	**2**	**7**
Part time NFP Nurses	**1**	**0**	**1**
Fulltime NFP Supervisors	**1**	**0**	**1**
Part time NFP Supervisors	**1**	**0**	**1**
Full time Health mediators	**3**	**1**	**4**
Part time Health mediators	**0**	**1**	**1**
Total	**11**	**4**	**15**

- We have two teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse (+ other staff) ratio: 1:6.5
- We have enrolled 171 NFP clients since starting Phase Two (as of 2 March 2020)

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

Clinical leadership, support and guidance:

For the whole reporting period the NFP clinical leader for Bulgaria (Maria Evgenieva) has been on maternity leave but has kept her role in the program on an indirect part-time basis. She has been providing consultations and reflective supervision to the team supervisors over the phone and has participated in some consultancy calls with NFP International.

Due to these circumstances, the program implementation has been led and monitored by the NFP Project Manager (Ivanka Puleva) who joined the national unit within TSA in late 2018. Along with the administrative and strategic responsibilities, she has assumed most of the Clinical Lead duties requiring direct involvement and supervision of the teams' working process (accompanied home visits, observation of reflective supervision sessions, regular feedback to nurses, training need assessments, team meetings and supervision of case conferences, etc.). This development has been approved by NFP International Consultant (Ann Rowe) who has been providing guidance and support in the process.

The central team has signed a contract with an expert on maternal and infant health from the National Centre for Public Health and Analysis (the research unit of the Ministry of Health) who has engaged to further support the advocacy efforts to scale up the program on a national level. The expert is currently working on formal adjustment of the Program to the Bulgarian system of health and social services. At the end of 2020 she is expected to deliver a detailed description of the Program methodology and ways to be structured under the formal healthcare system in Bulgaria. The collaboration will also produce a set of recommendations for Program's quality assurance and improvement.

Description of our National implementing capacity and roles (how these functions are organised):

- Service / implementing agency development

TSA holds the position of central implementation agency for NFP in Bulgaria. The central implementation team within the organization consists of 4 members – full-time Project Manager and part-time Data Analyst, Coordinator and Clinical Leader.

In 2019 the Project Manager was responsible for the overall program implementation and its quality, as well as taking steps to reaching strategic goals. She manages the NFP teams and leads on communicating the program with partner organizations, local and national stakeholders.

In mid-2019 Olya Georgieva joined the team as a part-time coordinator. She replaced our colleague Boyan Dimitrov who previously assumed that position.

Olya's main responsibilities include the coordination of local and national advisory boards and the effective communication and collaboration among all participants. She takes care of the smooth workflow with all partners and grantees.

Prior to joining TSA, Olya has worked on several international projects related to the promotion of initiatives and best practices for sustainable development at European level, with a focus on education, migration and effective inclusion of people with disadvantages in the society. She has a

Master's degree in Governance, Leadership and Democracy Studies at the Catholic University of Lisbon.

In addition, the TSA evaluation expert (Dena Popova) whose duties in early 2019 were expanded to include supporting the team in its assessment of NFP implementation so far, has worked on interviews and insights from the family nurses, health mediators and central team members in order to draft a Lessons Learnt report based on the nurse practice as a foundation for further adaptation and quality improvement efforts. The report is expected to be ready by the end of April 2020.

NFP implementation is overseen by the TSA First Foundations Program Officer (Iskra Stoykova) and CEO (Sarah Perrine).

- Information system and data analysis and reporting

Our online-based information system has been in use since 2017. It has proven to be an easy-to-use instrument, which provides useful and timely information to nurses, supervisors, Site teams and National unit. It provides reporting on individual, team and national level and is actively used to inform the work of the implementing agency. More training and guidance are needed for nurses and supervisors in order to be used regularly for informing their practice.

In 2019 the Information system has been updated by integrating all comments and needs the NHV teams have shared based on their practice. The process has been facilitated and supervised by the Data Analyst (part of the central team at TSA). She is the one analysing the data on regular basis and training staff on generating reports for data-informed practice.

- Senior Nursing Leadership

Our Clinical Leader has been engaged on a part-time basis since March 2019 (due to her maternity leave). Her availability has averaged 10 hours per week, and this is expected to last until May 2021.

- License holder

The top level is the licensee. The licensee refers to the responsible individual that has been granted the NFP license to replicate NFP in Bulgaria by the licensor i.e. University of Colorado, Denver. As there should be a named licensee who has overall responsibility for implementing NFP, this individual is TSA's Executive Director Sarah Perrine.

- Other (please describe)

In Sofia TSA has subcontracted HESED (Health & Social Development Foundation) to provide services for supervisory support for the HV team. The supervisory support team consists of:

- 1 developmental psychologist – part-time
- 1 social worker – part-time (until September 2019)

In Plovdiv TSA has subcontracted (since April 2019) NAVA (the National Alliance for Volunteer Action) to provide services for supervisory support and continuous learning for the team of HVs. NAVA is a well-established NGO that has extensive experience in working with vulnerable groups and Roma in particular. The supervisory support team consists of:

- 1 developmental psychologist – part-time
- 1 local coordinator – part-time

- 1 social worker – part-time
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Initially, plans for the NGO partner in Plovdiv were focused on contracting For Our Children Foundation, which is also very well-positioned both locally and nationally. It has numerous initiatives related to maternal and child wellbeing and support. However, at the moment of our program initiation, the organization in Plovdiv was experiencing some human resources and re-structuring problems, so it wasn't able to respond to our needs and expectations. Thus, we had to look elsewhere for a suitable partner.

Description of our local and national NFP funding arrangements, including plans for funding for a randomized controlled trial:

Through the license agreement, TSA has committed to fund and implement Phase 1: Adaptation and Phase 2: Feasibility and Acceptability through Pilot Testing and Evaluation of the NFP replication in Bulgaria. TSA has also been continuously working throughout these two phases to ensure the program sustainability and build government/municipal support for funding of Phase 3: Randomized Control Trial and Phase 4: Replication and Expansion.

In December 2019 TSA's main donor – America for Bulgaria Foundation (ABF), which has been funding NFP since the beginning of its implementation, confirmed its commitment to fund the program throughout the new financial period (September 2020 – September 2023). However, this is the last financial commitment of ABF to the NFP implementation which at this point means setting a phase-out plan to be implemented by September 2023 if no alternative funding or program transfer is secured.

Considering these funding developments, it is expected that we will continue to enroll clients in Site 1 and Site 2 until July 2021, unless other funding is secured. Thus, we will make sure that all clients have the chance to receive the service in full and graduate within the 3-year financial period.

Plans for funding a randomized controlled trial:

We will finalize Phase 2 of the program replication by September 2023, when at least 200 clients will have graduated from the program. To prepare for an RCT, we are now exploring various funding opportunities to set up a third NFP site in 2021 to be fully developed by 2023. We are reaching out to private donors and we are also planning to engage the municipalities where NFP sites are located to partner in joint applications for EU-funded projects aimed at supporting the health and social sector.

In the next three years we are also planning to test collection of key outcome data, including the adaptation and validation of instruments such as the Bayley Scales for language development. TSA has previously partnered with J-PAL researchers under a grant by the Strategic Impact Evaluation Fund (SIEF) of the World Bank that supported an RCT for improving access to pre-school education for disadvantaged groups and we have discussed approaching SIEF with a proposal to fund an RCT for NFP in Bulgaria.

Description of our research team and capacity to conduct quantitative and qualitative evaluation (feasibility and acceptability study):

The formative evaluation was assigned to a research team at OSI-Sofia (Open Society Institute). OSI has built and continues to develope an institutional profile of an organization that both manages donor programs and as well as carrying out operating and research activities on its own initiative,

as well as providing services and technical assistance for various contracting authorities. The OSI team carries out independently or in partnership with other organizations: economic and social surveys; management of funds and programs in support of civil society; development of complex assessment tools and assessment of the impact of programs and projects; technical assistance.

At the end of March 2019, this research team issued the first preliminary field report "Development and implementation of a feasibility and acceptability longitudinal study to inform future adaptation of the NFP pilot project in Bulgaria". In June 2019 the findings of the report were discussed with UCD in light of the future plans for Phase 3 (impact evaluation).

Additionally, TSA's internal capacity has been increased in the last year with the employment of a full-time Evaluation Officer – Jeffery Warner, who contributes to the monitoring efforts, indicators' design and evaluation insights of all projects and programs, including NFP.

Prior to joining TSA, Jeffery worked at Teach for Bulgaria where he was the Head of Teacher Support. Jeffery first came to Bulgaria as a United States Peace Corps education volunteer in 2007. During his Peace Corps service, he taught English and led education projects in Kardzhali, Bulgaria. Jeffery currently serves on the board of the Bulgarian-American Fulbright Commission. He holds a Master of Public Policy from the Gerald R. Ford School of Public Policy at the University of Michigan, as well as a Bachelor of Arts in History (cum laude) from Western Michigan University.

Current policy/government support for NFP: (Including plans for responding to challenges and opportunities in government policy, funding constraints, professional changes):

In our continuous efforts to strengthen government support for the Program, we had numerous formal meetings with high level officials from two ministries – Ministry of Health and Ministry of Labor and Social Policy.

Two **National Advisory Boards** (NAB) hosted by the Ministry of Health took place in July and December 2019. They were very well attended by heads of medical institutions such as the National Center of Public Health and Analysis and professional medical organizations such as the Bulgarian Doctors Union, National Alliance of GPs, National Alliance of Midwives, Bulgarian Pediatric Association, etc.

Along with updates about the NFP implementation in both sites, the attendees participated in discussions around various important topics such as the possibilities to incoroporate the home-visiting service into the healthcare system in Bulgaria, the lack of nursing workforce to guarantee adequate national expansion, obstacles to prenatal care access for vulnerable pregnant women, etc.

The last session of the NAB proved to be especially positive in terms of officials expressing openly support for NFP. The chairpersons of the National Center of Public Health and Analysis and the Bulgarian Pediatric Association both stated that NFP has the potential to be an excellent national service addressing acute needs of the most vulnerable population. The director of the oldest specialized obstetric and gynecological hospital in Bulgaria – Sheynovo (our partner in Site 1) also joined the statements of support pointing out that NFP is now a good practice that needs to find its place under some of the government policies for maternal and infant health.

The National Program for Maternal and Infant Health (2014-2020) which is expiring at the end of this year is currently viewed as the only logical option for structuring NFP as a national health service. To explore this opportunity and maintain the dialogue with the government in that

direction we had two separate meetings with the Director of the Medical Activities Department within the Ministry of Health – one in April and one in December. The aim of those conversations was to explore the Ministry's intentions in terms of continuing the National Program and possibly structuring the home visiting service (both universal and NFP) there.

However, there's not much clarity about either of those issues. The Ministry has formed a working group to look into the future of the National Program but there is certain resistance to the plans for its continuation.

On the other hand, for the past year the plans for introducing the universal home-visiting model on a national level (a model which was tested by UNICEF and supported by the state) were put on hold – largely due to social pressure based on speculations that home-visiting would become a tool for institutional monitoring and surveillance within the families, which could eventually lead to taking children away from their parents.

As it was our expectation that NFP would be positioned as a targeted service within the universal HV model, and in an attempt to find out more about potential further steps regarding the universal model, we also initiated a meeting at the Ministry of Labor and Social Policy (as another possible operator of the universal service). However, we did not get any answers as the institution's officials directed all the issues in question to their peers from the Ministry of Health.

Due to continuous public pressure, in January 2020 the government canceled a newly developed Law for Social Services which was expected to provide a legislative base for the home visiting service in the country.

As a result of all these developments, we reinforced our efforts to look for possible EU funds for the service delivery sustainability in the next few years. However, these initiatives require state/municipal participation as well, which further expands and intensifies our advocacy communication.

Along that line, we signed a contract with an expert from the National Center of Public Health and Analyses (adjacent to the Ministry of Health) to work on adapting the Program's methodology according to the Bulgarian healthcare system and social services. In November 2020 we are expected to have the **Bulgarian version of the NFP methodology** which could then be offered to the government for future implementation. We believe this will facilitate and speed up the negotiation process with the state institutions as we will be equipped with a specific product in the form of a guidance document on how the service could be positioned and made operational on a national level.

The expert in charge of that task is Assoc. Prof. Krasimira Kostadinova – head of "Child and Youth Health" Unit within the Department of "Health Promotion and Disease Prevention" in the National Center of Public Health and Analyses. Along with the Bulgarian methodology of the service, she will also be working on further adaptation of the materials for nurses and clients, as well as on drafting a set of recommendations that would guarantee the quality of the Program implementation in case of scaling up.

Since December 2019 Assoc. Prof. Kostadinova has been observing each of the core model elements and nurse practices within the Program's framework in order to better understand and assess the service in terms of drafting the methodology.

To gain government support for NFP we have also initiated a **Policy Brief** to inform a future national implementation. We plan to use the brief as an advocacy tool in forthcoming meetings with institutions and professional medical organizations. It can also serve as a fundraising instrument to better explain the Program in Bulgaria, its achievements, challenges and expected opportunities.

As the central implementation team is quite limited in terms of human resources, TSA has attracted a Fulbright research student, Lorenzo Rodriguez, to draft the policy brief. Lorenzo is US graduate student with anthropology major and a minor in sociomedical science. His focus in Bulgaria is to research the ways in which funding and staffing challenges within health care facilities impact local communities in the capital Sofia and neighboring cities. In late February 2020 we received the first draft of the brief, but it needs to be additionally edited in terms of content and visually. We expect to have a final product before the next National Advisory Board in June/July 2020.

Another advocacy tool we expect to have finalized by the end of May 2020 is a **promotional NFP video** featuring our clients and nurses, medical experts and TSA management. The idea is to show our work and achievements, to hear the voice of the clients and of those renowned experts and physicians who have already expressed support for our service.

In order to remind authorities of the ongoing program in-between formal meetings (NAB every 6 months) and to gain additional support for our activities, in July we launched the first issue of NFP **Newsletter**. It is currently being sent out on a 3-month basis to all local and national partners, institutions and other stakeholders but we consider making it a monthly initiative.

On a local level we have also proved productive and have managed to gain some municipal support for NFP. We organized and held **6 Local Advisory Boards** (LAB) in May and September 2019 and in January 2020 – 3 in Sofia (Site 1) and 3 in Plovdiv (Site 2).

In Sofia this initiative has already become a tradition gathering representatives of NGOs, municipal institutions and services (Regional Health Inspection, Child Protection, Social Assistance, municipal health mediators, etc.). All meetings of the LAB have been hosted by the Healthcare Department of Sofia Municipality and we are glad that the supportive collaboration has been maintained throughout the year.

In Plovdiv the first LAB meeting in May was held at a hotel conference room. However, our team kept working on gaining the support of the local authorities and establishing collaborative relationship. As a result, the next two LABs were hosted by the municipality and we hope that we have already set a local tradition in Plovdiv as well. The LAB in Plovdiv aims to lay the foundations of an active referral network in the city, so our team and local partner from the National Alliance for Volunteer Action (NAVA) have pushed for attracting more representatives of institutions and organizations at the LAB. We succeeded to get the municipal social services interested but still struggle with the doctors (GPs and obstetricians) – none have attended the meetings so far.

Description of our implementing agencies/sites:

- High level description of our implementing agencies/sites:

According to Bulgarian legislation, nurses and midwives are not allowed to have independent practices, and they can perform their professional duties only if employed by a medical institution. Thus, since 2016 TSA has implemented NFP through grant agreements with hospitals – first with Sheynovo Hospital, to employ our family nurses in Site 1, and subsequently – with St. George University Hospital for our team in Site 2.

Sheynovo Hospital (Employer of Site 1 team)

In 2019 we continued our fruitful cooperation with Sheynovo Hospital which is formally employing the NFP Site 1 team in Sofia. In October we have signed a third annex with Sheynovo hospital in Sofia to extend the duration of their grant with one year until September 2020.

Sheynovo Hospital is the oldest specialized obstetric and gynecological hospital in Bulgaria and has been functioning since 1935. The hospital develops innovative technologies in the field of obstetrics and gynecology, neonatology and anesthesiology. The hospital employs 123 healthcare professionals who work in the fields of prevention, treatment of risk pregnancy, sterility and oncological diseases of the female reproductive system. The hospital is a training base in the field of gynecology and neonatology.

Given its profile, the Sheynovo Hospital has proved to be a suitable match for the base of our NFP Site 1 team. The project coordinator and accountant on the hospital side are now well into the habit of the administrative work around the team management and the program implementation. The communication and coordination with the TSA national unit is smooth and on a satisfactory level.

The office of the NFP Site 1 team is located in the hospital premises, close to the main entrance. This is strategic in terms of getting administrative support but also potentially using the services of the hospital for program clients.

St. George Hospital (Employer of Site 2 team)

St. George University Hospital is the largest hospital in Bulgaria with a total staff of over 2600. It is in Bulgaria's second biggest city – Plovdiv and has two bases: Base 1 (Therapeutic Clinics) and Base 2 (Surgical Block), with a 24-hour logistical connection for transporting patients and doctors/consultants. The hospital has 1500 beds and is the biggest emergency care center not only for Plovdiv but also for the whole of South Bulgaria.

The hospital team which facilitates the administrative support for the NFP program consists (same as in Sheynovo Hospital) of a project coordinator and an accountant. However, communication and operational work is much harder and slower than those in Site 1 because of the enormous size of the medical establishment – all administrative and operational issues go through a series of bureaucratic requirements and procedures which creates obstacles for the efficient working process of the Site 2 team.

As the hospital was unable to offer office space for the nurses, an office was rented in the central part of Plovdiv, closer to other service providers. The location is very central but convenient for the nurses in terms of transportation to neighborhoods that are currently being served.

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

- How we select and develop new sites:

As our license agreement includes a TSA commitment for piloting NFP in only 2 sites with 100 clients each, in 2019 we did not select any new program sites. However, we officially opened Site 2 and all our efforts were focused on developing it and making the program fully operational on a local level.

After completing its first NFP core education module on pregnancy in January, our team of 1 supervisor, 2 full-time and 1 part-time nurses and 2 health mediators (field work associates) officially started its operational work on February 11, 2019. Because of the essential lack of universal medical database about patients, national/regional pregnancy register and a functioning

referral network for access to services, we had prepared a thorough **information and client recruitment campaign** and started implementing it. Initially we had a contract with a local community leader (head of a Roma NGO) who was supposed to coordinate the recruitment campaign. However, he didn't show the necessary level of engagement, so his contract was discontinued, and the team kept working on the initiatives on its own.

We knew that in order to reach our potential clients (at that time young pregnant women in the biggest Roma neighborhood – Stolipinovo), we had to use a community approach – targeting young moms through other family members, community leaders, religious leaders, health and educational mediators, other NGOs and service providers in the area, etc. We were particularly conscious about the mothers-in-law who play a significant role in Roma families and in caring for young mothers and their children in the Roma communities. The provision of care, therapy, or other services for the expectant mother or the children by an external stakeholder typically occurs after permission from the mother-in-law.

Our initial baseline study had shown that most of the people in the area we selected for delivering the NFP service have a low level of education and income, as well as limited access to quality health services (for financial and socio-cultural reasons). Also, the community is predominantly Muslim, Turkish speaking, much more conservative in comparison to other Roma communities around the country and has a deep level of distrust in service providers.

Because of this difficult context we had to utilize all possible channels of communication during our client recruitment campaign. Thus, it included the following activities:

- **Using the medical facilities in the neighborhood** (Diagnostic-Consulting Center – DCC)

Two DCCs operate in and around the territory of Stolipinovo. Our team had and keeps having meetings with the directors and the medical personnel in the centers – to raise awareness about the program and to invite the medical staff to refer eligible pregnant women and to distribute program materials. Posters and leaflets are still available at the DCCs.

- **Involvement of religious leaders**

There is a well-structured and functioning local Muslim community on the territory of Stolipinovo. Although predominantly for the male population, we targeted it by having meetings with religious leaders asking them to assist in dissemination of program materials and information. Our previous Site 1 coordinator Boyan Dimitrov attended several information events in the Muslim community with the assistance of local leaders and talked with worshippers (partners and fathers of potential clients).

A similar approach was used to liaise with the Evangelist and other Christian churches in the neighborhood. Site 2 Supervisor Raya Ivanova held several meetings with pastors and women attending religious ceremonies.

- **Mobile medical team initiatives**

Our team of family nurses organized weekly mobile team activities – setting "medical station" tent at different locations in Stolipinovo and measuring the blood pressure of people passing by. While doing that they were talking about the program, promoting its services, distributing program materials and asking people about potential clients in their families or residential buildings. The initiative was actively supported by the health mediators.

- **Door-to-door initiatives**

One of the main activities of the team in the first few months of the program was door-to-door awareness raising, distributing program materials and talking to people on the streets in the neighborhood.

- **Distribution of posters**

The liveliest places in the neighborhood were identified and program materials (posters and leaflets) were distributed. This included busy streets and squares, hairdressing salons, cafes, pharmacies, grocery stores, other non-governmental organizations, religious centers, markets, etc.

- **Informal events - weddings, religious rituals**

With the help of health mediators and local community leaders the team was able to distribute small gifts and program materials during family events in the neighborhood - weddings, religious rituals for babies, birthday parties. Personal face-to-face contact and conversation were crucial to building trust and disseminating information about program services.

- **Meetings with representatives of Regional Health Inspectorate**

Our team and local partner coordinator had numerous meetings with representatives of the Regional Health Inspectorate in Plovdiv to inform them about the launch of the program and its developments locally. They are provided with program materials, contact information and ways to refer potential clients.

- **Relations with Regional Branch of the Social Assistance Agency**

Pregnant women whose families have low income are entitled to one-off social assistance. They submit application to the regional offices of the Social Assistance Agency, so the representatives of these municipal institutions, along with the GPs and obstetricians, are the first contact points for young pregnant women eligible to be enrolled in NFP. Thus, our team Supervisor and local coordinator visited on numerous occasions the three offices of the SAA in Plovdiv, presented the program and following developments, provided NFP materials and encouraged client referrals.

- **Involving other local NGOs**

Organizations providing services in the neighborhood were identified. Our team had reoccurring meetings with their staff to exchange information on services and good local practices, as well as to exchange program materials.

- **Using social media platforms**

With the help of the health mediators from the community, we identified local groups on Facebook and disseminated information about the services in the program. We used the Facebook pages of NFP-Bulgaria and TSA as well – to popularize our work in Plovdiv and reach out to potential clients. However, so far, we have not translated and posted any information in Turkish which might have been useful for our specific target group, so this is something yet to be attempted.

Despite having our detailed plan and undertaking all these initiatives, the results in terms of number of clients enrolled were less than satisfactory. There was a lack of referral engagement among community and institutional partners, as well as other serious obstacles such as migration trends, communication barriers and others, which can be found below under the challenges section of the report.

Since mid-2019 our local NGO partner – National Alliance for Volunteer Action (NAVA) started playing much more active role in developing Site 2 in terms of creating referral network and gaining municipal support for the program.

NAVA Foundation was established in Plovdiv in May 2000 to revive the tradition of volunteerism in Bulgaria and to improve the public perception of volunteerism through organizing various initiatives. Some of them are developing social services for prevention and reintegration of children and people at risk; providing support for their families; increasing awareness and sensitivity toward problems related to abandonment and institutionalization; developing social entrepreneurship and other models for supporting people at risk.

Because of its profile and substantial experience in successfully implementing projects and causing positive change in society, NAVA is locally and nationally a well-established NGO with good connections to government and municipal authorities. Since the organization had been a previous

TSA grantee with extensive work in support of vulnerable groups and Roma in particular, it was a perfect match for our partnership needs.

Initially, we had some disappointments by the local coordinator NAVA had appointed – he was an experienced social worker but not really communicative and outspoken when it comes to external representation. After a few months of work, it was mutually agreed that he would take the position of a social worker advising the team on a monthly basis, and the coordinator position would be assumed by another NAVA staff member – Vera Mihaylova. Since she took the role, the communication with the team and the central implementation unit intensified and became much more productive. Vera initiated series of meetings in the Roma community but also with doctors, institutions and authorities on a local level, which resulted in some client referrals and municipal approval to have the Local Advisor Board meetings at the central municipality building. This, of course brought additional credit to the event and attracted more participants.

In a strategic attempt to further develop NFP Site 2 and to speed up the client recruitment process, in November 2019 we opened the Program to the whole city. The supervisor and the local coordinator initiated a series of meetings with GPs and obstetricians to raise awareness about the service and encourage potential client referrals. As a result of all these measures, 5 new clients were enrolled in November alone.

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

<u>Successes</u>

Both implementing agencies (Sheynovo and St. George hospitals) are well-known and renowned medical establishments whose reputation contributes to the **credibility of the team and the program** as a whole – both in terms of field service delivery but also when it comes to meetings with state institutions and other stakeholders.

Both hospitals provide some benefits for their employees in terms of paid annual leave, additional bonuses, etc. This, combined with the support coming from NFP national unit, has contributed to the fact that 3.5 years after the start of the program in Sofia **the team of nurses there is more or less the same**. Moreover, because of the **existing demand for the service**, 1 new nurse joined the team in April 2019. This we consider one of the great successes in Site 1.

Another major success that continues as a trend from last year has to do with the ever-growing client-referring-client network in Sofia. Many of the **current or graduated clients refer other potential clients to the program** (mostly friends and relatives). This has become one of the main ways of recruiting new clients into the program and a waiting list of potential clients has formed at various moments throughout the year.

One of the main successes for Site 2 is related to the fact that we managed to find and contract a **suitable local NGO partner NAVA** which supported our team with an **active local coordinator** – for the program promotion and information initiatives and liaising with regional institutions. NAVA also used its volunteer database to recommend **suitable candidates for the health mediator's position**. This was very important after we had a fair share of unsuitable and disengaged health mediators for the first 6 months of the program delivery (more on this in the Nursing Workforce section). One of the candidates recommended by NAVA was hired and is still working in the Site 2 team.

Due to NAVA's work since September 2019 our **Local Advisory Board meetings are being hosted by Plovdiv Municipality**. The last meeting was attended by a deputy mayor, the head of the Social Services Department and a deputy director of the St. George Hospital.

With the support of the local coordinator, NFP in Plovdiv got a **decent media coverage** on a regional level. The team supervisor had several radio interviews, online media publications were also quite regular in the last few months of 2019.

Another major success should be pointed out regarding the implementation of the awareness raising and **client recruitment campaign**. Despite all the challenges, our team managed to execute all the steps that had been planned and to regularly repeat some of the activities in order to spread information about the NFP service and to attract new clients.

Challenges

Although both hospitals are well-known and bring credibility to the NFP work in both sites, we do feel that **engagement on their side is too formal**. They could be active supporters and contributors to the program's strategic goals but seem to be very disinterested in NFP and the actual work of the nurses, despite the efforts of the central team. This is one of the challenge or more of a missed opportunity that could mitigate some of the risks and obstacles to the effective and efficient service delivery.

Additionally, as it was mentioned above in the description of the implementing agency in Site 2, St. George hospital's **administration is very big and slow**. All team requests in the first half of 2019 were taking weeks until they received the necessary responses and reactions. Thus, TSA central unit decided that most of the activities and budget lines from the hospital grant would be transferred to the grant of the local partner NAVA. This includes all the funds related to securing materials for the team and office supplies, medicines and health insurance for the clients and their babies, etc. This modification made the whole working process more operational and responsive to the team needs.

Another major set of challenges when delivering the NFP service in Site 2 had to do with the **client recruitment rate** – it remained very slow despite all our efforts and initiatives on a local level. There were various factors/challenges which hindered the enrollment of new clients and the retention of those already enrolled:

- **Migration abroad** – since the beginning of the year there has been a growing trend for young Roma women and families to leave Bulgaria and emigrate to Western Europe (mostly Germany, Austria, France and the UK). Most of them join relatives and friends already settled in those countries with the intention to find jobs and/or to receive social assistance. This was particularly the case for pregnant women from Stolipinovo who left the country with the intention to give birth abroad and apply for child allowance from the social welfare system in the new country. This disturbing tendency was creating the impression that only elderly people and families with older children remained in Stolipinovo area, and the number of potential NFP clients was in practice quite low (in comparison to what our baseline study showed earlier).
- **Communication obstacles** – our baseline study for Stolipinovo area had shown that for 78% of our potential clients the primary language spoken at home was Turkish. However, we did not realize that most of the clients would not have any knowledge or use of Bulgarian. As a way to prepare our team for basic conversations with the families served, in early 2019 we enrolled the nurses into Turkish language course for 3 months. However, this was hardly enough for the needs of the home visits – it just presented a way for the NHVs to more easily break the ice during their first encounters with the clients and their families, but

nothing more than that. At one point we realized that the home visits could not be taking place without the involvement of a health mediator (or someone from the client's family members) to serve as an interpreter. We received instructions from UCD on the use of interpreters for delivering NFP, however, these were not really applicable to the Bulgarian context for two main reasons: 1. Interpreting services are expensive and we had not really planned such an expense; and 2. Turkish language spoken by Roma in Plovdiv is much different than the official Turkish spoken by professional interpreters. So, instead – we trained our mediators on confidentiality issues and started using them or in some cases the mothers-in-law. This, however, is not the optimal solution because of confidentiality concerns and concerns that client would not be open enough with her nurse (after all the mediators are part of the same community, and the mother-in-law is not always the most trustworthy person for the client). At the same time the nurses shared concerns about the quality of their work or therapeutic relationship they could have with the client, given that they cannot communicate directly with the client and the nurses are not sure about the quality or the translation.

- **Conservative communities** – most of the families in Stolipinovo neighborhood are Muslim and very conservative when it comes to young women's choices, rights and freedoms. Not only the mother-in-law but also the father-in-law needs to be convinced of the program's benefits to allow the enrolment of the potential client. Also, talking about and using contraception is considered a taboo, so having that concern in mind often resulted in elderly family members refusing NFP for their daughters-in-law.
- **Fear of Child Protection services** (having their babies taken away) – as already mentioned above, in the second half of 2019 because of a legislative document called Strategy for the Child which provoked a lot of speculations and manipulations of the public opinion, protests erupted and fake news on social media were widely spread. This affected negatively our work even more – families got scared that the home visits might mean "social monitoring" by the Child Protection authorities and this could result in the clients having their babies taken away.
- **Expectations for in-kind/financial support** – for many of the vulnerable families we contacted to offer the NFP service the expectation to receive in-kind and/or financial support was a leading factor when deciding on their enrolment. Many of the eligible young pregnant women (or their families) refused to be enrolled in the Program due to the lack of regular material provisions or "tangible" support.

Other relevant/important information regarding our NFP program:

As a result of the teams' observations, especially when working with the most vulnerable and poorest families, in 2018 TSA initiated two crowdfunding campaigns (through the Global Giving online platform) to additionally support NFP clients – one was focused on raising funds for **opening a medical office** in the biggest Roma neighborhood in Sofia – Fakulteta; and the other one aimed to collect donations for purchasing and **providing healthy nutritious food** for pregnant women, young moms and their babies.

As a result of those crowdfunding efforts (more than 20 000 USD raised), in December 2019 we had the official opening ceremony of a fully equipped and licensed Medical Center in Fakulteta, where all mothers and their children can have an easy access to the medical care they need. In September the Regional Health Inspectorate approved our application to have the medical office operational and granted permission to the doctors we managed to "recruit" for the office in cooperation with our partner NGO in Sofia – HESED Foundation. Two obstetricians and a pediatrician have already started providing consultations and check-ups of pregnant women, mothers and their children in need. We are in the process of negotiating how uninsured pregnant women could receive free prenatal care.

As for our nutrition call for donations, we collected a much smaller amount but utilized it accordingly by providing one-off individual food packages to 10 of the most at-risk NFP families. They were selected by applying a list of vulnerability criteria. The packages contained baby food for infants up to 12 months and essential products for toddlers and pregnant women.

Again, based on the family needs that the nurses observed and raised as a concern, in September 2019 TSA initiated a **national campaign for collecting books and toys** appropriate for children up to the age of 3. The NFP teams had shared with the central unit that many of the clients served do not have any books or toys because they do not have financial means but also because they also didn't have those items when they were children. So, there was a serious concern expressed over the unfulfilled potential of the NFP clients to interact with their children in an optimal way. The campaign got a huge media coverage and TSA collected more than 1500 books and toys (used and new). They were distributed among all families in Site 1 and 2, and the nurses had PIPE lessons on the use of the new items and how they could contribute to the children's development.

All these donation campaigns are ongoing, and TSA is committed to keep additionally supporting our NFP clients.

PART TWO: NFP CORE MODEL ELEMENTS (CMEs)

Core Model Element	Successes (including progress against benchmarks)	Challenges and suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% of our clients enrolled in the program participate voluntarily and have signed Informed Consent Form.	We do not have challenges regarding voluntary participation in NFP.
2. Client is a first-time mother	Almost all the clients enrolled in the program are first time mothers.	We have a client whose baby was born with congenital heart defect and died at three months. She did not have the chance to care for the baby. The Clinical Lead has decided that she can re-enter the program with her second pregnancy, 15 months after her initial enrollment.
3. Client meets socioeconomic disadvantage criteria at intake	Our socioeconomic disadvantage criteria are: • Expectant mothers up to 22 years old; • Living in a Roma segregated community and/or economically disadvantage (personal monthly income is less than the minimal monthly salary); • No previous live births; • Pregnancy by 28th gestation week. The recruitment slowed down in the second half of 2018 as nurses in Site 1 Sofia were reaching their full caseload capacity. With the start of the new Site 2 Plovdiv, the two new nurses hired and graduation of a lot of clients in Site 1 Sofia there was a spike of recruited clients in the first half of 2019. We now have a steady growth of recruitment in the last two quarters in both Sites and a capacity for 48 more clients.	Exception has been made for women, who have lost their babies before they had the chance to care for them outside of NICU. Exception has been made in Plovdiv, where recruitment has been very slow. 77 women have been enrolled in the program in the last 12 months – 46 in Sofia and 31 in Plovdiv. We have now set up a new target for recruiting 7.5 clients a month – 5 in Sofia and 2.5 in Plovdiv until reaching full caseload capacity of the nurses in both teams or until July 2021. For more information on enrollment of clients and demographic information on our clients see Annual Data Report attached (CLIENT ENROLLMENT & CLIENT CHARACTERISTICS).

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.	73% of eligible referrals who are intended to be recruited to NFP are enrolled in the program This percentage is now 100% for Site 1 Sofia, where the program has operated for 3.5 years and is well recognized and accepted in the served communities.	In Site 2 Plovdiv 53% of eligible potential clients are enrolled in the program. Identified eligible clients in Plovdiv, who express readiness to enroll in the program, migrate to other European countries.
	39% of pregnant women are enrolled by 16 weeks gestation or earlier The fact that the program is now well recognized among the served communities in Sofia and a lot of new clients are being referred by clients (who are or have been enrolled in the program) and their family members are most likely the reasons for this positive change towards enrollment in early stage of the pregnancy.	The challenges discussed in previous reports persist - superstitions and lack of pregnancy register.
	99 % of our clients received their first home visit no later than the 28th week of pregnancy.	There are two clients in Plovdiv, who were enrolled in the 31st and 32nd gestation week. Recruitment process in Plovdiv has been very slow and difficult, which resulted in the decision to enroll women in a later stage of their pregnancy as an exception. This exception has been made to allow more referrals to the program by health and social practitioners, who encounter pregnant women in the later stages of the pregnancy, when clients receive social payments related to their pregnancy.

<table>
<tr>
<td>5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.</td>
<td>100% of clients have an identified NFP nurse.

70 min. average length of home visits
(range 9 – 300 min.)

No client has discontinued because of the transfer to a different nurse.</td>
<td>The turnover of nurses in the new site in Plovdiv and the change of the Supervisor in Sofia required transfer of clients to other nurses. This has resulted in the transfer of 14 clients – 8 in Plovdiv and 6 in Sofia.</td>
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<td>6. Client is visited face‐to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.</td>
<td>94% of home visits are conducted in the client's home and the most common alternative is a friend/relative's house (about 4%). A little over 1% of visits are the nurse accompanying the client to a Public Health Office or a doctor's appointment. There are 6 cases of the nurse accompanying the client to a school for enrollment in educational program.

55% of the home visits are one-to-one, which is an increase of 3% since last year.</td>
<td>The nurses in Plovdiv need an interpreter in some of the visits where girls do not speak Bulgarian. This role is assumed by the mediators of the program. We will set up reporting for the use of interpreters, which already exists as a question in the Home Visit Encounter Form.

For more information on participants in home visits see Annual Data Report (HOME VISITS).</td>
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<td>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.</td>
<td>The data based on the 42 graduated clients, shows that average program dosage by phase was as follows: 103% at pregnancy, 76% at infancy and 73% at toddler phase.
<table>
<tr><th>Program dosage</th><th>Pregnancy</th><th>Infancy</th><th>Toddler</th></tr>
<tr><td>Below 60%</td><td>1</td><td>4</td><td>13</td></tr>
<tr><td>100% or above</td><td>23</td><td>4</td><td>2</td></tr>
</table>
Average number of visits per phase:

11 pregnancy / 21 infancy / 16 toddler</td>
<td>In 4 of the cases the low dosage is due to temporary absence of 3 clients – one of them was temporary absent in two of the program phases. In 14 of the cases the low dosage is due to frequent cancelation of visits by 11 clients in one or more phases of the program.</td>
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	Currently there are 3 clients on alternative visit schedule, who are being visited on a weekly basis.	
	We are using NFP International benchmarks: 60% cumulative retention rate – 82% NFP Bulgaria 90% pregnancy – 93% NFP Bulgaria 70% infancy – 87% NFP Bulgaria 60% toddler – 82% NFP Bulgaria	Retention rates for Sofia and Plovdiv are different. For pregnancy Plovdiv is below the benchmark. We should set new benchmarks based on our experience so far. For more information on clients' retention see Data Annual Report (CLIENT ENROLLMENT).
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	There are two Midwives and three Nurses in the Sofia team and their Supervisor is a Nurse. The team in Plovdiv has two nurses and their Supervisor is a Midwife. Only the Supervisor in Plovdiv has bachelor's degree in Midwifery. The rest of the nurses have 2.5 or 3.5 years of training in Nursing or Midwifery. However, 5 of them have bachelor's or master's degree in other majors.	Nurses and midwives in Bulgaria only began to be able to access bachelor's degree-level education in 2008. This has resulted in a change of variance for this CME. Regardless of the level of education, a strong need for additional training for both nurses and midwives has been identified and a special curriculum was created for all NFP NHVs by the Central team.
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	All our nurses and the supervisors have completed Core Foundation training. All our nurses and the supervisors, except for one newly hired nurse in Site 2 Plovdiv, have completed Core Infancy training. All our nurses and the supervisor in Site 1 Sofia, except for the two newly hired nurses, have completed Core Toddler training.	One newly hired nurse in Site 2 Plovdiv will undergo Core Infancy training this year. The team in Site 2 Plovdiv together with the two newly hired nurses in Site 1 Sofia will undergo the Core Toddler training this year.

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<td></td>
<td>Regular team meetings are held weekly in both teams: 24 in Plovdiv and 28 in Sofia for last year.</td>
<td>There have been only 9 case conferences last year – 3 in Plovdiv and 6 in Sofia. Case conferences are still a challenging element of the program for our nurses.

The Learning Needs Assessment sessions which need to happen twice a year are still not happening regularly.</td>
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<td>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.</td>
<td>The time spent on the five program domains in different phases of the program are mostly within the benchmarks with couple of exceptions.

<table>
<tr><th>Area</th><th>Pregnancy</th><th>Infancy</th><th>Toddler</th></tr>
<tr><td>Personal Health</td><td>51%↑</td><td>15%</td><td>12%</td></tr>
<tr><td>Maternal Role</td><td>24%</td><td>57%↑</td><td>50%↑</td></tr>
<tr><td>Environmental Health</td><td>6%</td><td>7%</td><td>11%↑</td></tr>
<tr><td>My Family & Friends</td><td>7%↓</td><td>9%↓</td><td>13%</td></tr>
<tr><td>Life Corse Development</td><td>11%</td><td>12%</td><td>14%↓</td></tr>
</table>
</td>
<td>Personal Health in Pregnancy is the domain which has the highest deviation from the benchmark, exceeding with 11% the upper limit. Compared to last year’s results there is a drop of 6% and this has resulted in more time spent on other areas, most significantly in My Family and Friends, which is still below the benchmark in this phase, but only by 3%, compared to 6% in the previous report.
Higher than expected are also the Maternal Role in Infancy with 7% and in Toddler with 5% and Environmental Health in Toddler with 1%. There aren’t significant differences from last year.
My Family and Friends is below the lower limit of the benchmark in Pregnancy, as mentioned above, and in Infancy with 1%. Life Course Development in Toddler is below with 4% which is additional drop of 1% since last year.</td>
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<td>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.</td>
<td>There have been regular 1:1 reflective supervisions of supervisors by the Clinical Lead – 41, and by the Psychologist working with NFP teams – 21. Total of 62 out of 76 expected. The regular supervisions started in the second half of 2019 and are now maintained weekly as expected.

The Project Manager has started regular home visit observations with supervisors in the second half of</td>
<td>The 1:1 reflective supervisions with supervisors did not happen regularly in previous years and in the beginning of 2019.</td>
</tr>
</table>

	2019 and so far, there have been 2 out of 2 expected.	
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	We have two supervisors assigned to each team. Reflective supervision has now become regular practice within both teams and nurses receive on average 3 reflective supervisions per month. A total of 211 reflective supervisions have been performed in both NFP teams last year – 78% of expected. There have been regular home visit observations by the Supervisor in Plovdiv (5/9). Regular HVOs started in the second half of 2019, when the team had recruited more clients. Home visit observations by the Clinical Lead are supposed to be carried out with nurses twice a year. In the last year the Clinical Lead has been on a maternity leave and the Project Manager has assumed this role. She started regular HVOs in September 2019 after undergoing NFP Core trainings and the additional trainings with Site 2 Plovdiv team. As the supervisor in Site 1 Sofia is unable yet to assume fully her role, the Project Manager will be performing home visit observations in the team on quarterly basis. So far there have been 2 out of 2 expected HVOs in Plovdiv and 8 out of 10 expected in Sofia (two were scheduled for March).	The supervisor in Sofia still has more clients than expected. As her clients are graduating, she is expected to fully assume her role as a supervisor and perform 1:1 supervisions with all team members. This will happen in July 2020. Until then the Deputy Supervisor is performing supervisions with mediators and with one of the nurses. The Clinical Lead performs the supervisions with the Deputy Supervisor. The home visit observations are performed by the Project Manager.
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,	Each newly hired nurse and supervisor (8) received an individual training on use of the NFP Information System (IS). Each nurse and supervisor (12) received an individual training on use of data reports in the IS. Two team trainings (one for each team) on use of data and data	The use of data reports is still a challenge in both teams. More generally we plan to involve the nurses and supervisors in quarterly reporting meetings, where the NFP Site teams will gather information which is not collected through the IS, prepare report and share it with the National team.

and guide clinical practice/reflective supervision.	reports in the IS have been delivered. Discussion of the last Annual Data Report has been facilitated in each team. An NFP conference with both teams on use of data forms has been organized. Data reports are presented and discussed at LAB meetings three times a year in each NFP Site and twice a year at the NAB meetings. New reporting has been set up in the IS, where supervisors can get reporting on individual nurse's data and can use it in reflective supervisions.	Quarterly meetings are planned for next year in both teams to review and discuss data on Site level. These meetings will be facilitated through reports from the Data Analyst on data gathered in the IS and the reports prepared by NFP Site teams with data outside the IS. The use of data on individual level (both nurse and client level) in supervisions is also still a challenge and an individual session between an NHV, a Supervisor and a Data Analyst is planned for each nurse in order to outline and model the use of data reports in supervisions. A guidance document on regular use of data reports in team meetings and reflective supervisions will be put together for the use of the NFP Sites, based on international NFP experience and reflections from first Quarterly team meeting and facilitated reflective supervisions with individual data reports.
14. High quality NFP implementation is developed and sustained through national and local organized support	There have been regular LAB and NAB meetings – 6 out of 6 expected LAB meetings (3 in each Site) and 2 out of 2 expected NAB meetings. LAB meetings in both Sites are now hosted by the respective Municipalities and the NAB meeting continues to be hosted by the Ministry of Health.	The LAB meetings in Plovdiv have lower attendance rate than expected.
15. Mediators will be included within NFP teams to promote engagement of the community served, ensure cultural sensitivity in program delivery and support client access to other services.	Mediators are also provided weekly reflective supervisions in Plovdiv and biweekly supervisions in Sofia. For last year a total of 64 reflective supervisions with Mediators have been performed in both NFP teams.	There has been a turnover of Mediators in Plovdiv due to the high mobility of the community as a whole and the frequent migration out of the country.

	In both NFP Sites Mediators are still the main channel for recruitment of new clients. In Plovdiv this is especially true, where the program is still gaining the trust of the community and visibility among all Roma communities in the city. They are present in 3% of home visits and this is usually in the beginning when the nurse is still seen as an outsider for the community. After the first few visits, they usually only accompany nurses in the neighborhood. In Plovdiv, where mediators also act as interpreters, their presence in the home visits is marked as interpreters in the Home Visit Encounter Forms after the initial visit. We do not currently have reporting on the presence of interpreters in the home visits.	New reporting on the Home Visit Encounter Form is needed in the IS to track the use of interpreter (usually the mediator and in some cases the mother-in-law) as the Plovdiv team is actively using this option.

Any requested CME variance(s): ✓ No ☐ Yes (please attach completed variance request form)
Where CME variances have previously been granted, please add date of review of the evaluation of these here:

Any Additional Approved Model Elements (AAMEs): ✓No ☐ Yes
Where AAMEs have been granted please attach completed document and comment on progress with these below

PART THREE: PROGRAM IMPLEMENTATION

Reflections on clients, family members, and the community

- # of NFP clients participating in the program over the last year: **139**

A total of 171 clients have been recruited since the launch of the program in August 2016 – 140 in Site 1 Sofia and 31 in Site 2 Plovdiv. In the last year a total of 77 clients were enrolled. So far, 42 clients have successfully graduated the program, 31 clients have discontinued, and we currently have 99 active clients. Within last year 139 clients have been active in the program.

- % of those eligible clients offered the program who have enrolled over the last year: **73%**

This percentage is now 100% for Site 1 Sofia, where the program has operated for 3.5 years and is well recognized and accepted in the served communities. There was a waiting list for the program last year, before recruiting two new nurses (with a total caseload capacity of 40 clients), who were to compensate for the nurse on maternity leave and the nurse who became the new Supervisor of the team (with a total caseload capacity of 22 clients). More than 40% of the clients are now referred by clients of the program and the mediators are well recognized.

In Site 2 Plovdiv the picture is different – 53% of eligible potential clients are enrolled in the program. For Sofia this percentage was 62% up until 2018 and 66% until last year. However, a lot of identified eligible clients in Plovdiv, who express readiness to enrol in the program move abroad, which makes recruitment there more difficult. We are optimistic that in a year the numbers will go up as the program becomes more visible and established in the communities. We have already seen a spike in the recruitment process in the last three months, since the program was made available in other Roma neighbourhoods in the city.

- Our initial reflections regarding the characteristics of our NFP clients:

The nurses in Site 1 Sofia have put a list of vulnerability criteria which in their experience working in the community put the clients and their children in particularly vulnerable situation, especially when 3 or more of these are present. The list includes The following criteria: client lived in an institution, no running water in the home, living in social housing, age 16 or under at conception, has no formal education or up to primary education level, has chronic illness, domestic violence in the home, overcrowded housing (more than 2 people per room), has no ID, client is a single parent, garbage is used for heating, partner uses drugs and/or has criminal record, works with no formal contract, client is under 16 and lives with a partner who is either under 16 or over 18.

Based on the first 10 vulnerability criteria, for which we have data in the IS, a quarter of our clients (43) fall into the group of more vulnerable clients and a third of them have more than 3 of these factors in their lives and are our most vulnerable clients. Compared to the rest of the clients, these 43 clients have a higher dropout rate – 23% (compared to 15%), they are more likely to be temporarily absent from the program – 3 clients out of 43 (compared to 2 out of the rest 128 clients), they are more likely to cancel visits with the NHVs – 16% of clients with a total of 60 cancelled visits (compared to 5%). Two of the three child deaths in the program happened to these more vulnerable families. 30% of the subsequent pregnancies are also in this vulnerable group.

These results can be explained by the great adversity in the lives of our clients. They usually do not have financial stability, secure housing or support network. A lot of them are illiterate, with poor health and unable to obtain any social or financial support.

Despite their unfortunate circumstances, a third of the clients have managed to graduate the program successfully. More elaborate data analysis on areas like Control & Mastery, Mental Health and Involvement in Home Visits might give us additional insight on these clients and what NHVs can focus their efforts on in order to better help those who are most in need. Additional conversation among nurses from both teams on most vulnerable clients and successful strategies for engaging and retaining them within the program is a necessary next step in this direction.

For more demographic information on our clients see Data Annual Report (CLIENT CHARACTERISTICS).

- Client engagement in the program (including client retention):

Client retention is 82% with 84% in Sofia and 77% in Plovdiv. We have 8 new cases within last year, where the client moves out of the service areas and this is mainly in Plovdiv, where people from the served community migrate abroad. This is also the biggest reason for the lower retention rate in Site 2. We also have 1 child death last year, where the baby was extremely preterm (26th gestation week / 900 grams) – the baby died after a month in NICU. There are 3 cases of pregnancy loss – 2 miscarriages and one medically indicated termination.

Clients are present in 99% of home visits, with 100% in pregnancy, 99% in infancy and 97% in toddler phase. In infancy and toddler phase there are instances when the NHVs go on a scheduled visit and only the mother or the mother-in-law is present. In these instances, the nurses take the opportunity to talk to them, as they are the most influential figures in the family, especially when it comes to care for the child. We now have two cases in which the infant was left to the care of the mother-in-law, in one case for a month and in the other case for almost the entire period of the toddlerhood, which explains the lower percentage of client presence in this phase.

NHVs have rated clients' average involvement in home visits at 91%, their understanding of the material at 92% and their acceptance of the material at 95%.

- Engagement of fathers:

Fathers are present and active in 5% of the home visits, which is normal given that they are usually the bread winner and that home visits take place on weekdays during working hours. We do not currently have reporting on presence of family members, who are not active in the home visits, which will give a clearer picture on what the engagement of fathers and other family members is. We will set up such reporting, as this information is collected through the Home Visit Encounter Form.

Fathers are most active in the pregnancy phase. They are present and active in 8% of the home visits and their participation drops to 5% at infancy phase and to only 1% in the toddler phase of the program. Their involvement in home visits is rated at 76% by the NHVs, their understanding of the material at 82% and their acceptance of material at 86%.

There have been examples of both extremes according to the nurses. There are partners who disapprove of clients' participation in the program and pressured them to discontinue. There have also been cases where the partners work closely with the nurses and have sought their help for enrolment in educational programs for example.

- Engagement of other family members:

Clients' parents, mothers-in-law and other family members are also present and active in home visits. Only 55% of all home visits are one-to one (only nurse and client), which means that although they are present and active in only 5%-9%, including the fathers, they are present in almost half of the visits.

Mothers-in-law are present and active in 5% of home visits, same percentage as the partners. They are more active in the pregnancy and infancy phase where they are active participants in 6% of home visits in both phases and become less active in the toddler phase, where they are present in only 3% of the visits.

Client's parents are present and active in 7% of home visits with respectively 7% in pregnancy, 9% in infancy and 5% in toddler phase. The mothers' involvement has been rated highest on average among family members at 90% and their understanding of materials is rated even higher than that of the client at 94%. The acceptance of material among mothers of clients is rated by nurses at the same level as that of the clients - 95%.

Friends and other family members are present and active in 9% of home visits, where they are most active in pregnancy – in 11% of home visits, in 9% of home visits in infancy and only in 1% of home visits in the toddler phase. Friends and other family members and mothers-in-law's involvement in home visits, understanding and acceptance of materials are rated together at respectively 79%, 80% and 84%.

- Engagement of community, in particular primary care providers and child welfare agencies:

Nurses in both teams are doing their best to collaborate with child welfare agencies to provide support and safety for vulnerable clients. Social services in Bulgaria, however, are limited in scope and resources and there are often situations where housing, childcare or welfare are limited or not available for the clients.

For yet another consecutive year we do not see much of an engagement with our NFP clients from the primary care providers and the child welfare agencies. This is mostly due to the lack of a national database with records of pregnant women, children and patients in general that could be easily accessible by all stakeholders and service providers. In addition, there is no regulated/unified mechanism or pathway in place when more than one institutions/agencies have to be involved in the management of a particular case. Whatever is being done or achieved in that direction has taken place on an ad-hoc basis depending on the determination and persistence of the NFP nurse on one hand, and on the will of the care provider on the other hand.

Because of the stigma and precarious living conditions most of our clients live in, the nurses have devoted a great deal of their time on social work – exploring options for their clients, accompanying them to service providers, following-up, thinking of creative ways to be supportive. However, because of the lack of systematic case management networks and safety nets in the healthcare and social fields in the country, those team efforts often seem like a "bits-and-pieces" work depending on personal connections, leaving the nurses frustrated, disappointed, helpless and discouraged to try again with another client.

However, it is not all hopeless. Due to our program already functioning for 3 and a half years in Sofia, the nurses have already found and formed their own pathways of assisting the clients in various situations – the program is already familiar for some of the GPs, obstetricians and

pediatricians working with the Roma communities in Sofia. The nurses have developed connections with the Child Protection Agency and collaborate with its staff in cases of signs of domestic violence or some sort of exploitation in the family, for example.

We do register several referrals from doctors and the child protection services in Site 2. Plovdiv is generally much smaller city than Sofia and we have noticed that different service providers know each other quite well. This simplifies the team's communication with them, and it brings more representatives of those institutions on the table when we hold our Local Advisory Boards.

As for the access to prenatal care, we still do not have much success in persuading doctors to provide one free prenatal examination granted by law to pregnant women without health insurance. The NFP budget continues to cover medical examinations, laboratory tests and medicines for full pregnancy monitoring and care for all uninsured women. For the ones under 18 who are insured NFP provides prescribed medicines when the family cannot afford to buy them. Babies/ toddlers are insured, but even when medical check-ups occur, medicines are not covered so we provide them as well. All clients and their babies have access to vitamins, the mothers get breastmilk pumps and bottles when needed, and free contraception.

- Success/challenges with receiving referrals

Overall, we can still report a great level of reluctance from medical professionals to refer potential clients. As evident from the annual data report, in 2019 in Site 1 there have been NO clients referred by primary care providers and only 1 client referred by our partner NGO – HESED. Most of the eligible young women we have reached throughout the year have been referred by current/ graduated clients or identified through the field work of the health mediators and the nurses.

We do have some referral success in Site 2 (20 clients referred, 8 of them enrolled) which is due to two main reasons:

- In an attempt to speed up the client recruitment process, we have signed referral contracts with several doctors in Plovdiv (GPs, obstetricians and pediatricians), with educational mediators and other service providers. Whenever they refer a potential client to the NFP team, they receive a modest referral fee.
  This was actually initiated as a means to resolve a very challenging situation we experienced in early 2019 – one of the obstetricians working in the DCC (medical facility) in Stolipinovo area was discouraging her patients (potential clients) from the NFP service. She was even threatening her clients to discontinue monitoring their pregnancies if they decided to enroll into the program. Despite our efforts to resolve what we perceived as a misunderstanding, it turned out the doctor wanted a financial incentive to stop discouraging and start encouraging potential clients. Once this form of contractual agreement was introduced, it was only fair to offer it to other medical professionals as well.
- Because of the smaller size of the Site 2 location and the smaller number of municipal structures providing services, the efforts of the Plovdiv team to popularize the program among those health and social services providers proved much more successful compared to Sofia (we had 2 clients referred by a Mothers Transition Shelter).

So, overall, we have these numbers (evident also in the Data Report):

- Most clients are still recruited by the Mediators of the program (60%). About a third (30%) of the clients now have been referred by current and graduated NFP clients.
- There have been more referrals from other service providers in the last year as well (10% of enrolled clients). The situation in Sofia and Plovdiv, however, is very different.

- In the last year in Sofia 41% of client were recruited directly by the NHVs and referrals came from NFP clients, compared to only 11% of enrolled clients in the previous two years, who have been referred by other clients. There has been only 1 client (2%) enrolled in the last year who was referred to us by a local NGO, which the team works with in close collaboration (HESED). This is also the only referral in Sofia in the last year.
- In Plovdiv, 64% of clients were enrolled through our mediators and nurses' recruitment campaigns and individual efforts. 13% of the enrolled clients were referred by current NFP clients directly to the NHVs. This percentage includes 2 successfully enrolled clients, referred by particularly supportive mother-in-law from the community. The rest 23% of enrolled clients came from referrals by Obstetricians, GPs, Health Mediators and Social Workers.

We plan to continue our efforts to create and encourage referral networks in both locations – through the Local Advisory Boards, media coverage, videos on social media on how anyone could refer a potential client, local coordinators' meetings with external stakeholders, central unit support, TSA wider grantee network and project partners.

Program Implementation

- Any adaptations, changes, enhancements made to: Visit-to-Visit Guidelines, Nursing Assessment/Data Collection Forms etc.:

Minor changes were made to Nursing Assessment/Data Collection Forms last year.

- STAR Framework instructions for risk assessment were revised with the help of Ann Rowe in order to incorporate the assessment of vulnerability criteria identified by the nurses, which were not originally included in the framework.
- STAR Framework Coding Form was updated by removing three fields which were not used by nurses: Duration of Caregiving Activity (minutes); Duration of time child was present (minutes); Child's Age at Assessment (months).
- In the Home Visit Encounter Form a change was made to the way the presence of the child is indicated. The nurses could not reach a consensus on when to indicate in the form that the child is present and active or present but not active. Decision was made with the help of Ann Rowe to only indicate the presence of the child in home visits, the way presence of interpreter is indicated in the Home Visit Encounter Form.
- Home Visit Observation Form was updated to allow using one data form for all observations of one nurse's work in a year. This new version makes it possible the information from all 4 HVO per nurse made in a year to be stored in one data form and thus allowing a more comprehensive way of assessing and supporting nurse's work.

New Observed Supervision Form was developed modelled on the Home Visit Observation Form and based on the Guidance Document: Reflective Supervision from 2019.06.10.

- Brief description of our nursing education program:

Both NFP teams undergo a series of trainings on an annual basis in order to complete the set of skills and competences required for delivering the NFP service with the highest quality and fidelity to the model. Although the central team prepares an annual Capacity Building plan for nurses in both sites, it is being modified on an ongoing basis depending on the Learning Needs Assessments and supervisors' observations throughout the year.

In 2019 Site 1 team participated in the following trainings:

1. Contemporary guidelines for early child development;

2. Social and family environment of the newborn;
3. Case management;
4. Child protection;
5. Attachment parenting;
6. Depression and anxiety scales;
7. Field work;
8. Domestic abuse and intimate partner violence (update);
9. ASQ assessment tool (update based on experience so far).

Apart from those formal trainings provided by external experts (psychologists, social workers, doctors from Medical University-Varna), the team was involved into various workshops whose aim was to strengthen their knowledge and skills around some of the tools and topics they use in the everyday work with clients. These were workshops delivered by the central team (Project Manager or Database Analyst) on:

- PIPE essentials and use
- Reflective supervision
- Learning Needs Assessments
- Case conferences / Team meetings
- Data forms/data collection;
- Use of STAR;
- Data-informed practice (using IS reports)

As for Site 2 team, in 2019 it passed two of the core NFP trainings – Pregnancy (January) and Infancy (May) delivered by the international consultant Ann Rowe. Both teams had a very good collaboration during the second training on the Infancy Phase as the team supervisor and a nurse from Sofia participated in the PIPE days of the training in Plovdiv. This was necessary as the Site 1 team was still experiencing difficulties and a bit of reluctance to put PIPE into greater practice. Currently, as a result of the training days and a follow-up workshop with the whole Sofia team, PIPE is being used with clients more frequently and confidently by the family nurses in Site 1.

For Site 2 team the first half of 2019 was much more intense in terms of additional trainings because of the low number of enrolled clients and the necessity to build capacity within the team that had just started implementing the program. Altogether, throughout the year the team participated in the following trainings:

1. Care for a healthy newborn;
2. Social and family environment of the newborn;
3. Breastfeeding (practical consultations);
4. Complimentary feeding – according to International Standards;
5. Growth charts – WHO for exclusively breastfed infants and Bulgarian charts;
6. Bulgarian immunization calendar;
7. Use of ASQ assessment tools;
8. N-cast tools, reading the baby ques;
9. Domestic abuse and intimate partner violence;
10. Data-informed practice - using IS reports;
11. Burnout prevention;
12. Depression and anxiety scales;
13. Contemporary guidelines for early child development;

14. Attachment parenting;

Also, as initially planned for their ongoing education, all NFP nurses from both teams passed a practical breastfeeding training in collaboration with Sheynovo Hospital in Sofia. Each nurse spent a day in the hospital consulting new mothers on the importance and practice of breastfeeding. The whole process was supervised by the Clinical Lead.

In terms of our 2020 plans, both teams will participate in the following trainings:

- Embracing diversity
- Identification of addictions and working with clients with addictions
- Smoking health impact

Along with the third module of the NFP core education (Toddlerhood), Site 2 team will go through those particular trainings:

- Case management
- Field work
- Child Protection
- Early childhood development
- Trauma-informed practice.

Health mediators from both teams have taken part in some of the training activities of the family nurses, such as:

- Client recruitment for NFP
- Client engagement and challenges
- Human ecology theory and self-efficacy theory in NFP
- Reflective supervision
- Social work and case management

- Any enhancements we have made to the program:

In the second half of 2019 the central unit initiated a meeting with the Site 1 team to discuss the need for capturing and using all information related to specific vulnerabilities in the communities being served. Based on the field work and nurse observations since the start of the program implementation in Sofia, team has been sharing concern of different vulnerability levels among the clients and families receiving the service – vulnerabilities that might require special attention or intensity of work and could be applied to further narrow down the impact follow-up for the most at-risk NFP clients.

As a result of the half-day workshop with the NHVs, a list of vulnerability criteria was drafted, and some of the factors were also pointed out as blank spots in our data collection.

The list is the following:

1. Client in public support accommodation
2. Accommodation is overcrowded (3 adults + the baby, and up)**
3. No running water**
4. Family uses garbage for heating*
5. Partner using drugs/criminal behavior/ in prison*
6. No primary education past 4th grade
7. Client without parent/ guardian and/or raised in institution**
8. Client working without legal labor contract*
9. Client undocumented**
10. Client is under 16 years at the time of getting pregnant

11. Client is minor – under 14 years, and living with minor/adult partner/husband*
12. Domestic violence in family
13. Client has chronic disease
14. Client is a single parent (also without any family support)

*= not currently collected as data
**= rated as most important risk factors

The criteria have been used to identify most at-risk clients to receive nutritional support (the 10 families who received food packages funded by our crowdfunding campaign on Global Giving). Moreover, the teams started contemplating on ways to collect risk information not yet routinely included in the data forms to better inform their practice in the future. During team meetings they agreed on possibilities of using facilitators to discuss some of the risk factors with their clients in more sensitive way and be able to record responses (for example using the STAR data form). This has been assessed as one of the great enhancements of the program implementation in 2019.

Program Fidelity

- Our assessment of program dosage patterns and length of visits in relation to client strengths and risks to date:

Program dosage	Pregnancy	Infancy	Toddler
Below 60%	1	4	13
100% or above	23	4	2

The data based on the 42 graduated clients, shows that average program dosage by phase was as follows: 103% at pregnancy, 76% at infancy and 73% at toddler phase. There are: 1 client in pregnancy, 4 in infancy and 13 in toddler, who received less than 60% of expected visits. In 4 of the cases the low dosage is due to temporary absence of 3 client – one of them was temporary absent in two of the program phases. In 14 of the cases the low dosage is due to frequent cancelation of visits by 11 clients in one or more phases of the program. There are almost no cancelations of visits during the pregnancy phase. Most cancelations and temporary absences are during the infancy and toddler phase and this can be seen in percentages of the dosage by phase above. As discussed earlier, the more vulnerable the client, the more cancelations of visits and more temporary absences of the program. These are two areas we need to work on improving – how to keep clients engaged during the infancy and toddler phase of the program and how to keep the most vulnerable clients engaged.

Average number of visits per phase are as follows: 11 in pregnancy; 21 in infancy; and 16 in toddler phase. The average length of home visits is 70 minutes, with 69 min. in Sofia and 77 min. in Plovdiv. As interpreters are used with most clients in Plovdiv, the home visits there naturally take more time. Regarding the length of home visits in Sofia, nurses share that in some households and especially with the most vulnerable clients, a lot of times there aren't any chairs in the room or place where the nurse and the client can sit and talk at length. In some overcrowded households it is difficult to have open and productive conversation with the client. Sometimes their home visits are being interrupted and cut short by other family members. This makes the work with those clients who need more time, the most difficult.

- Our assessment of program content delivered to date (domains):

Area	Pregnancy	Infancy	Toddler
Personal Health	51%↑	15%	12%
Maternal Role	24%	57%↑	50%↑
Environmental Health	6%	7%	11%↑
My Family & Friends	7%↓	9%↓	13%
Life Corse Development	11%	12%	14%↓

The time spent on the five program areas in different phases of the program are mostly within the benchmarks with couple of exceptions. Personal Health in Pregnancy is the domain which has the highest deviation from the benchmark, exceeding with 11% the upper limit. Health status of our clients and the discrimination, which makes it difficult for them to obtain health services can explain the difference in our context. Compared to last year's results, however, there is a drop of 6% in this domain and it has resulted in more time spent on other areas, most significantly in My Family and Friends, which is still below the benchmark in this phase, but only by 3%, compared to 6% in the previous report.

Higher than expected are also the Maternal Role in Infancy with 7% and in Toddler with 5%. This is a question worth exploring with the nurses. Environmental Health in Toddler is with 1% higher, which can be explained with the unsafe home environment and neighbourhood. As the child is growing and learning to crawl and walk, the hazards in the home become easier to reach and thus more dangerous for the child. There aren't significant differences from last year in these areas.

My Family and Friends is below the lower limit of the benchmark in Pregnancy, as mentioned above, and in Infancy with 1%. Life Course Development in Toddler is below with 4% which is additional drop of 1% since last year. Given the social and economic disadvantages, this area should be of priority in the work of the nurses and this will be explored in the first quarterly meeting for discussing the results from the data report.

- Our assessment of any other program fidelity benchmarks: see Annual Data Report

- Our reflections on the issues revealed and actions we are taking /planning in response to these:

Some mitigation strategies have been set in place where possible. For example, meetings with one of the clients in Plovdiv are being conducted in the office. In Sofia HESED has provided space for meetings with clients, who do not have the house conditions for home visits. When possible and appropriate, nurses conduct their home visits in the yard of the home, in the home of a family member or a friend, in the park or another public space. The nurses still visit the homes to assess conditions and give guidance to clients but are also using these alternative spaces in order to assure the quality of their meetings with the clients.

Nurses can use the option for alternative schedule – more frequent or less frequent visits, more actively to ensure client retention, as well as to be able to support those who are most in need of their services.

Client and Child Program Impacts

Please provide a summary of your annual program client and child outcome indicators, collected through your NFP information system or attach a copy of your annual data report (guidance can be found in the document 'Producing data for the annual report', which can be downloaded from the International NFP website).

Annual Data Report is attached.

- Our reflections and key learning from our data regarding program impact:

The results from our work in Sites 1 and 2 are promising. However, further research and expansion of the program are necessary to more definitively assess the impact of NFP in the long-term and be able to secure a government takeover.

Some results registered so far:

- Reduction in women experiencing severe and mild anxiety - from 15% at infancy 1-8 weeks to 4% at toddler 18 months
- Reduction in women experiencing severe to mild depression - from 11% at infancy 1-8 weeks to 4% at toddler 18 months
- Decrease in subsequent pregnancies after childbirth due to increased access and awareness of contraception - from 24% (baseline study) down to 16%
- Increase in children receiving complete immunizations on time - from 56% (baseline study) to 60% at infancy. Most of the mothers (95%) are aware of the immunization calendar and status of the child at 24 months.
- Decrease in infant hospitalizations - only 3 out of 129 babies in the program have been hospitalized
- Decrease in infant hospital visits
- Decrease in alcohol use during pregnancy
- Decrease in smoking during pregnancy
- 92% of clients were breastfeeding at birth and 62% were breastfeeding exclusively
- Increased number of clients (and their partners) going back to educational activities as a result of the program

- Our reflections on what we could do in addition to enhance program impacts for clients:

  - We plan to adapt and introduce the IPV form, new facilitators and pathways into NHVs practice
  - We will push for early application of vulnerability criteria to newly enrolled clients for need-tailored NFP practice of the nurses (the list of risk factors is applied within the first 4 home visits of each client)
  - We will push for quality and fidelity of the program implementation by following a monitoring plan, encourage data-informed practice (use of IS reports by teams) and regular reflective supervision (to include reflections on program impacts for clients).

Client Experiences

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

In the upcoming months (after the Annual Report review meeting) we will be able to send to UCD a promotional video on NFP in Bulgaria. Interviews with 5 clients in Site 1 have been recorded in February 2020 showing their experiences so far, their interactions with the nurses, as well as testimonials from the nurses themselves. We had planned for March 2020 additional interviews with medical experts and TSA management to complete the program implementation picture and have external stakeholders' impressions of the service. However, the Coronavirus outbreak has currently put on hold those plans and we are unsure when the final video will be edited.

In the meantime, here it is a quote from one of the clients that were interviewed:

"My baby had numerous very complicated health problems, some of them cardiological, which I didn't understand. So, when she was born, I was terrified. With the help of my family nurse, who was working with me since I was pregnant, I managed to understand my daughter's condition and take actions. My NFP nurse supported me with consultations and accompanied us to different doctors and medical institutions. Now my child is much better, she is very curious and energetic. I have learnt how to properly take care of her, communicate and play with her. This program helped me make plans for the future – I am now taking my exams to get a high school diploma and would like to enrol my daughter to a kindergarten, so I can apply to a university." – ***Esmeralda, 19 yrs, Roma client from Sofia***

NFP program innovations

- We are using/plan to use the following program innovations/enhancements (e.g. STAR Framework, DANCE, IPV, Mental Health, other):

After our work on determining the vulnerability criteria for our NFP clients and following team discussions on how this essential data could be captured, we modified the STAR Framework document. After consultations and involvement from our International Consultant the form was updated to include questions for information on the risk factors we had not collected before (such as Family uses garbage for heating; Partner using drugs/or has criminal behavior/ or is in prison, etc.). This is rated as one of the most useful "innovations" in applying the STAR tool more adequately to the Bulgarian context in order for the nurses to deliver the service in the most need-tailored way, as well as for program evaluation purposes.

We have not yet introduced, but plan to work on modifying the IPV form, especially in relation to possible pathway for our clients to receive access to external services and adequate support. After a Study Visit initiated by the central unit to Northern Ireland and communication with the FNP Clinical Lead, we are about to receive support and knowledge about their IPV processes and activities. This would be helpful as a starting point in adapting the form when we approach Bulgarian experts in the field (who have trained our nurses on domestic violence issues) to collaborate with them on the matter.

On another note related to program innovations – we are proud to underline that in the past 12 months Site 1 team not only improved the fidelity and quality of the program implementation, but also got inspired to be "innovative" and self-initiative. In January 2020 during a regular team meeting for the first time the nurses created their own facilitator to be used with the clients during home visits. The facilitator is based entirely on the Bulgarian context (healthcare system and client needs) and explores the question "What to do when my child gets sick and needs medical attention". It gives a clear pathway for the mothers in the program on when/how to contact their GPs, the emergency line 112, or other medical service providers.

This facilitator was a result of a collective opinion that there is a great necessity for such visual instructions for the young moms who often contact the nurses asking what to do when their GP does not answer the phone, for example. They often felt frustrated by the whole healthcare

network and needed to be navigated. Thus, we believe that our new NFP product will be of significant help for all families served.

Our central team has also developed a simple but very useful data form, used during observed reflective supervision sessions. As observed supervision was introduced in 2019 following the new RS guidelines, we felt the need for having a tool to record the findings/feedback for better follow-up of the process and for quality purposes.

Also, a new PIPE book was put together with all materials for which we have permission to translate and use - guidelines for nurses and handouts for parents (adapted from the 2015 color version of the materials). This new tool is divided by phases and gives a more clear and comprehensive view of the available materials for nurses to use with clients.

- Assessment of our successes/challenges in implementing/adapting these program innovations:

The STAR Framework is now comprehensive, and our teams feel much more confident in both assessing the risk levels for their clients and planning accordingly on ways to mitigate those risks. However, it is not always possible to gather all the information about the strengths and risks of a family – some of the questions explored in the form are highly sensitive and clients are unwilling to discuss them or be open about them. And in the case of Site 2 clients – the lack of ways for direct communication and building a 100% trust relationship creates additional challenges for the nurses to properly assess the STAR situation in the families.

It is a general expectation that the IPV form will be hard to introduce into the NHVs practice for various reasons. First of all, the issue of domestic violence is one of the biggest taboos in Bulgarian families as a whole, but especially for the clients and communities we serve. Also, there are not many and/or adequate services readily available for women who have experienced IPV and what is more important – there's lack of sustainable support and solutions for the women that do get some kind of initial help (in terms of shelter, for example). As a result, social workers and medical professionals (including NFP nurses) are reluctant and resistant to raise concerns and address issues that are sensitive and would probably not be met with a long-term solution for their clients.

- Any alternate tools we will use/are using and why: n/a

- Reflections on use of these alternate tools to date: n/a

Our information system and analytical capacity:

- How we are currently collecting, analysing and using NFP program data (information system, data quality, how it is used at NFP nurse, supervisor, team/site, national levels etc.):

Data is collected and input by the nurses on an ongoing basis. Data quality is guaranteed by automated checks in the information system and through manual check of each submitted form by the Data Analyst. The information system provides readily available reporting on an individual, team and national level, which is updated with each data entry. This requires monthly download of the reporting and the full export of data in order to have time series of the collected data.

NFP data is used in NAB and LAB meetings to report on progress to stakeholder and in regular reports to our board members and donors.

So far, we have used data reports twice a year in sharing Annual Data Report results and in discussions on data forms and the use of the information system. However, these meetings proved to be insufficient. Now that nurses in both teams are focused on quality improvement of the program, we plan to continue these meetings. We will set up additional quarterly meetings. These meeting will be based on data reports prepared by the Data Analyst and

Another area for improvement on our data collection and use will be including the nurses in the reporting process especially with data, which is not collected through the information system, as well as with some qualitative data, which will give us more insight on the impact of the program. We will set up additional quarterly meetings. These meeting will be based on data reports prepared by the Data Analyst and reports prepared by the NFP teams. We hope that the facilitated use of data reports on quarterly basis will help the quality improvement of the program.

On a nurse level, we plan to start with at least one reflective supervision per nurse, in which Data Analyst will be present and will assist with analyzing data and available reporting in the information system on a nurse level. We hope that this will both model the use of data reports in the reflective supervisions and will also give more insight on what kind of data, which is not already included in the IS reporting, might be helpful for the nurses and supervisors.

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

New reporting on some data points are identified as needed and will be developed in the information system. The new quarterly meetings on data reports and the use of data reports in supervisions will give us more insight on new useful reporting to be developed in the information system.

- Our plans to develop a Continuous Quality Improvement process:

By December 2019 the central unit of the Program has completed a field and office monitoring of both teams' work. All nurses were accompanied by the Project Manager during home visits with clients. Paper and database client files were also inspected. The results of these activities were highly satisfactory, and we plan to keep them on a regular basis to push for quality improvement in the future. Accompanied home visits will follow the requirements of the model while the paper and database monitoring are planned for every 6 months.

In 2019 the Data Analyst was engaged in numerous workshops/discussions with the nurses on the use of the IS and its reporting functionalities. We intend to keep those activities as a means to increase the quality of the team's work and the quality of our IS when we identify ways for its further development. Moreover, the data analyst will work individually with each nurse to ensure quality and completeness of gathered data – again, on a 6-month basis.

In the last days of February 2020, the NFP leadership team (Project Manager and two Supervisors) undertook a study visit to Northern Ireland where the Program has been functioning for the last 10 years. The Bulgarian team participated in the annual learning event of the NI teams focused on maternal mental health. They spent two days on the field with local teams and a day with the Clinical Lead and the Data Analyst – discussing methods of data collection, reflective supervision, advisory boards, etc. Based on what was observed, some tips for quality improvement have been discussed with the Bulgarian teams and will be introduced in their practice, such as using the "client tree" during case conferences or reflective supervisions.

Again, based on the experience in Northern Ireland, the central unit has planned to get the nurses involved in the drafting process of the annual report. Some templates for data and reflections will be provided for the nurses' inputs on a quarterly basis. This will allow them not only to contribute to the report but also to track their individual and team progress, and to analyze the quality and fidelity of their work.

The Data Analyst is now attending quarterly calls with the International Research and Analytical group, which will allow for peer learning, exchange of information about different countries' experience and generating of new ideas on quality improvement process.

Nursing Workforce

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

Currently we have two teams of home visitors (nurses and midwives) delivering the NFP service in Site 1 and 2 together with health mediators/field workers as stipulated by the additional CME for Bulgaria approved officially by UCD in January 2019.

In the last year both teams went through some serious changes in team staffing and dynamics. In Site 1 the transformations were more positive. The team supervisor resigned in April which was a desired move by both TSA central unit and the NHVs as well. Although the supervisor had stayed with the team for 3 years, she did not show the necessary level of engagement to the model requirements related to her position. All processes around reflective supervision, team meetings, capacity building and learning needs assessment were suffering as a result of this. TSA efforts to support and encourage a positive transformation within the team leader felt short of the necessary success and when a monitoring plan was introduced to follow the supervisor's performance, it was her decision to leave the program. As a result, the deputy supervisor (part-time nurse) took the role as she had been trained for the purpose and was originally the supervisor of the team when it first started operating in 2016. The whole team welcomed the changes and was motivated by what they saw as a "new beginning".

In addition, a new nurse joined the team in April because of the growing demand for NFP and respectively the rising number of clients. She got trained on the core program education together with the Site 2 team and started working with clients right away. The new colleague has an additional degree in psychology and brings that to a good use in the team during group supervisions, case conferences and team discussions.

We still have one of the nurses (part-time) from the initial team composition on maternity leave and expect her to re-join the team in May 2020. In addition, last summer we recruited one more health mediator (part-time) who replaced a colleague on the same position who also took a maternity leave. We expect her work to restart in July 2020.

As for Site 2, the team suffered a lot of turbulent dynamics with many of their colleagues leaving or being dismissed because of dissatisfactory performance. Out of the 5 team members which started the NFP operational work in February 2019, at the end of the reporting period, only 2 of them have remained – the team supervisor and one of the nurses. Another nurse was recruited in October completing the size of the current team to a total of 3 people (a SV and 2 full-time NHVs). At present, however, the supervisor has also announced her decision to leave and we have advertised the position hoping to recruit and train a replacement by the end of May 2020.

The main reason for the high attrition rate of the nurses in Plovdiv has been the exhaustion and disappointment of the slow recruitment rate, as well as the fact that the team members had to

devote a great deal of their time to recruitment activities rather than clinical work as they expected and where they feel much more competent. Some of the nurses faced their own boundaries related to working with Roma communities and in challenging field conditions which proved to be an additional constraint for them.

Huge turnover took place among the mediators we employed. We started in February with two field workers who did not have the official health mediator qualification but assumed the mediator's duties. One of them resigned after just a few months, and the other one migrated abroad. After recruiting another pair of trained and experienced health mediators (the only two female qualified mediators in the neighborhood) we faced a huge disappointment in their commitment and engagement as they prioritized external for our program projects and tasks of their own. Finally, in the second half of 2019, and especially after expanding the NFP coverage to all the city areas, we settled with a male health mediator for Sheker neighborhood and two female field workers for Stolipinovo (recommended by our NAVA partner).

However, the whole staff turnover process in Site 2 has been very hard and exhausting for the team and the supervisor as they couldn't really build up a coherent group and the necessary relationship of unity and trust. The process was challenging for the central implementation team as well because of the constant need for administrative changes, recruitment and training. TSA has made considerable investments in people who left the program in less than a year which is one of the risks we knew of but did not expect to face on such a large scale in Plovdiv.

- Successes/challenges with NFP nurse/supervisor recruitment:

In 2019 we initiated 2 recruitment rounds in Sofia (1 for employing a nurse and 1 for a health mediator) and 2 rounds in Plovdiv (each for employing a nurse). In general, our observations have remained the same as those from the previous year - recruiting nurses/midwifes outside of the capital city of Sofia is particularly challenging. The job offers outside of Sofia get less attention and less people apply - there is an acute lack of such professionals in general in the whole country but outside of Sofia the deficiency is even deeper. Few candidates were interviewed for the Plovdiv positions and the pool we had to select from was much smaller with much more underqualified nurses, at least for the NFP purposes.

The slow client enrolment rate of Site 2 also affected our staff recruitment there. We realized we didn't need and could not support the "normal" size of an NFP site (4 nurses and 1 supervisor) given the unfulfilled capacity of the current team members and the close-out phase we are facing in 2023 if no additional funding becomes available. With that potential "deadline" in mind which also limits the client enrolment period to the summer of 2021, we decided we would proceed with delivering the program through a team of 2 full-time nurses and 1 supervisor (total capacity of 50 clients). This was consulted with UCD.

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

During the current reporting period the Plovdiv team completed successfully the second part of the NFP education (on Infancy) in May. They were joined by the two new nurses in Sofia team, and the health mediators for some of the training modules. The general feedback from the training was very positive with lots of new skills and knowledge acquired.

However, the staff turnover in Site 2 caused a lot of challenges in terms of delivering the core education to the new team members (especially when they were hired at different times). We had to engage the Clinical Lead as the only option for an NFP trainer to deliver the Pregnancy and Infancy

modules at two individual trainings for new colleagues. The supervisor had to also step in for additional training and mentorship of the new team members.

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

We consider a great success having both teams completing most of what was on their ongoing education plans for 2019. The year was very intense for the family nurses in terms of learning events and filling the gaps related to different NFP tools (PIPE, depression scales, ASQ, etc.). This allowed the central team to focus also on pushing for the quality aspect of the program implementation.

Again, all the phases of human resources changes brought serious challenges for the ongoing education delivery. As some of the trainings had already been organized and provided to the nurses by external experts, having some of them leaving the program posed questions of how those trainings could be delivered to the new colleagues and how to keep the skills/knowledge balance in the team.

- Successes/challenges with delivery of NFP nurse reflective supervision:

One of the greatest successes in 2019 has been the re-integration and full-speed use of the reflective supervision in Site 1. After the change in the SV position and several supervision workshops initiated by the central unit (including watching and discussing RS videos from Scotland), the nurses started having regular weekly supervisions as regulated by the program model.

Moreover, as stipulated by the outcomes from the Reflective Supervision Project (new guidelines for implementing this particular NFP component) the teams agreed to have observed supervision sessions (by the Project Manager) for quality improvement purposes and regular feedback to the supervisors. So far, this practice has proven very useful and well accepted by the nurses and mediators.

There have been a few minor challenges for Site 1 team related to the supervision. One was the fact that their office is a 1-room space which brings very practical questions of when and how a nurse and the SV can have the 1-to-1 session while some of their colleagues are in the same room working. We still haven't found a way to properly address the situation. However, the team has found working solutions – having the supervisions outside when the weather conditions allow it or conforming with each other's weekly schedules so that whenever some of their colleagues has a supervision, the others are out on home visits.

Another challenge has had to do with the capacity of the SV. As she is on a part-time position (available for 5 hours a day) and had a relatively high number of clients (because she was a family nurse before assuming the SV position), she didn't have much time to cover the supervision sessions for all nurses. To solve this problem, we agreed with the deputy supervisor to do the supervision with one of the nurses and the two health mediators.

As for the Plovdiv team, they got well into the supervision practice and habit from the very beginning – mostly due to the efforts of the supervisor. Initially the nurses there showed some resistance as they didn't see the benefit of RS in the initial phase of the program when they didn't have such a substantial number of clients. However, the central team and the supervisor worked in close collaboration to discuss and clarify to the nurses/mediators the essence and importance of the NFP supervision. Currently, there are no disruptions in the weekly schedule of those sessions.

Both teams have experienced some challenges related to the supervisions of the mediators as they have found it difficult to understand and participate in. It took some time for both sites to adapt the sessions to the needs and specifics of those field workers.

- Successes/challenges with delivery of reflective supervision to our supervisors:

Due to the part-time position of the current Site 1 Supervisor and her substantial number of clients (as she used to be a regular NFP nurse), she needed to be supported by her deputy SV during the period of caseload reduction. So, the Clinical Leader had to hold reflective supervision sessions with 3 new supervisors – the one in Plovdiv working with all nurses and mediators, and 2 in Sofia covering with weekly supervisions respectively 4 nurses and 1 nurse + 2 mediators.

This situation created tension in both teams and needed dedicated help from the Clinical Leader to support each SV to align their new roles and responsibilities with the team goals. During the supervisions the focus was on the SVs reflecting on how to create safe climate for team members to openly and supportively discuss any issues, challenges and successes related to their work with children, families, colleagues, etc. There are still some difficulties to communicate openly and honestly but we are constantly working on it.

We have progress in both teams in creating a work environment that promotes productive problem solving without judgment. We are trying not to allow the specific Bulgarian health structure, systems and processes to interfere with the achievement of our NFP goals. During our reflective supervision sessions, we are constantly working on strengthening the self-confidence of the new SVs and making sure that they are clear in front of the team members about critical clinical issues and important events.

In both teams, the SVs are still struggling with giving team members similar and meaningful levels of responsibility due to different factors. We managed to overcome with tough measures a NHV who had destructive team behavior - this was affecting the work of her SV and the whole team. After many efforts for improvement her contract was eventually terminated. This resulted in constant work on focusing the team efforts around the children and families we serve instead of team dynamics and interpersonal issues.

We have some improvement on regularity and commitment to reflective supervision of health mediators in both teams. All supervisors show different level of mastering their new role, but they are constantly improving, learning and reflecting on their experience. The emotional impact of the work is affecting all supervisors, and this is often deeply discussed with them. Overall, we have exceptional progress in both teams in these challenging circumstances.

We are now structuring the work of the teams (including the continuation of regular supervision sessions) in a situation of quarantine (because of the Coronavirus outbreak), without an adequate stable contact and finding alternative ways with our clients. This is the biggest challenge with our clients that we have ever faced, and we are still in process to find the balance with the program fidelity, quality, team safety and compliance with national quarantine measures.

- Any plans to address nursing workforce issues:

In view of the staff turnover in Plovdiv, one of the biggest concerns for the program implementation and development so far, it is important to note that TSA has not been a passive observer of the situation. Nurses were supported financially, resource-wise, psychologically, by providing weekly

guidance and several team buildings. Problems were addressed and efforts were made to alleviate the nurses from the client recruitment pressure.

Both teams kept having their monthly group supervisions with a psychologist and will have those in 2020 as well. They participated in trainings focusing on their psychological and emotional wellbeing as NHVs. Both teams had the chance to learn more about burnout prevention, conflict resolution and mechanisms for coping with loss/grief.

We provided opportunities for regular meetings and communication between both teams, so they could exchange experience, ideas and good practices. Team buildings and Christmas parties were also part of their 2019 experience as we wanted to create better team environment.

Although we had a challenging year in Site 2, we believe it would have been even harder if we had not undertaken all these measures. More of those are planned for 2020 with more frequent workshops and meetings on burnout prevention and emotional support. We are also in the process of recruiting a new supervisor for Plovdiv – interviews and initial trainings are planned for April and May 2020 (depending on the coronavirus situation in the country).

In May 2019 we were able to offer a 10% increase in the salaries of the Sofia nurses (as they had already worked for 3 years in the program). We believe this was an additional incentive for them, together with the new team supervisor, to continue their work in best possible way given the challenging context. If the budget allows it, we can offer a similar boost to the Plovdiv team later on in the program implementation.

Summary

- What have we achieved this year:

  - After successfully expanding the program implementation to a second site – Plovdiv, we managed to execute a wide range of activities planned under a client recruitment strategy.
  - In Sofia the program has been growing in terms of clients. We recruited a new nurse and a new health mediator due to the increasing demand for the NFP service.
  - Site 2 team and mediators (including the new nurses from Site 1) successfully passed the second part of the NFP core education (Infancy) and completed most of the additional trainings planned for 2019.
  - Due to the increasing number of successfully graduating clients (over 40), we have developed and started following archiving guidelines for the client folders.
  - New filing order of program materials was introduced in Sofia, based on the experience in Plovdiv, which given the limited space has significantly helped the work of the nurses
  - Vulnerability criteria list was created and started being used for determining the risk levels of each client
  - STAR framework was adapted to include data collection on the risk factors (the ones that had not been already included)
  - Site 1 nurses developed their own client facilitator to navigate young moms through the healthcare system and medical facilities when the babies get sick
  - After several workshops and team discussions and the introduction of the new tool, PIPE has been reintroduced into the Site 1 practice, it is fully utilized by Site 2 as well
  - Reflective Supervision sessions are done by both teams regularly and according to the model requirements; observed supervision has also been introduced for SV feedback and quality improvement

- Accompanied home visits are now a regular part of the NFP supervision as stipulated in the program
- New Observed Supervision Form was developed modelled on the Home Visit Observation Form and based on the Guidance Document: Reflective Supervision from 2019.06.10
- Information System has been further updated and modified to accommodate all comments and needs generated by the NFP teams
- Due to our active local coordinator and team supervisor, we started having some referrals from medical professionals in Site 2, as well as from other service providers (social support agencies)
- There were 6 LAB meetings (3 in Site 1 and 3 in Site 2), and the municipal authorities in Plovdiv expressed support for the program by starting to host the meetings in the main municipal building
- There were 2 NAB meetings, hosted by the Ministry of Health; state authorities and professional medical organizations expressed support for our goal to make NFP a national service
- We signed a contract with a state expert to draft a Bulgarian methodology of NFP that will help the government to integrate the program into the country's healthcare and social systems
- Funding for NFP (maintaining 2 sites) is secured for the next financial period (September 2020 – September 2023)
- Due to needs raised by the NFP nurses and TSA-initiated crowdfunding campaign, we now have a fully operational medical office in the biggest Roma settlement in Sofia – Fakulteta. Mothers and their children get the necessary care provided by 2 obstetricians and a pediatrician.
- Due to needs raised by the NFP nurses and TSA-initiated national campaign, all babies in the program received packages with books and toys appropriate for their age and helpful for their cognitive development.
- We initiated a study visit to Northern Ireland to learn from their FNP experience and came back to Bulgaria with many ideas and tips that could be put into our practice.
- Data Analyst became part of the NFP International Research and Analytical Group and participates in regular meetings.

- What challenges do we face?

  - Despite our comprehensive client recruitment campaign in Site 2, the enrolment rate has remained very low with just recently pushed to reach 2.5 enrolled clients per month
  - High levels of migration among the Roma communities in Site 2 – has severely affected enrolment of new clients and retention of clients already enrolled
  - Slow client recruitment is also due to lack of national pregnancy register and effective referral systems across sectors and services
  - Most doctors that do refer potential clients expect some level of financial remuneration in return (contracts in Site 2)
  - Lack of adequate communication with clients in Site 2 due to linguistic differences – most of the clients in Plovdiv speak Turkish and speak or understand very little Bulgarian (if any). This imposes the need for interpretation during the home visits which raises concerns about confidentiality, quality of the interpretation, level of understanding of the materials, building of therapeutic relationship.
  - Huge staff turnover in Site 2 – due to the overall challenging situation making the nurses frustrated, exhausted, disappointed and stressed

- General acute lack of nurses and midwives in the country making our efforts of finding replacements even harder; this will also affect any attempts for scaling up the program
- Lack of autonomous practice of nurses and midwifes, and the hierarchical structure of the health sector, where nurses and midwifes have a secondary role – makes introducing practices like reflective supervision very challenging
- Need for extensive additional training of nurses due to gaps in the university education; this investment proves very expensive when nurses leave the program and new nurses have to be trained
- High levels of illiteracy among our clients in general which causes limited use of Program materials
- Obstructed access to prenatal care for uninsured pregnant women; lack of access to prescription drugs for low-income families
- Clinical Lead on maternity leave with only part-time involvement which was insufficient for the clinical needs of the nurses and their supervisors
- Funding for NFP ends in September 2023; TSA must fundraise for RCT, opening of a third site and maintaining those 3 sites
- RCT is very expensive for Bulgarian context and there is no national expertise for conducting such impact evaluation
- For some of the program outcomes (i.e. language development for children below 2) there are no validated measurement instruments, data is not collected or is difficult to get from doctors/institutions (with implications for the control group in an RCT)
- Bulgarian politicians are not engaged with evidence-based policy making
- Lack of clarity about costing in the case of scaling up
- Unclarity about the future of home visiting in Bulgaria and health structure that can host NFP.

- Anything else: n/a

Any other relevant information:

PART FOUR: ASSESSMENT OF PROGRAM TESTING AND EVALUATION

Our feasibility & acceptability study:

- Goals:

A key aim of the evaluation is to explore whether it is possible to implement the NFP program according to these core model elements within the Bulgarian context and to identify barriers and enablers to implementing the NFP model, and to inform policy and practice around its future development.

The study is looking to find answers to the following questions:

- Is it possible to deliver the NFP program elements (e.g. nurse-led intervention, referral process (including additional help from health mediators), curriculum, frequency of visits, community partnerships) with fidelity in the current Bulgarian context (focusing on both existing health and social services offered to pregnant women and first-time mothers)?
- Is the program being implemented as intended (and if not, why not)? What is the nature and extent of any changes that have had to be made to planned implementation arrangements to deal with existing problems?

- Are the NFP program elements (e.g. nurse-led intervention, referral process (including additional help from health mediators), curriculum, frequency of visits, community partnerships) acceptable to nurses, young, first-time mothers and their family members, and community stakeholders (policy-makers, health and social-service providers; professional associations; medical universities)?

- Methods:

The study is intended to be both formative (feeding back into the work of the sites as they develop) and summative (drawing conclusions at the end). In addition, the study will be longitudinal in character, following the experiences of a group of young mothers – and the staff working with them – over a period of time and through the various stages of the program. The study will employ two main types of information: quantitative monitoring of data collected from (or about) all clients at key stages in the delivery of the program, and qualitative interviews with clients, NFP staff and other stakeholders with an interest in the program. The qualitative element of the evaluation aims to capture a diverse range of circumstances, characteristics, views and experiences and to generate insight and understanding about how the program operates on the ground. However, it is not intended to ensure „representativeness" in a statistical sense.

- Sample:

Overall, at the end of the study there will be conducted 183 in-depth interviews, 2 panel survey waves of 200 respondents (400 quantitative interviews), one survey of 20 nurses, and 2 focus group discussions with Roma elders. The aim of the survey is to cover the knowledge, awareness, opinion, attitudes and practices of 14 types of stakeholders, concerning the pregnancy and childbirth, infancy and toddlerhood, and with regard of the existing social work policies and early childhood development programs in Bulgaria.

- Progress to-date:

We received our first Preliminary Field Report in the beginning of 2019. It outlined the scope and methodology of the study and gave a lot of details on the situation in Bulgaria, as well as the served communities. However, it failed to include analysis of the interviews done with clients, as discussed with UCD.

We plan to have our second Preliminary Field Report by the end of 2020 and the final Feasibility & Acceptability Study Report by mid-2021. We will share the reports, as well as our reflections and plans based on the reports in a timely manner when we receive them.

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 UCD to know?

PART FIVE: ACTION PLANNING FOR NEXT YEAR

Our planned program priorities for next year:

- Hire and train a new Supervisor for Site 2 and stabilize team dynamics;
- Keep a minimum client recruitment rate (target for Site 1 is 5 clients per month; for Site 2 – 2.5 clients per month)
- NFP Toddler Training for Site 2 and new nurses from Site 1 team
- Put communication strategy initiatives in practice (video, media posts, etc.) for raising public awareness and governmental support for NFP
- Focus on quality and fidelity of program implementation (monitoring, RS, data-informed practice)
- Finalize Bulgarian methodology of NFP (normative regulation of NFP as a new integrated health service for vulnerable groups)
- Finalize Lessons Learnt Report based on NFP implementation in Bulgaria up to date
- Finalize Policy Brief as an advocacy tool for government adoption of NFP
- Receive and review the second Preliminary Field Report of the Feasibility & Acceptability Study
- Strengthen relations between teams and health service providers + municipal authorities and widening/strengthening referral mechanisms
- Recruit non-Roma clients in both sites
- Plan first steps of RCT phase / look for funding
- Provide planned ongoing education modules to fill the gaps in NFP nursing workforce
- Elaborate client graduation process and celebration
- Adapt and introduce IPV form, facilitators and pathways into NHVs practice
- Think of ways to collect data and track fathers' progress as a result of the program implementation
- Push for early application of vulnerability criteria to newly enrolled clients for need tailored NFP practice.

Any plans/requests to UCD for program expansion/adaptation?

- Support in preparation for the next stage of replication as we will be applying to various funding institutions in 2020 to expand the team in Site 2 and bring it to its regular size of five HV nurses and to set up a third NFP site with 5 nurses, 1 SV and a caseload of 100 NFP clients.
- Adaptation of the model for emergency situations (in light of the Coronavirus outbreak and quarantine)

This is what we think we need to be doing next year to adapt and improve the quality of our NFP program in the coming year:

In 2019 the central implementation team started focusing its attention more intensely on activities for quality improvement, especially with regards to the work of Site 1 team (observed supervision sessions, accompanied home visits and regular feedback to nurses and SV, monitoring of client files and IS input, etc.). We plan to continue undertaking these activities in 2020 with both teams, while also concentrating in the following steps (as outlined in detail in the Plans for Continuous Quality Improvement section above):

- workshops/discussions with the nurses on the use of the IS and its reporting functionalities
- getting the nurses involved in drafting quarterly reports and discussions for their work individually and as a team (this will give them room for reflecting on their experience, lessons

learned, ideas for improvement, and it will also be valuable for drafting the forthcoming annual reports)
- participating in the quarterly calls of the International Research and Analytical group, which will allow for peer learning, exchange of information about different countries' experience and generating of new ideas on quality improvement process
- continuing with regular NFP international consultancy – to address questions about quality improvement
- follow the NFP international website (resources page and forum discussions) to be aware of good quality improvement practices in other countries
- consider recommendations by research team (OSI) working on the F&A study
- consider and undertake further adaptation of materials for the challenging context in Site 2 (facilitators with visuals for the Turkish speaking clients)
- plan and undertake improvements of the LAB meetings process – making the attendees more involved, inviting NFP clients to have their voices/stories heard, etc.

Our research/program evaluation priorities for next year:

- Continue with implementation of F&A study in both sites and receive/review the final report. We will ensure close communication and collaboration with the OSI team, so that the planned methodology (interviews with clients, nurses and medical experts) for the F&A study is implemented as planned for both sites.
- Finalize the TSA report on Lessons Learnt from the program implementation so far (interviews with nurses, clients and central team were completed in 2019 by one of TSA's evaluation experts).
- Research the potential for enhancing the role of the graduated mothers to become ambassadors of the program and disseminate key health messages.
- Research available data, which is reliable to be used in preparation of an RCT, and also the feasibility to collect data against particular measures like speech development for example. Research the options for setting NFP sites on the territory of Bulgaria based on geographical distribution of potential clients.

How we will know if we have been successful in meeting our objectives?

- New Supervisor for Site 2 is hired and trained
- 5 clients per month are recruited in Sofia; 2.5 clients per month – in Plovdiv
- Site 2 team and new team members from Site 1 pass successfully the NFP Toddler Training
- Communication strategy plan is followed with weekly interviews/publications and public is more aware of the NFP; government expresses support and makes commitments
- Plans for monitoring and reflective supervisions are followed; IS and central team record higher quality and fidelity of program implementation
- We have a Bulgarian methodology of NFP as a final product
- We have Lessons Learnt Report as a final product
- We have Policy Brief as a final product
- We register more potential client referrals by medical professionals and service providers
- We have enrolled at least 5 non-Roma clients in both sites
- Planned ongoing education modules have been completed by teams
- One client graduation event has been organized at the end of 2020
- IPV forms, facilitators and pathways are in use by the teams
- Vulnerability criteria are applied within the first 4 home visits of each newly enrolled client.

This is what we would like from UCD through our Support Services Agreement for next year:

- Deliver NFP Toddler Training to Site 2
- Meetings to review F&A study – interim and final reports
- Meetings/support for funding opportunities and planning of RCT (setting up a third site, design of impact evaluation, etc.)

Our suggestions for how NFP could be developed and improved internationally are:

- NFP presentations during events/conferences on the occasion of the WHO Year of the Nurse/Midwife
- NFP International Newsletter (on a quarterly basis) to be informed of major developments in the other countries with program implementation
- Drafting of general guidelines of NFP implementation during crisis situations such as pandemics or other disasters (in light of the Coronavirus outbreak)

PART SIX: ANNUAL REPORT FROM UCD

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

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

- Advice and guidance to Clinical and implementation leads through regular mentoring and consultation calls
- Planning and completion of NFP infancy training
- Meetings to progress planning for phase three and RCT
- Meeting re potential future funding
- Support for arrangement of study trip to Northern Ireland
- Responses to ad hoc questions, requests for documents and contacts etc.
- Access to NFP International website and resources, Clinical Advisory Group, research and data analytical network and other International collaborations.
- Involvement in, and access to results of, international Reflective Supervision project.

Identified strengths of program:

- The commitment, talents and resourcefulness of the leadership in TSA, resulting in continued adaptation and development of program implementation and an exemplary annual report
- The development of the Information system and the analysis of data evident in the annual data report and is giving considerable insight into client characteristics and circumstances, as well as forming the basis for improvement projects
- The tenacity and creativity shown in continuing to support and sustain the second site in Plovdiv
- The commitment of the nurses, mediators and supervisors
- The high rates of client enrolment on the basis of recommendations by clients
- The ongoing strategic work with the aim of creating a sustainable future for the program in Bulgaria, including the continued progress of the national advisory board.
- The willingness of all involved to continue to learn, adapt and improve the program and work towards phase three.

Areas for further work:

- As identified in part 5
- In addition to consider development of a simplified dyadic assessment tool based on DANCE
- To work with nurses re establishing indicative CME benchmarks for Bulgaria over time
- To develop pathways for nurses to use re client housing/ home safety challenges
- To refine client inclusion criteria for non-Roma population

Agreed upon priorities for country to focus on during the coming year:

As above

Any approved Core Model Element Variances:

Variance #8 re nurse education – no change
Approved additional model element re Mediator role – no change

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

- Deliver NFP Toddler Training to Site 2
- Meetings to review F&A study – interim and final reports
- Meetings/support for funding opportunities and planning of RCT (setting up a third site, design of impact evaluation, etc.)
- Feedback on feasibility of a simplified DANCE tool
- Feedback on Munich speech and language assessment
- Response to TSA list of client eligibility characteristics

