University of Colorado
Anschutz Medical Campus

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

International Nurse-Family Partnership® (NFP)

PHASE TWO ANNUAL REPORT

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

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

Purpose of annual report:
As part of the license agreement with the University of Colorado, each country is required to prepare and submit an annual report. Through the annual report, data are reported, analysed and reviewed, to guide discussion of the country's implementation successes and challenges, as well as emergent outcome variations. The annual report forms the basis of the Prevention Research Centre, University of Colorado's (UCD) annual review of NFP implementation and fidelity in licensed partner countries and for discussing quality improvement plans. By using quantitative and qualitative data, the annual report creates an opportunity for each country's leadership team to reflect on progress and develop quality Improvement plans for the following year.

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

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

The report should be sent to Dr David Olds, Ben Jutson and the country's International Consultant at least three weeks prior to the Annual Review meeting. Further guidance on the conduct of the annual review meeting can be found on the 'International NFP Resources' page of the international website.

PART ONE: PROGRAM OVERVIEW

Name of country:	Bulgaria	Dates report covers (reporting period):	March 2020 – February 2021
Report completed by:	Ivanka Puleva, Petya Zeynelova and Luybka Georgieva	Date submitted:	March 31, 2021

The size of our program:

	Number	**Total**
Fulltime NFP Nurses	**6**	**6**
Part time NFP Nurses	**1**	**1**
Fulltime NFP Supervisors	**1**	**1**
Part time NFP Supervisors	**1**	**1**
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)	**5**	**5**
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable	**0**	**0**
Total		**14**

- We have 2 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:6

- Current number of implementing agencies/sites delivering NFP: 2
- Current number of NFP teams: 2
- Number of new sites over the reporting period: 0
- Number of new teams over the reporting period: 0
- Number of sites that have decommissioned NFP over the reporting period: 0
- Successes/challenges with delivery of NFP through our implementing agencies/sites: (see following sections)

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

License holder name: Sarah Perrine, CEO, Trust for Social Achievement Foundation (TSA)
Role and Organisation: TSA has the role of a central implementation agency for NFP in Bulgaria. The central implementation team within the organization is responsible for the overall implementation of the program, quality improvement efforts, team supervision and education, strategic goals in terms of sustainability and national dissemination of the service. The central team consists of 4 members – a full-time Project Manager and part-time: Data Analyst, Communication Expert and Clinical Leader.

Description of our National implementing capacity and roles:

- Clinical Leadership:

For the reporting period, the NFP-Bulgaria clinical leader (Maria Evgenieva) was on the second year of her maternity leave. She continued to support the central unit and the NHV teams on a part-time basis depending on her availability and urgent teams' needs. She has been providing ad-hoc consultations and partial clinical supervision to one of the team supervisors over the phone and has participated in some consultancy calls with NFP International. She has additionally provided 2 trainings to different team members: Program Overview training to the Site 2 health mediators and field workers, and the Core Foundations training to the new NHVs in Site 2 in an online format due to the Covid-19 restrictions. We expect her to re-join the central team in August 2021.

Overall program implementation has been led and monitored by the NFP Project Manager (Ivanka Puleva). Along with administrative and strategic responsibilities, she has continued to cover most of the Clinical Leader duties requiring direct involvement and supervision of the teams' working process (accompanied home visits, weekly reflective supervisions with team supervisors, observation supervision sessions between team supervisors and family nurses, regular feedback to team members, training need assessments, team meetings and guidance in case conferences, etc.). This working process has been regularly consulted and supported by the NFP International Consultant (Ann Rowe).

- Data analysis, reporting and evaluation:

NFP data analysis is coordinated by our part-time Data Analyst – a position that was assumed by a new TSA team member in January 2021 (Lyubka Georgieva). Along with the NFP data analysis duties (50%), she is also a Junior Program Officer in TSA's Family Economic Success Program. Her work is focused on increasing the chances of individuals from vulnerable communities to find work by acquiring marketable skills and experience. Prior to joining the Family Economic Success team, she coordinated the Equal Chance Program: Access to high school education. She also supported the grants management and compliance functions by assisting the team in the grant approval and monitoring process.

Since January 2021 Lyubka has been trained in the NFP data management and involved in an extensive handover process with her predecessor Petya Zeynelova, who has remained a TSA member but has taken on the position of Evaluation Officer. The new NFP Data Analyst will continue to be responsible for managing our online-based information system, monitor and guide the data collection process, extract and analyse data for all program needs. The Data Analyst has been participating regularly in the meetings of the NFP International Analytical and Research Group.

Our information system was developed in 2017 but gets ongoing improvements based on the field teams' feedback and needs, mainly for the purposes of quality improvement – both in terms of service delivery and data analysis. It is the Data Analyst who guides the process of the system upgrade by maintaining regular communication with the external IT support and development service provider.

Overall, the information system has proven to be a user-friendly instrument, which provides valuable and timely information to nurses, supervisors and central implementation team. It provides reporting on an individual, team and program level and is actively used to inform the work of the

field teams and the implementing agency. In 2020 we successfully implemented our plans to provide more training and guidance for nurses/supervisors to generate IS reports and use them regularly for informing their practice. Since April last year, every NHV has had a reflective supervision based on the IS data for her work – an innovation that has been introduced as part of our quality improvement plans for data-informed practice and has been integrated into the reflective supervisions on a quarterly basis.

In terms of program evaluation, the central team has almost finalized the process of having the formative evaluation completed by an external partner organization – Open Society Institute-Sofia. Two interim reports have been delivered in the reporting period – with a focus on clients and stakeholders' acceptability (more info in the respective section below). The final Feasibility and Acceptability report is expected in mid-2021.

In addition, and as an unexpected development, TSA applied for and was granted additional funding by an external donor (Swiss-based UBS Optimus Fund) to conduct a small-scale, quasi-experimental evaluation of NFP in Bulgaria, so as to compare participating mothers with a comparison group of mothers that meet eligibility requirements for the program. This will not be as robust as an RCT, but we feel that it will provide meaningful evidence concerning the impact of the program, which will help in our efforts to advocate for its adoption into nationally funded services.
TSA's Evaluation Officer is naturally very much involved in the current and future actions from the program evaluation process. The fact that she has been the NFP Data Analyst for more than 4 years and knows the program in detail will be beneficial for the quality of the study design and implementation.

- Service development/site support:

The reporting period turned out to be quite unusual for the program implementation and the support that local sites found themselves in need of. Due to the new working and social realities brought by the coronavirus pandemic, the service development was more of a service adaptation for most of 2020.

After the initial shock of the restrictions imposed in mid-March 2020, both NFP teams managed to restructure and adapt their work relatively quickly by switching to home-office mode and maintaining alternative contacts with the clients. All phone and online communication channels were used whenever possible and according to the clients' abilities and preferences – phone calls, chats, video and audio connection through apps like Viber, Messenger and Whatsapp, etc. Program materials were sent as picture attachments prior or during the alternative meetings. Health mediators and field workers visited the families that did not have access to phones or other mobile devices, and/or financial means to cover their phone and internet bills. Connection between those most vulnerable clients and their nurses was maintained through the phones of the field workers from the NFP teams.

Naturally, both program sites received enormous support from the central unit in this critical period – from a logistical viewpoint with the provision of personal protective equipment, office disinfectants, Covid-19 materials to be used with the families, but also with regards to guidance on

how to continue delivering the service with fidelity and care for the needs of each family. The NFP Telehealth Guidance was translated in Bulgarian, updated and sent out to NHVs in support of their unusual working process. Numerous team meetings were organized to discuss frustrations from the new way of working, fears of clients' attrition and engagement levels, pandemic impact on both - teams and families, etc. Support for the service delivery was also received by the NFP International trough the regular consultations and the Covid-19 report which shared knowledge and best practice approaches from other countries.

For most of last year, depending on the Covid-19 situation locally and nationally, NFP teams have switched on several occasions from entirely Telehealth visits to hybrid work mode (in-person home visits and Telehealth visits).

- Quality improvement:

A positive side effect of the pandemic turned out to be the increased and improved levels of communication between the central team and the NHVs. Due to the constant need for guidance and feedback because of the unusual program delivery circumstances, combined with the improved computer skills and software use by the nurses, online meetings with the Project Manager and the Data Analyst were almost a daily occurrence for the nurses in the period March-June 2020. This led to the general agreement within the whole NFP-Bulgaria team that the work-from-home period and the intensified communication could be used for paying more intentional attention to different quality improvement measures we have been wanting but had previously not had enough time to introduce in the program.

Thus, we decided to start holding regular **half-day long strategic meetings (both teams together with the central team) on a quarterly basis,** with the first meeting in the beginning of April (based on performance in Q1 – from January to March 2020).

The structure of those meetings is as follows:

- Data Analyst delivers a presentation on the data from the previous quarter – on national and site levels
- Presented data is commented and analysed by the nurses (why certain trends are there, what lies behind particular CMEs deviation, etc.)
- Based on the data from their collective performance, nurses identify areas for improvement of their work and the service delivery
- Based on the identified areas, nurses come up with 3 quarterly goals for the next quarter and indicators that would show if these goals have been achieved
- Overview of the goals' achievement is done at the beginning of the next quarterly strategic meeting with discussion of lessons learned – why certain goals have not been achieved, what they have learned in the process, how other goals were achieved, etc.

This quality improvement measure is **one of the main successes for NFP-Bulgaria in 2020** and has had a tremendous positive effect on various levels. On one hand these meetings empowered the nurses to also be in the role of decision-makers, not just implementors; they started feeling ownership of the program decisions and service delivery and shared that they felt more motivated

to chase particular outcomes for the duration of the quarter. On the other hand, the process of analysing their own data developed analytical skills and critical thinking among the nurses – they started seeing in practice the power of data-informed work. Despite some intensified discussions at times when setting the quarterly goals, nurses have shared that these meetings (combined for both teams) brought back the sense of unity and belonging to a common cause in times when physical team buildings and combined activities were not an option. And last but not least, the strategic meetings improved the data results for many of the initially problematic areas that have to do with CMEs or other aspects of the program (and would most probably lead to better client results in the long run).

In the process of organizing each strategic meeting, nurses were also involved in the preparation and required to send their own quarterly reports with data that is not being collected, reflections on their own work and suggestions for quarterly goals that could potentially be explored during the meetings. The central team had decided that this would be beneficial for the annual report as well since additional data that is traditionally reported but not collected in the IS would be collected on a regular basis with the NHVs' quarterly reports.

Additionally, as a continuation of the strategic meeting, each nurse and supervisor were required to dedicate **one of their weekly supervisions (following the Q meeting) to reflecting on the quarterly data report for her own work** (as mentioned above in the data section). The first few IS-based supervisions were led by the Data Analyst and were later taken over by the Team Supervisors. During those supervision sessions, nurses were not only required to take a look and analyse their own data but also to repeat on a smaller scale the decision-making from the team strategic meeting – she would identify areas for improving her own work and would set 2 individual personal goals for the quarter. Achievement of those goals gets later discussed during the next data-based supervision in the next quarter.

Nurses and supervisors got used to the strategic meetings on an individual and team level and demonstrate understanding of the need for such activities as well as the benefits for the working process. We have had 4 strategic meetings so far with positive results on a team level, such as:

- Retaining clients' engagement through Telehealth and after the renewal of the in-person visits
- Increased awareness among clients regarding the importance of following the babies' immunization calendar (including the creation of new facilitators on the topic)
- Percentages of some program areas aligned with program recommendations
- Defining a procedure for applying the list of vulnerability criteria and updating the clients' vulnerability status
- Revisions and improvements of the STAR framework, the registration form, etc.
- Adaptation of the referral to services form to be used as a tool for tracking fathers' progress, etc.

In another quality improvement effort, we found a way to make team meetings more focused and efficient. Instead of previous ad-hoc conversations and needs that were discussed with no particular order or teams expecting the Project Manager to come up with an agenda for the meeting, a

particular **structure of the team meetings was introduced** with the expectation that the team itself will be responsible for the content and the supervisor will have a leading role in the meeting.

Structure of team meetings:

1. Administrative issues (15 min)
   - Administrative needs of the team – documents / vacation / vouchers / transport cards, etc.
   - Materials and consumables needed for the office / nurses
   - Organizational and logistical issues - upcoming trainings / meetings / events, etc.
   - Administrative issues raised by TSA
2. Field work issues (15 min)
   - Clinical work issues
   - Information system / data collection issues
   - Questions and needs related to the field work
3. Top 1 of the past week – each team members shares something inspirational or memorable for her from the previous week (10 min)
4. Discussion topic – particular aspect of the program or the service delivery that nurses want to discuss /they have a list of identified areas and topics for discussions/ (45 min)
5. Choosing a topic for the next team meeting (5 min)

Another quality improvement effort targeting particularly the service delivery in Site 2 (Plovdiv) was focused on **capacity building for the 3 health mediators / field workers**. Due to the community specifics with majority of our clients speaking only Turkish and the mediators serving as interpreters in most of the home-visits, the central team designed and provided a **one-day training by a professional interpreter**. The training was delivered in September 2020 and had two components:

- NFP program overview with a focus on client recruitment and engagement – delivered by the Clinical Leader.
- Basics of interpretation (ethics and professional behavior, tips for efficient interpretation, specifics of the content, practical exercises) – delivered by a professional interpreter who has worked on translating all NFP program materials and is familiar with the NFP terminology.

Although the focus of the training were the mediators, the whole team of Site 2 was present and got involved in the exercises sharing real experience from home visits. Feedback from both nurses and mediators was positive immediately after the training and a few weeks later when implementing tips and knowledge from the training.

Sticking to the practice of having **reflective supervisions observed by the Project Manager and discussed with the Team Supervisor** on a 6-month basis contributed to the quality of the process, respectively of the work with the clients. Additionally, the Project Manager transferred the duty of accompanied home visits with the nurses back to the Team Supervisors (who should perform this task but had previously no experience in performing it) – after they had gained knowledge and confidence on how to deal with those visits and follow-up feedback to nurses, they started accompanying the NHVs either in person (in the summer months) or online (Telehealth visits).

- NFP Educators:

Currently, the Clinical Leader is the only educator qualified to deliver the NFP Core Education in Bulgaria. Due to the small size of the program here, all staff members are engaged in service delivery and have either reached or in the process of reaching full client capacity. Thus, it is not a reasonable solution to develop a particular team member solely as a NFP educator (as it is the practice in other countries with much larger scale of the program).

However, we have recognized the need to have an alternative NFP educator especially in situations like the last two years of the program implementation when the Clinical Leader was not fully available. This has created numerous difficulties with delivering the core education modules to new team members. As a result, the central team has decided to have one of the team supervisors (of Site 2) together with the Project Manager trained in the educator's role as an alternative for whenever the Clinical Leader might be unavailable.

- Other (please describe)

In terms of our implementing capacity and roles, another change within the central team needs to be mentioned. The TSA evaluation expert Dena Popova who worked in 2019 and early 2020 on the NFP Lessons Learnt Report has adopted the role of a part-time Communication Expert for NFP. In this capacity she has replaced our part-time Project Coordinator Olya Georgieva by covering her communication tasks since September 2020. Thus, for half of the reporting period Dena has been responsible for communication with media, articles and social media posts, NFP newsletter, organizing local and national advisory boards, managing our annual books donation campaign for the NFP babies, etc.

NFP implementation has continued to be overseen by the TSA First Foundations Program Officer (Iskra Stoykova) and CEO (Sarah Perrine).

Description of our local and national NFP funding arrangements:

In October 2020, TSA transitioned to a new 3-year financial period with most of its projects and activities (including NFP) continuing to be funded by our primary donor – the America for Bulgaria Foundation (ABF). So, officially now NFP has received guaranteed funding through September 2023. However, as already shared in the previous annual report, ABF has signalled that it will stop supporting the program after this period and its current funding would not cover the costs for Phase 3 being it an RCT or any other program evaluation.

With having this information well in advance, the central team has started exploring opportunities for additional funding and in October 2020 managed to win a grant by the UBS Optimus Foundations which has supplemented the ABF budget in two lines: expanding the Site 2 team with two more nurses (as the ABF grant covered the cost of just two NHVs and one SV) and conducting a small-scale quasi-experimental study of the program impact.

As we have a short timeline to ensure sustainability for NFP beyond 2023, we have already made inroads in our communication of the program with the Ministry of Health and the Ministry of Labour and Social Policy. We believe that there is a good chance to win national support through the state budget (more unlikely) or the EU funds operated by either of the ministries (more likely).

In addition, TSA has won a participation in the 3M Global Health Impact Program which matches pro bono consultants from the international 3M corporation with non-profit organizations that need support for some of their projects or activities. TSA had submitted a project for receiving pro bono guidance for marketing NFP to individual donors in Bulgaria and abroad. The project was approved, and we already started working with our team of pro bono consultants in two main directions:

- Building a strong NFP Bulgaria brand and brand recognition
- Marketing strategy for long-term engagement of individual contributors.

The project will last 8 weeks with final products expected by the first week of May 2021.

Current policy/government support for NFP:

In light of the financial sustainability pressure described above, we are committed to strengthen and expand our advocacy efforts towards adoption of the NFP service by either municipal or state authorities. In June 2020 we had a meeting with Plovdiv (Site 2) Deputy Mayor to gain municipal support for the program and explore potential interest for a joint application to attract EU funding for the local implementation of the program with a post-2023 horizon. The municipal authorities expressed support for NFP and confirmed readiness to cooperate with TSA when a suitable funding opportunity occurs in the near future.

Because of the pandemic which shifted entirely the focus of the Ministry of Health to Covid-related problems and solutions, our dialogue with the institution has witnessed a setback. Representatives of the ministry that we approached in the reporting period were not responsive and did not attend any of the events we organized, including the National Advisory Board meeting (which under normal circumstances is hosted by the Ministry).

However, since the second half of 2020 we got in closer and more regular communication with the Ministry of Labor and Social Policy. The central team had 3 meetings with representatives from the International Projects and EU Funds Department who got interested into the Program's details and offered some practical funding options for consideration in the next 3 years. One of the Deputy Ministers expressed further interest in NFP by participating in the 1st NFP International Seminar and by later attending the online National Advisory Board (NAB) in February 2021. In her speech during the board session, the Deputy Minister openly confirmed her support for the home-visiting service and described what sustainability options she saw ahead within the Ministry's range.

Besides the online NAB meeting, for the reporting period we also had 2 Local Advisory Boards (one per each site) in the same format and 2 more local ones in-person (early 2020). All events were well-attended with many stakeholders sharing positive opinion and support for the need of such a targeted service on a national level. We plan to build up this support by continuing intense communication with all national and municipal stakeholders - by additionally using practical and

evidence-based instruments such as the formative evaluation report (to be submitted by the research agency in mid-2021), the evaluation report (expected by the end of 2022), Bulgarian methodology of NFP (postponed for the end of 2021 because of Covid-19 and uncertainty of what is structured in the upcoming National Program for Maternal and Infant Health 2021-2030), Policy Brief (to be completed based on the guidance in the Bulgarian NFP methodology), video materials of the program implementation and clients' testimonials, etc.

For the past 1 year our communication, advocacy and visibility efforts included:

NFP Quarterly Newsletters

4 issues of the NFP newsletter in Bulgarian have been published and disseminated among the NFP mailing list which includes members of the National Advisory Board, Local Advisory Boards, NGO and medical specialists from across the country. The news highlighted in the 4 issues of the newspaper are:

- **April, 2020**
- NFP and TSA teams supported NFP families with humanitarian packages as the first COVID-19 lockdown was announced in Bulgaria in March, 2020
- Exchange of good practices at international level – the NFP team leads in Bulgaria visited the NFP team in Northern Ireland
- Providing accessible prenatal check-ups for pregnant women in one of the neighborhoods where NFP is implemented in Sofia
- **July, 2020**
- In a series of interviews posted on the TSA website and NFP Facebook page, key experts, members of the NFP NAB, shared their opinion about the need and impact of home-visiting care on the national level in Bulgaria and the benefits of NFP
- NFP home-visiting program was presented at the European Public Health Week
- NFP family nurses transition successfully to distance tele-health in times of pandemic
- **October, 2020**
- NFP was highlighted in the media as good practice for accessible health service
- Health mediators and field assistants from the Plovdiv NFP team took part in training to work in multilingual context and better support the family nurses
- NFP family nurses take an active part in quarterly strategic meetings for planning and reflections
- **January, 2021**
- Highlight about the 2nd national book donation campaign "Give a Fairy tale" which received more than 650 donated books from all over Bulgaria and a wide media outreach
- NFP-Bulgaria was presented at international academic conference on Public Health, organized by the Medical University in Pleven
- NFP-Bulgaria was selected for additional funding from Sofia Municipality to provide electronic devices and facilitate telehealth service with those mothers in greatest need
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NFP outreach in the media

Throughout the reported period, NFP was showcased as a good practice and example for accessible health and social service, especially for vulnerable communities in times of crisis. Two analytical knowledge pieces were developed by the NFP communication expert that covered:

- *Coronavirus and the New Dimensions of Poverty: Voices from Roma Neighborhoods in Bulgaria*, published in Bulgarian online newspaper, Dnevnik, reflecting on data collected by the family nurses in the first 50 days of the Pandemic in Bulgaria and providing key insights and giving voice to people from vulnerable communities. Republished in English by RoMoMatter project blog: https://romomatter.org/2020/05/21/coronavirus-and-the-new-dimensions-of-poverty-voices-from-roma-neighborhoods-in-bulgaria/
- *Bulgaria, Where Medicines Are Most Costly and Infant Mortality Is Highest in the European Union*, published 1st October in Dnevnik online newspaper – which presents NFP as example for accessible health service in Bulgaria and addresses the need to provide mechanisms for free and/or accessible medicines for pregnant women and children.
- *NFP showcased as good practice for home-visiting program on the Bulgarian National Radio,* 18.11.2020, when NFP Clinical Lead, Mariya Evgenieva and Plovdiv NFP team lead, Stanislava Simeonova participated in an hour-long interview in the program Night Horizont. The invitation was extended as a result of the Book Donation campaign outreach in the month of November. https://bnr.bg/post/101375834/proektat-zaedno-zdravo-bebe-zdravo-badeshte-podkrepa-mladi-maiki-ot-uazvimi-grupi
- As part of the National Book Donation Campaign – "Give a Fairytale" /Podari prikazka/, a total of 12 media published news about the campaign or disseminated information. One of the objectives this year was to place NFP program and the work of the Family nurses as the focus of the campaign.
    - 5 radio interviews
    - 5 news or information about the campaign published on online media websites
    - 1 interview given for uspelite.bg
    - 1 info blurb shared on the website of National Network for Children

NFP and the National Book Donation Campaign

Our campaign was launched on November 1st, a national holiday that celebrates culture and writers in Bulgaria, and was active throughout the month of November.

The objectives of the campaign were:

- Promote positive parenting and responsive care among the wider audience
- Promote early reading and learning through video recordings of favorite tales read by parents
- Find supporters from the general public that learn more about the NFP program and positive parenting
- Collect book donations to distribute among NFP families in need and surprise them and their children for the Christmas families
- Encourage early reading /telling stories to babies among NFP parents

More than 650 books were collected through donations that came from all corners of Bulgaria.

A key aspect of the second national campaign was inspiring more people to record and send their videos reading favorite children's books. A total of 9 videos from Bulgaria, USA, Spain were sent.

The posts and news about the campaign were reshared in other Facebook networks such as: Detski Knigi, National Network for Children, America for Bulgaria Foundation. All relevant posts to the campaign were indicated with #podariprikazka.

TSA's partner organization from Alicante, Spain – Tierra de Todas and FAGA – adapted the campaign among their girls' network and donated a package of 56 books for children (age 0-2) to the NFP families.

Children book author, Katerina Neynska, also supported the campaign, shared within her readers' network and send us a video reading an excerpt from her book.

NFP Communications Materials and Participation in Media and Other Initiatives

A short NFP presentation video was produced by the NFP team, both in English and in Bulgarian, that showcases the work of the family nurses on the field, as well as the objectives and results of the home-visiting program in Sofia and Plovdiv. The video has been shared at the National Advisory Board meeting in early February, as well as on the social media channels.

NFP was presented as a good practice at the Early Childhood Matters /ECM/ webinar, organized by TSA, Worldwide Orphans and For Our Children Foundation. The NFP Plovdiv team supervisor shared highlights about responsive caregiving elements incorporated in the NFP curriculum and work with parents (PIPE).

NFP mothers from Site 1 (2 clients) and field workers from Site 2 (2 mediators) were recruited as community bloggers to share unmediated stories and voices about social and health injustices in the COVID-19 context. They work closely with a co-journalist mentor from TSA and their stories are published on https://www.otherfrontline.org/stories/bulgaria/

NFP in the Social Media

NFP's main social media channel remains the Facebook page, where currently 9081 people have liked the page and 9114 follow the page.
On average, 2-posts-per-week get published, sharing relevant news about NFP activities, results, findings, as well as other relevant events, information and articles.
A new series of posts #резултатиТЕ /the results/ was launched in October, presenting posts that reflect positive outcomes and results from the NFP program, based on the ongoing data collection for the past 5 years.
Key news about the program are then reshared on the other TSA social media channels: Facebook, Instagram and LinkedIn.

NFP at a medical conference and published in medical literature

In November 2020, NFP-Bulgaria was presented at an international medical conference, organized by the Medical University-Pleven. The university later published material about our program in its

collection of reports (presented at the conference) titled "New Approaches in Public Health and Health Policy":
http://www.mu-pleven.bg/forms/dokladi_novi_podhodi_v_obshtestvenoto_zdrave_i_zdravnata%20politika.pdf
The publication is dedicated to the 15th anniversary of the MU's Public Health Department. In this collection of more than 400 pages, the special NFP report (starting on page 241) explains our progress with the service so far and concludes with the importance of having this kind of a home-visiting program on a national level. After our participation in the medical conference, this is yet another way to communicate our progress and goals to the medical community and the respective health institutions in Bulgaria.

NFP Communications – Challenges

A significant challenge for communications efforts is the lack of public debate on the topic of home-visiting services and the lack of interest from mainstream media to write longer pieces/feature stories on the work of NFP.
Due to the context of the Covid-19 pandemic and safety measures, it has been difficult to advance with the video production of the NFP presentation video (envisioned as a longer video with interviews) and wrap up the final cut.
It has been difficult to travel and keep track of personal storytelling from the NFP teams and families due to Covid-19.

How our NFP supervisor and nurse education is organised:

This question has been briefly touched upon in the "NFP Educators" section above. In addition to the information there, we can summarize that the nurse and supervisor core education since the start of the program has been mainly delivered by the NFP international consultant with the support of an interpreter. In the few instances of staff turnover, the NFP Clinical Leader has stepped in to provide the core trainings (two times for 3 new team members in total for previous reporting periods and 1 time through e-learning for 2 new team members in this reporting period.) The trainings follow entirely the NFP education plans – by days, presented content, case studies, collected feedback, etc.

In case the core education needs to be delivered by the new training team – Site 2 Supervisor and Project Manager when they are fully trained, the plan is for the Supervisor to have a leading role and cover most of the clinical and program delivery elements, case studies, etc. The Project Manager will only have a supporting role (due to lack of clinical/nursing experience) with a focus on the NFP theories, some CMEs, history and model of the program, NFP structure in Bulgaria, TSA's and partners' roles in the process, etc.

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

For the effective implementation of the program on local levels in both sites – mostly in terms of team support, TSA has continued to partner with two agencies (local NGOs) which provide psychological group supervision, social work consultations and continuous learning support to the NFP teams.

In Sofia (Site 1) our local NGO partner is HESED (Health & Social Development Foundation) and it provides services for supervisory psychological support to nurses and health mediators. A psychologist conducts group supervisions with the team on a monthly basis with an option for individual consultations with team members, if additional psychological support is needed.

In Plovdiv (Site 2) TSA has formally extended its partnership with NAVA (the National Alliance for Volunteer Action) whose commitments for psychological support are the same as those with HESED in Site 1. However, due to the relative remoteness of the second site from the central implementation team at TSA and the fact that the program is still gaining community and municipal support, the NAVA team is expanded to also include 1 part-time local coordinator (helping with local events and communication with stakeholders) and 1 part-time social worker (providing monthly consultations on case management).

Because the Site 2 implementing agency (University Hospital St. George) that formally employs the NFP team of NHVs and mediators operates with lengthy and very heavy administrative and financial procedures which would cause additional obstacles to the operational service delivery, NAVA has stepped in to be our partner whose budget accommodates all client-related expenses – for example, for medicines and medical examinations, health insurance, contraception, etc. This kind of administrative cooperation is extremely important for the efficient work of the nurses who can easily access those budgeted resources and cover urgent needs of the clients.

NAVA's psychologist is also engaged in the ongoing education plans for the Site 2 team with a total of 5 trainings which will take place in 2021.

Other relevant/important information regarding our NFP program:

PART TWO: PROGRAM IMPLEMENTATION

Clients

# of NFP clients participating in the program over the last year: 168 (2020)

- Current clients: Pregnancy phase (%): 24 (21%)
- Current clients: Infancy phase (%): 49 (43%)
- Current clients: Toddler phase (%): 42 (36%)

- Our national benchmark for % of eligible women referred/ notified who are successfully enrolled onto the program is _____% - we do not yet have a national benchmark. We enrol all clients who wish to be enrolled until we reach the full capacity of the teams.

- % of eligible women offered the program who have enrolled to date (over lifetime of the program): 68%

- Within this year the % of eligible women referred/ notified who were successfully enrolled in the program was 66%

  - Our reflections on this figure (including any consideration of an appropriate national benchmark): In 2020 there was a large turnover of staff which led to low capacity of the teams and this has resulted in enrolling less clients of the identified eligible clients. The trend has been the following: 2016/2017 - 64%; 2018 – 83%; 2019 – 81%; 2020 – 66%; we do not think that currently we need a benchmark as we will continue to enrol all clients who wish to be enrolled until we reach the full capacity of the teams.

Engagement of fathers/partners/other family members

- % of home visits, where father/partner is present: 6%

- % of home visits, where other family members are present: 16%

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

Fathers are present and active in 6% 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. When present, fathers remain mostly active in the pregnancy phase and are being engaged through facilitators and active discussion (especially in Q&A sessions where fathers ask questions they are interested in around parenthood and nurses respond). Partners generally approve and support clients' participation in the program. There have been cases where partners also look for direct support by the nurses in terms of re-enrolment in school or improving skills to find a job.

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

Clients' parents, mothers-in-law and other family members are also present and active in the home visits. This trend has remained even in the Telehealth period since many clients do not have their

own phone/device and use the ones of other family members. Nurses have continued to try reaching the whole family unit in their work and maintain good relations with the mothers-in-law, so they could get their support in influencing the life courses of our clients.

Nursing Workforce

Average nurse caseload:

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	7	2	5	15
# of staff who left during reporting period	2	1	0	3
% annual turnover	29%	50%	0%	20%
# of replacement staff hired during reporting period	3	1*	0	3
# of staff at end of reporting period:	7	2	5	15
# of vacant positions	1	0	0	1

*one of the nurses became a supervisor

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

Staff turnover continued to be one of the main challenges we faced in both sites in 2020. Despite all our efforts to retain the Site 2 Supervisor since the second half of 2019, she eventually decided to leave the program after we finding a suitable replacement. The central team spent a few months (April-June 2020) in recruitment efforts but could not identify a suitable candidate. As a result, we approached with an offer one of the Site 1 team members who demonstrated great potential for this leading role. She accepted and moved to Plovdiv to head the Site 2 team as of July 2020, and spent a two-week handover period with the leaving Supervisor.

However, this shift reduced the size of the Site 1 team which was additionally suffering the loss of another nurse (who left the program at around the same time but stayed on a part-time basis until November 2020 in order to complete the program with a few about-to-graduate clients). With these staff changes the size of the Site 1 team shrank from 5 nurses + 1 SV to 3 nurses + 1 SV. Naturally, this resulted in additional workload for the remaining nurses since both colleagues who left the team were at a full capacity of 20 clients. Over 30 clients had to be transferred to the other team members and the process was very difficult (especially given the Covid-19 context when most of the client-nurse communication was in the form of alternative contacts).

These changes also caused additional work for the central team in terms of nurse recruitment and possible training arrangements (obstructed on one hand by the limited availability of the NFP educator, and on the other hand by the Covid-19 restrictions and prospects for the need of online education).

- Successes/challenges with NFP nurse/supervisor recruitment:

Successes:

One of the main successes last year was the effective transition of the Site 1 nurse to the Supervisor's position in Site 2. In a very short run, she has proven to be the best possible choice – well accepted by the team members, skilful in terms of team management and knowledgeable in terms of program delivery and education, great fit for all SV's tasks.

Another major success was the attraction of external funding (UBS Optimus Foundation) for the expansion of the Site 2 team with 2 additional NHVs. This accordingly expanded the client recruitment capacity and granted opportunity for program to reach its full potential on a local level. Filling the two positions was relatively easier compared to our experience from 2019 and to the lack of success in finding new team additions for Site 1.

One of the new family nurses in Site 2 is a midwife with 30 years of experience and she joined the team on 1 November 2020. The second one is a nurse with an extensive experience both in nursing and social work – she joined the colleagues on 1 March 2021.

Challenges:

The main challenge we faced was caused by the Covid-19 and the way it impacted the whole medical field around the world but particularly in Bulgaria where acute deficiency of medical professionals was an enormous problem even before the pandemic. With the sky-rocketing needs of nurses in every hospital and medical institution around the country, recruiting for some for the available positions in the team turned out to be nearly impossible. Salaries of medical professionals everywhere got dramatically increased with coronavirus-related bonuses on top of those boosts. This robbed additionally the attractiveness of our NHV's job offer.

As we are limited by our budget arrangement, competing with the state salaries in the long run, is not an option at this point.

Covid-19 negatively impacted the nurse recruitment in another aspect as well. Besides the financial incentive in hospitals, nurses we approached with job offers shared they had fears to perform such a service which requires visiting families and communicating in close contact with many people (especially those from vulnerable groups where hygiene and living conditions are relatively poor). So, prevailing concerns of getting infected with the coronavirus while working on the field also resulted in insignificant number of CVs we received.

We spent 6 months in recruitment efforts for the 2 available positions in Site 1 and had 3 rounds of interviews with very few interested candidates. We offered the positions to a few selected ones which eventually turned the offers down.

One nurse signed a contract with us and decided to quit after a week because of another offer she had received in the meantime. A second nurse was about to sign a contract but refused in the very last moment – again, due an offer for a hospital-based position with a much higher salary.

Recruitment efforts are still on, the 2 positions we have been advertising remain yet unfilled.

- Any plans to address workforce issues:

The unexpected and uneasy working context that Covid-19 created led to frustration and anxiety among some of the NHVs and mediators. Thus, both teams will continue to receive structured psychological support through group consultations, but we have also arranged for an increased number of individual consultations, if some of the team members need additional support to cope with the difficult situations.

After the 2019 10% increase in the salaries of the Sofia nurses, last year we were able to offer the same boost for their colleagues in Plovdiv. Additionally, in the new financial period we have budgeted a 5% annual increase of all NHVs in the program.

Moreover, we explored opportunities within the partner hospitals whether NFP NHVs could receive additional salary bonuses (granted by the state budget for all medical staff working in a Covid-19 higher-risk environment). The Site 2 hospital agreed to include our NHVs in the list of medical staff receiving those bonuses monthly as of January 2021. We believe this would justly compensate our staff for their hard work in the current complicated context. However, the Site 1 hospital refused to include our staff in the respective bonus lists.

We will continue to support both teams with technical equipment, personal protective equipment, regular guidance and capacity building. When in-person gatherings and group events become safe enough to be organized, we will resume our team building and learning-exchange activities.

NFP education

- Briefly describe your NFP education curricula

In addition to the NFP Core Education modules, the NFP teams in Bulgaria receive 10 additional trainings that we have evaluated as providing key basic skills and knowledge for the adequate implementation of the program. Those are:

- Pregnancy and giving birth
- Prenatal psychology
- Attachment and bonding
- Early childhood development
- Depression scales
- Case management (also for mediators)
- Outreach and fieldwork (also for mediators)
- Social work and child protection (also for mediators)
- Domestic violence (IPV) (also for mediators)
- Nutrition – pregnancy, breastfeeding, baby nutrition

Both teams have gone through these essential trainings with just a few exceptions (the very new NHVs) who are yet to receive them by the end of 2021.

Along those education elements, Supervisors and the Clinical Lead/Project Manager continue to regularly assess the learning needs of the team members and find ways to respond accordingly – either through internal learning exchange or through external trainings. We plan to have a formal NFP-Bulgaria education curriculum as a final product by the end of 2022.

- Changes to NFP education since the last report

No changes have been introduced since the last report. There was a temporary modification – due to Covid-19 the Foundations training was modified to be delivered to the new NHVs in an online format (the training was delivered in half-day mode because of our awareness that a full-day screen time version would not be a feasible option). Some modules and practical exercises were delegated to the team Supervisor to conduct with the new nurses at another offline time.

Additional training was delivered to the health mediators/field workers in Site 2 (on interpretation during home visits) as such necessity was expressed by the team and assessed by the Supervisor. This was done in-person in the summer period when face-to-face events were allowed. The training was very useful and increased the quality of the interpretation, respectively the nurse-client communication, during the home visits.

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

Our main struggle for the period has been the delivery of the NFP Toddler training for the Site 2 team. It was initially planned for May 2020 (to be done in-person by our International Consultant). Covid-19 made those plans unrealistic, and we tried to reschedule the training according to the availability of our part-time Clinical Leader. We had the training scheduled and cancelled by the CL twice in the period August 2020 – February 2021. As of now, the Site 2 team (plus a NHVs from Sofia) has still not passed this core education element but has worked with toddlers for almost a year. We hope to fill this gap at the earliest convenience of our CL.

Online education delivery is another downside of the 2020 working environment. All participants in the online Foundations training, including the CL and the Project Manager, share the same opinion – that this format falls short of the effectiveness and robustness of the full in-person version. Still, it is a success that we managed to deliver it, so the new NHVs in Plovdiv can officially start working with their own clients.

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

Ongoing education was also negatively affected by the pandemic. All external trainings that the central team had planned for the first half of 2020 were cancelled – because of uncertainty around Covid-19, unpreparedness of the training providers to switch to e-learning, trainers and/or nurses getting infected by the coronavirus, etc. We hope to be able to do the trainings in 2021 (ASQ - black and grey zone intervention, ECD, practical breastfeeding consultation, etc.)

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

Induction training was done for the Site 2 mediators in 2019. Their program knowledge was refreshed with the NFP overview module during the interpretation training delivered in September 2020. Since we managed to do it in person at the program office, the whole team showed high

interest and concentration during the theoretical and practical parts and gave positive feedback of the training's applicability to their work.

Reflective Supervision

- Successes/challenges with NFP nurse reflective supervision:

Reflective supervision is one of the program areas that has been marked by a tremendous improvement in the last 12 months. After this key CME was re-integrated into the Site 1 practice and started making sense for the Site 2 team in 2019, last year the regular practice of those supervisions in both teams together with the feedback to the SVs from observed sessions with the NHVs has shown a great improvement of the quality of the reflective supervisions. Both sides in this practical element of the program – supervisors and nurses/mediators, have demonstrated in-depth understanding of the structure and the benefits of those supervisions not only for their emotional/mental state and ability to cope with difficult situations, but also for the final results with the clients.

The supervisors specifically have demonstrated improved NFP communication skills (open questions, reflections, affirmations, etc.) and ability to facilitate the dialogue in a constructive manner.

The online format of the supervisions (during Covid-19 lockdown periods) did not greatly disrupt their regularity or quality. On the contrary, nurses in Site 1 have shared that it has made the process even easier (because they typically face a limitation in terms of the premises, with the Site 1 program office only including a 1-room space and having 1-to-1 reflective supervision without other colleagues around is logistically hard to arrange).

The introduction of IS data-based supervision sessions every quarter as a promotion of the data-informed practice and a step for better program delivery is another major success we register in 2020.

One struggle that some NHVs still face in the reflective supervisions is the need to share too many client cases or topics at once, or the need to receive ready answers/directions from their supervisors. One area for improvement is the planning and preparation they make before the supervision sessions with a focus on their own plans for actions as a response to a case or a complicated situation they face. Additional guidance in that direction will be provided by the central unit and the team supervisors.

- Successes/challenges with reflective supervision to our supervisors:

In 2020 the responsibility for the reflective supervisions with the supervisors was transferred from the Clinical Lead to the Project Manager. The process of conducting regular sessions was smooth with the supervisors having no setbacks because of this handover. They have assessed the supervisions as very helpful in terms of receiving emotional relief, guidance for team management and program delivery.

A challenge in those supervisions have been the provision of clinical support to the team supervisors. Clinical needs and topics have not been very extensively represented in the weekly sessions due to limited experience of the Project Manager in the field.

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

In 2019, supervisions of the mediators in Site 1 were conducted by one of the NHVs as the part-time supervisor had recently assumed the role and had still a substantial number of clients. After gradually transferring most of the clients to the nurses, in mid-2020 the supervisor took back her leading role in the sessions with the mediators. Observed supervisions with those field workers from both teams have showed very positive results in terms of the quality of the trusting relationship with the supervisors and the quality of the discussions (concerns over performance, client recruitment, translation, community context, NHVs needs, etc.).

NFP Information System

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

Our NFP information system (IS) is an online based custom-build platform with a user-friendly interface, which facilitates data input on an ongoing basis by the NHVs, SVs and CL, based on their respective roles and responsibilities. The DA creates the profiles of CL, SV and NHV in that order, so that SVs are assigned to a specific CL and NHVs are assigned to a specific SV. This way the CL can see all data inputs from SVs that she works with and respectively the NHVs working with those supervisors. SVs can see all data inputs from the NHVs they are working with and can approve new clients in the IS or the change of status of existing clients. NHVs create the profiles of their clients and input data from home visits and data collection forms and can see information only about their own clients. The DA can see information input from all CLs, SVs and NHVs and is responsible for manually checking and approving (or returning for revision) each data form input by the NHVs.

Client and child data is anonymized by assigning a unique ID number to each client and to each child. The profile of each client consists of several separate tabs: Client- with basic information needed for enrolment and info about the pregnancy of the client; Child –birth outcomes (weight, length, APGAR, gestation week, etc); Visits – chronological information about each visit with the client and data forms collected within each visit; Client Profile – charts showing client's results in time points of assessment on some data points (e.g. smoking); Child Profile - charts showing child's results in time points of assessment on some data points (e.g. length and weight against quintiles).

The IS also generates automated reports with aggregated data (all clients) on most CMEs and other relevant data points under – Model Fidelity, Life Course Development, Maternal Health, Child Health Development and Environmental Health sections. The reporting on these data points updates automatically with each data entry and is available for each role in the IS with the same logic as described above about visibility of information – NHV can see aggregated data about all her clients; SV can see aggregated data about all her clients and clients of her NHVs, etc.

The IS allows for printing of data collection forms and can easily be adapted for mobile devices, so that the NHVs can input data in real time directly in the IS and afterwards print out the forms for the paper file of each client. At the moment this is an available and feasible option when using a computer in telehealth visits.

- Commentary on data completeness and/ or accuracy:

Data quality is guaranteed through automated checks in the IS developed in time and through experience of using the system. The DA also manually checks each submitted data collection form for accuracy and completeness. In addition, the DA works individually with each nurse (monitoring the work in the IS) on a biannual basis to check for data completeness, which has proven useful in identifying and correcting mistakes like systematically failing to collect a particular data collection form at a particular time point, failing to input collected data form in the IS, and inputting the same data form more than once. This monitoring practice has also helped in unifying the understanding of NHVs and SVs about some data points collected. The DA together with the Project Manager perform monitoring of the paper files of clients, usually after the monitoring of the work in the IS, which has also proven useful for the nurses in correcting identified mistakes but also in reconfirming and sharing good practices of data collection among team members.

Besides the role of the IS and the efforts of all team members involved, the data completeness and accuracy depend also on the willingness and in some cases the ability of clients to share information. In this regard, we have identified several areas where it is difficult to achieve full completeness of data or where accuracy and overall quality of collected data is questionable. Such areas are:

- housing conditions – clients are not willing to share all information and sometimes the nurses are not sure how accurate shared info is.
- income – clients rarely share such information.
- immunization – even information from doctors cannot be always trusted in this case.

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

Apart from the automatically generated reporting in the IS, which is available for all team members, in the beginning of April 2020, new practices were established, as planned in the previous Annual Report. Quarterly strategic meetings (QSM) are held with all NFP team members, where data reports and identified trends on national level of the program are discussed. The reports are specially prepared by the DA (based on the information from the IS) for the purposes of these meetings and made available a week in advance for all team members.

In addition, new reporting practice was established, where the NHVs and SVs are asked to fill in individual quarterly reports with data points not collected in the IS and some reflections on their work. The reflections of all NHVs and SVs are combined in a common document by the DA and shared with both teams prior to the QSM. Data from quarterly reports is combined by the DA in Site

reports, which are shared and discussed in a team meeting after the QSM with each Site separately. This data also feeds into the Annual Report and the Annual Data Report (ADR).

Reflective supervisions (RS) based on data from the IS are also performed on a quarterly basis with each NHV and SV. Individual reporting on each is reviewed in the IS, starting in April with an overview of all reporting and now continuing with focus on specific reporting section in the IS in each supervision. An individual report on some CME about each NHV and SV are also prepared by the DA and discussed at each reflective supervision based on data. This practice was established and performed by the DA with each NHV and SV, where SVs were also present at the supervisions with NHVs. Starting this calendar year, the RS based on data are now performed by the SVs with the NHVs and by the PM with the SVs. Prior to the transition a meeting was held between the PM, DA and SVs, to outline the main points that should be covered in the RS based on data.

With these practices, there are now regular quarterly discussions based on collected data on a national, Site and individual level. On a national level, the NFP Bulgaria team is asked to set 2-3 goals for next quarter, based on trends reported for the previous quarters and priorities identified by the NHVs through their reflections on the work with families. The meeting in April is based on the Annual Report rather than a quarterly report. The Site reports have a more planning role, where elements like weekly reflective supervisions, observations of RS, group supervisions, accompanied home visits with SVs and CL, training needs assessment, team meetings, case conferences, and educational sessions are discussed, regarding their regular occurrence as planned by the program and as possible to perform in the COVID 19 situation. In the first meetings, some national benchmarks on some of the elements were established, however, other benchmarks will be set in this year's quarterly meeting in April. The individual RS based on data gives more detailed information about the work of each NHV, both to her and to her SV, which allows for unifying the work of NHVs towards delivering the program with fidelity to the model and allows for personal adjustments where necessary. The NHVs are also asked to set 2 quarterly goals for themselves based on the data and trends about their individual work.

The form of all three types of quarterly meetings, as well as the additional quarterly reports are continuously discussed with the teams to shape them in the most useful and effective way to support their work.

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

The information system is regularly updated when data collection forms are changed. Additionally, some changes on the functionality and reporting in the IS are introduced on ongoing basis with the input from the NHVs and SVs. The changes are communicated by the DA; however, their implementation depends on the IT company that has created and maintains the IS. This sometimes translates to significant delays in the implementation. Changes in staff within the IT company also slows down the process as the system is quite complex and is based on the logic of the NFP program, which must be communicated with new staff members and sometimes leads to additional work needed and more delays. With that said, some changes are being implemented now and we are

expecting to have results within a month. Some of these changes have been communicated in the last months and some were communicated in 2018. The different complexity of needed changes also reflects on the speed of implementation.

Changes that need to be communicated with the IT team to be implemented in the future are:
STAR form to be taken outside of the home visits and into a separate tab within the client's profile, so that all information can be filled in within one electronic form, which will give a better overview on the client's progress. This will improve the functionality of the IS regarding STAR framework.
The calendar to be updated with new functionalities so that NHVs can use it to plan their working week more easily regarding home visits, administrative tasks, and individual / team events. This will improve the functionality and the usefulness of the IS for the NHVs and SVs.

Some data points need to be added to the reporting and the reporting on some data points needs to be modified to give clearer picture. This will improve the usefulness of the IS for the entire team.
Some changes discussed and agreed upon with the NHVs in the Client intake and Client intake – update forms need to be implemented. This will improve the accuracy of the collected data.
Some data points might need to be added to the full export of data to be more useful for reporting purposes.

Furthermore, data is not available in a time series and should be downloaded regularly (currently on quarterly basis). All reporting sections are downloaded for the entire program and for Site 1 and Site 2 separately, for the need of quarterly reports prepared by the DA, but also to be able to identify trends.

Description of our implementing agencies/sites:

- High level description of our implementing agencies/sites:

With a major legislative amendment from June 2020, the Bulgarian authorities finally allowed the establishment of independent practices by nurses and midwives. Until then, the law had stipulated that those medical professionals could only be employed by a hospital or a doctor. This new development might potentially facilitate the adoption of a home-visiting service such as NFP by the government (since the service would not necessarily require the involvement of hospitals or other huge medical institutions).

However, since 2016 TSA has worked in partnership with two major hospitals – formal employers of our NFP teams through grant agreements and formal implementing agencies of the program on a local level. As already operational, this arrangement will be kept till the end of the current TSA's financial period (through September 2023).

Sheynovo Hospital (Site 1 team employer)

Last year we continued our fruitful cooperation with Sheynovo Hospital. In October we have signed a new grant agreement for the beginning of the new financial period - until September 2021. The agreement is traditionally extended on an annual basis via grant annexes.

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 in the hospital premises, close to the main entrance – TSA pays a monthly rent to the hospital for the office space. The proximity to the hospital administration is convenient for the team in terms of receiving administrative support.

St. George University Hospital (Site 2 team employer)

St. George University Hospital is the largest hospital in the country with a total of over 2600 employees. It was one of the busiest medical institutions in terms of accommodating and treating Covid-19 patients not only from Plovdiv district but also from the whole South Bulgaria region.

The hospital team which facilitates the administrative support for the NFP program consists (as in the 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. This is the reason for our decision to transfer almost all budget expenses besides labor costs to the local NGO partner – NAVA.

In 2020 we kept our office (rental) in the central part of Plovdiv, closer to other service providers. The location is convenient for the nurses in terms of transportation to neighborhoods that are currently being served.

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

- Reflections on our successes/challenges with delivery of NFP through our implementing agencies/sites:

Successes:

Having these partnerships with two of the most well-known hospitals in Bulgaria brings additional credibility to the program and the results our teams achieve, especially when it comes to meetings with stakeholders such as doctors, external services, municipal or state authorities. Additionally, when attending our NFP events (such as the National Advisory Board) or external conferences, the senior management of those hospitals expresses valuable support for the home-visiting service and brings awareness/approval among attending medical professionals. All these instances are a good

promotion and advocacy for NFP and we plan to create more opportunities for this kind of gatherings that focus stakeholders' attention on NFP and build on its reputation, such as different ECD roundtables (6 for the next 3 years).

Particularly in the 2020 coronavirus context, it was a benefit for our team members to have been employed by a medical institution – this way they were among the first people in the country (as medical staff) to have access to the Covid-19 vaccines. As employees of the hospital in Site 2, our nurses had the chance to be included in the bonus lists for frontline workers and get monthly salary increase.

As for the program implementation generally, we marked a significant progress in Site 2 client recruitment. What seemed as a very hard and exhaustive process when we initiated the field work in February 2019, became a lot easier in 2020 (despite the Covid-19) as the program gained more recognition and trust among potential clients and the served communities on a local level. In the last few months, the Site 2 team has accumulated a waiting list of potential clients and efforts were made for speeding up the initial education process for the new NHVs, so they could start building their caseload.

Additionally, the NFP service gained more credibility among Site 2 medical practitioners working with Roma patients (GPs and obstetricians). In the last year we continued our fruitful partnership with a few doctors referring potential NFP clients. Referrals were received from other service providers as well (Child Protection units, Mother and Baby centers, etc.) and as a result we have more than 20% of the enrolled clients referred to the service by a third party. This working referral network on a local level is one of the program implementation successes for the last 12 months as well.

Challenges:

Most challenges in the program implementation area last year were caused by the coronavirus outbreak and will be listed below under the "Program adaptation" section.

Ongoing challenges, as mentioned in previous reports, had to do with:

- Low level of program engagement on the side of the hospitals
- Slow administrative procedures behind some operational needs of the NFP teams
- Communication obstacles due to language barrier between NHVs and clients in Site 2
- As a result of the previous – almost permanent need for a health mediator/field assistant to serve as an interpreter during the home visits
- As a result of the previous – more difficult for NHVs to establish and maintain trusting relationship with the clients
- Conservative and very religious families in Site 2 – leads to the need to adapt some aspects of the program delivery to the local context (for example cancel almost all home visits for a month – for the duration of the Muslim holiday Ramadan; or not discuss the topics of contraception as it is considered a taboo among a great number of families, etc.)
- Migration abroad – this we faced on a smaller scale in the reporting period because of the negative effect Covid-19 had on crossing borders and people's movement in general.

However, after the first more limiting period of the pandemic, migration among families of our clients resumed.

- Clients living in extreme poverty and poor living conditions (exacerbated as a result of the coronavirus crisis) – again, at times nurses faced exhaustion, doubt and reluctance to enrol into the program and work with such clients.

Program adaptation

- Brief description of our program adaptation processes:

Whenever an important program adaptation is needed due to country/community context or client specifics, usually our approach is the following:

- Adaptation need is assessed and raised by the NFP field team
- The issue is discussed within the central team
- Adaptations are carefully planned
- Plan is discussed with TSA management
- All this is consulted with NFP international consultant and, if needed, with UCD (prof. Olds)

So far, program implementation in Bulgaria has been adapted to include free medicines for pregnant clients and for babies; coverage of prenatal check-ups or health insurance until birth; introduction of the health mediators as a CME for Bulgaria, etc.

- Adaptations undertaken during this reporting period and outcomes (successes and challenges) of these:

The only adaptation that was necessary in the reporting period had to do with the way our service was delivered to the clients during the time of the coronavirus pandemic. Adaptation of the working process was done on a daily and weekly basis at the beginning of the crisis at the end of March last year with the introduction of the Telehealth method. Every step of the way, together with feedback on successes and challenges has been shared with the NFP international consultant.

What we did in the last 12 months to adapt the program delivery to the ever-changing context went through the following phases:

- March-May – home office work for the NFP teams: home visits were replaced by alternative contacts with the clients (either through phone calls and messages or through mobile apps such as Viber and Whatsapp). Program materials were photographed and sent over the devices to be used in the phone/online conversations. Things were a bit more complicated for the Site 2 nurses where the intervention of a mediator as interpreter was also necessary. Conference calls were often used or the physical presence of the mediators at the clients' homes (by observing safety measures). Health mediators in both locations were used for reaching out to the poorest families without any access to phones or other communication devices.
- June-September – NFP teams resumed almost all in-person home visits with just occasional use of Telehealth.

- October-December – with the second wave of the coronavirus infection in Bulgaria, teams went back to increasing the percentage of the Telehealth visits in comparison to the real ones at the clients' homes. These were being performed in certain cases such as newly enrolled clients or clients with particular vulnerabilities requiring closer monitoring.
- January-March 2021 – almost entirely conducting in-person home visits due to a few reassuring factors such as: a number of NHVs went through the infection and had antibodies, Covid-19 vaccines were already available in the country, general statistics did not show very disturbing figures.
- Since mid-March 2021 – marked the beginning of the third wave which hit with an increasing number of cases, not enough vaccines being delivered (and choices available) and a new lockdown with restrictive measures from March 22. NFP teams switched once again almost entirely to Telehealth.

- Adaptations planned for next 12 months

To better serve our (mostly) Turkish-speaking clients in Site 2, we plan to:

- Assess which are the most frequently used facilitators in the different program phases and domains
- If feasible, reduce the text content and translate into Turkish
- If feasible, add more pictures which would help the clients understand the topic
- Get feedback on the adapted materials from a few moms before finalizing the last versions of the facilitators
- Start using those facilitators in the everyday work

On a more strategic level, in the next 12 months we would like to see the adaptation of the Bulgarian NFP methodology completed. This process was put on hold because of a few fundamental uncertainties around possible structuring of the NFP in the systems of health and social services on a municipal and/or national level. Government decision needs to be taken on a few strategic documents which would bring clarity to the way NFP could be framed and positioned as a state-delivered integrated service. This will probably take place after the general elections set on 4th April 2021. We still have our contractual relations with the ECD expert from the National Center for Public Health and Analysis (a unit of the Ministry of Health) who updates us with any progress on the issue and is ready to resume working on the methodology depending on the government's decisions.

- Reflections on successes and challenges with our adaptation approach:

Successes:

Our major 2020 success is the fact we were able to adapt the NFP service delivery quickly and efficiently to the unprecedented situation created by Covid-19. There was a huge uncertainty among all team members about the ability to work from a distance in a service which is based on the in-person presence and communication at the homes of the clients. Concerns were additionally increased by the specifics of the communities we serve and our NFP families in particular (poor living conditions, lack of communication devices, etc.). However, not only did we manage to adapt to the situation, establish and maintain relatively stable telehealth contact with the families, but

we also registered a great deal of positive feedback and appreciation by the clients that they were not abandoned in those challenging times of a worldwide crisis. For most of the period of the first lockdown in Bulgaria when authorities limited the access to regular check-ups for pregnant women and babies and additionally restricted through police checkpoints the movement outside of Roma neighbourhoods in Sofia and Plovdiv, the contacts with the NFP nurses were the only access to medical consultation and support for almost all of our clients.

This also leads to another huge success of the program in the last 12 months – despite our fears of a high drop-out rate among clients because of this unusual and hard for many of them program delivery process, we did not face any client attrition. On the contrary, we managed to enrol new clients who started building their relationships with the nurses from a distance and had the chance to physically see each other months after their enrolment.

Along with program delivery, teams were also monitoring the Covid-19 impact within families in the intervention. We managed to set up a system of regularly collecting data on the family situations, challenges and needs. Thus, we were able to take data-informed decisions on what priorities would lead our teams in their work during the pandemic. This also helped us to analyse the situation, mobilize resources to raise awareness on what Roma families go through within the general public via posts and articles in different media, and also share these learned lessons with NFP International under the Covid-19 international project.

In April 2020 when witnessing the deteriorating economic situation of many NFP families due to Covid-related loss of employment and income, we utilized donations and NFP emergency funds to provide in-kind support (food packages to all pregnant women and babies, and hygiene materials to all families in the program). This kind of support was also distributed in February 2021.

Also, the introduction of Telehealth was a completely new experience for the nurses – challenging them to improve their computer literacy, communication skills, creativity in terms of finding new ways to keep clients engaged. The Telehealth method additionally exposed them to a way of working they had never used in their practice before – digital medicine, which is still a very innovative area for Bulgarian medical experts.

Challenges:

Most challenges the teams have faced in the last 12 months were related to the need for efficient communication with the clients on one hand and the desire to respond to the difficulties families experienced during the pandemic.

When Covid-19 crossed the borders of Bulgaria and work had to be reorganized, each NFP nurse realized that a few of her clients did not have any access to a phone or any other communication device. This led to frustration and creativity on possible ways to reach those clients who are usually in greatest need of the service, so they do not feel abandoned in the hardest of all hard situations they have faced.

Additionally, the loss of employment and income of 40% of our families, also meant loss of financial means to cover their phone and/or internet bills. This led once again to the lack of adequate communication with some families and finding ways to reach them on a regular basis.

The communication gap caused by the lack of devices was actually an abyss for the Site 2 team – due to the language barrier and the need to include online interpretation into the telehealth

consultations. Despite working decisions that were taken and used on a daily basis, both the central and the field NFP teams are concerned about the quality of the work being conducted with those families in Plovdiv, which due of Covid-19 so far have received and will have received by the end of this year a bigger share of telehealth program delivery than the usual home-visiting delivery.

Along with the concerns for the physical survival of the clients and their families, nurses shared concerns about the moms' mental health and resilience in the Covid-19 context. Telehealth assessment demonstrated increased levels of anxiety and depression in the families, as well as a rising number of IPV cases. Nurses tried to do their best to respond to those challenges and support the clients from a distance, but they felt they had very limited resources and capacity to do it in an adequate way.

Any other relevant information:

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

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

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

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% voluntary participation Monitored /assured by: signed informed consent form.	100% voluntary participation	We do not have challenges with voluntary participation as our program is not enforced by any governmental agency. All clients are recruited on voluntary basis. A challenge is the opposite, when the client wants to enroll but one or more family members do not approve of her enrollment.
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: health mediators, who personally know the families and pregnant women, first visit by the nurse and signed informed consent form.	99,58% first time mothers	We have two clients who were enrolled in the program with their second pregnancy with the permission of the CL. One client's baby was born with congenital heart defect and died at three months and the mother did not have the chance to care for the baby. Another client lost the first pregnancy and was enrolled with her second pregnancy. Only one of

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			the clients had a previous live birth.
3. Client meets socioeconomic disadvantage criteria at intake	The eligibility criteria for inclusion in the program in our country are: • Expectant mothers up to 22 years old; • No previous live births; • Pregnancy by 28th gestation week. This includes the socio-economic criteria of: • Living in a Roma segregated community and/or economically disadvantage (personal monthly income is less than the minimal monthly salary); Application of these criteria are assured and monitored by: health mediators, who personally know the families and pregnant women, first visit by the nurse, medical documentation about the pregnancy and the SV.	96% clients enrolled who meet the country's eligibility criteria (1 client with second live birth and 9 clients enrolled after 28th gestation week). We do not have reliable data on socio-economic criteria for those living in Roma segregated communities.	No exceptions are made about the age limit. It was raised from 19 to 22 years old women. One exception to the criteria stipulating no previous live births was made for a woman, who lost her baby before she had the chance to care for the baby outside of NICU. A exception to the 28th gestation week rule was made in Plovdiv, where recruitment in 2019 was very slow. In the last year when the recruitment was no longer an issue, it was decided not to make more excerptions. One exception however was made for a family where the daughter and the daughter-in-law were both pregnant, but one was past 28th g.w. Both women were enrolled in this case. There are women who live in the segregated Roma communities but are not economically

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			disadvantaged. It was decided that they will be enrolled as well, because there was a risk of stigma for the program, that it is only for "poor people", which once established will defer even women in need, as they also try to differentiate from their socio-economic status. Some of the harmful practices in child rearing in the Roma communities do not depend on the socio-economic status, but rather on the culture and traditions observed in each community.
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	a) 96% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 68% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 39% of pregnant women are enrolled by 16 weeks' gestation or earlier in the program. In the previous reporting period 46% of new clients were enrolled by 16 weeks' gestation or earlier. In the current reporting period, 39% of the	a) From now on, clients who cannot receive their first home visit before or at 28th week of pregnancy will not be enrolled, with the rare exceptions like the one mentioned above. b) 66% of eligible clients referred to the program were enrolled. The percentage is lower than last year, and the average and it is probably due to staff turnover and low capacity of the teams during the year.

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		new clients are enrolled by 16 weeks' gestation or earlier.	c) We still do not have a national benchmark for enrolling women by 16 weeks' gestation or earlier, however, the trend has been: - 2016/2017 – 30% (19/64) - 2018 – 41% (11/27) - 2019 – 53% (33/62) - 2020/2021 – 35% (29/83)
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned a single NFP nurse.	100% clients are assigned a single NFP nurse.	The turnover of staff means that clients are transferred to a different nurse and in some cases (1) the clients leave the program when her nurse leaves. Nurses also report difficulties with establishing good trusting relationship with the client of another nurse. We have taken steps to have the initial nurse introduce the newly assigned nurse to the client, so that the transition is made easier for the client.
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.	Current National benchmark is: ____% visits take place in the home - we do not have such benchmark.	93% 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	Overall, about 90% of all visits before the pandemic were home visits. Within the last reporting period only 49% (1445) of visits have been actual home visits and 51% (1495) have been conducted through telehealth (THV). We have yet to get more reporting on telehealth visits and establish what

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		school for enrollment in educational program. In the last year the nurses have been conducting visits outside of the house (in the yard or garden), in the park and in some cases in a café with outdoor sitting.	is the range and mean of time spent in such visits, how is it conducted (telephone call, video call, chat) and how many other people are present at this type of visits. In the second quarter we set a minimum time spent in THV to 15 min as it was new way of communicating both for nurses and clients. The actual mean time spent in THVs for that quarter was 25 minutes.
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.	Current National benchmarks for: a) Program visit dosage patterns in relation to client strengths and risks benchmarks are: We do not have benchmarks for program visit dosage for clients who are on alternative visit schedule, as these are exceptions. b) Length of visits by phase country benchmarks are: • Pregnancy phase: • Infancy phase: • Toddler phase: We do not have benchmark for length of visits per phase. The benchmark for all periods is between 60 and 90 minutes with regular home visits.	a) Program visit dosage • 98% of clients being visited on standard visit schedule. • Average number of visits by program phase for clients on standard visit schedule is: in total 55 (based on data for the 69 graduated clients). – Pregnancy phase: 11 (95%) – Infancy phase: 24 (87%) – Toddler phase: 19 (87%) • 2% of clients being visited on alternate visit schedule. • Average number of visits by program phase for clients on alternate visit schedule is - such data is not available as no client is visited on alternate visit schedule	a) Most clients are visited on standard visit schedule and where schedules are renegotiated with clients, those who need more visits are usually visited on weekly basis rather than biweekly, and those who need less visits are visited once rather than twice a month. The alternative schedules are renegotiated when needed between the client and the nurse and this is also consulted with the SV. Data on this point is collected quarterly and there are between 3 and 4 such cases per quarter. In the last three quarters of 2020 there were between 1 and 2 cases of lower dosage and between 2 and 3 cases of clients receiving more

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	c) Client attrition by program phase country benchmarks are: 90% attrition in Pregnancy phase 70% attrition in Infancy phase 60% attrition in Toddler phase	for the entire program duration. b) Length of visits by phase (average and range): • Pregnancy phase: • Infancy phase: • Toddler phase: Data by program phase is not available. The average length of home visit is 68 minutes (6 min. the shortest and 300 min. the longest) c) Client attrition by phase and reasons: 91% attrition in Pregnancy phase 81% attrition in Infancy phase 77% attrition in Toddler phase	frequent visits. b) We are currently interested in data on length of telehealth visits. This will be considered in updating the reporting of the IS. C) There is a considerable difference in attrition rates in Sofia (80%) and Plovdiv (71%), as migration rates of Plovdiv clients to other EU countries continues to be high. Our attrition rates are still within the benchmarks we use, however, if the trends in Plovdiv within pregnancy phase continue, we will fall below the benchmark in the next reporting period. 12 out of 22 cases of clients leaving the program in pregnancy are from Plovdiv within 2 years, compared to 10 cases in Sofia within 4 years.
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by (e.g. standardized job description) - standardized job description; a copy of diploma is submitted upon signing of job contract. Countries may also want to analyze other	100% NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree.	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. Most of our NHVs have 2.5 or 3.5 years of training in Nursing or Midwifery. However, many of them

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	nurse variables such as age, years within profession, specialist qualifications etc.		have bachelor's or master's degree in other majors (public health, health management, psychology, economics, etc.).
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula 117% of NFP team meetings and case conferences are completed (against expected for the period April – December 2020) Data on team education sessions is not gathered at present.	33% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities. 172% completion of team meetings, 61% completion of case conference and % completion of education sessions – N/A	Three of the 9 NHVs and SVs have all required trainings completed. Teams needed more guidance on case conferences and in Sofia they were happening almost on a regular basis in the last three quarters of 2020 (78% of expected). In some cases, the team in Sofia has a short team meeting + case conference. In Plovdiv, however, due to staff turnover, the team still has not started regularly conducting case conferences and has team meetings instead. These are also the reasons for having more than meetings than expected for the reporting period.
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	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.	Please complete the section at the end of this table*. .

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
apportioning time appropriately across the five program domains.			
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	100% of 4-monthly Accompanied Home Visits completed (against expected). Nurses are expected to have 1 AHV with an SV each quarter and 1 AHV with CL every 6 months, which is a total of 6 AHV a year per nurse. This benchmark might need revision.	11% of 4-monthly Accompanied Home Visits completed (in the period April – December 2020).	3 AHV were made in the beginning of 2020 in the Sofia team, one with the future SV of Plovdiv Team. After the health crisis with COVID 19 started in March the AHV were postponed and only 4 AHV were conducted in Plovdiv by the SV with the two new nurses.
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100% of NFP teams have an assigned NFP Supervisor 100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurses). The minimum reflective supervisions (RS) per quarter include: 8 RS by SV for NHVs and by CL for SVs; 1 RS based on individual data report; 3 RS by psychologist for SVs and 3 group RS by psychologist for NHVs.	100% of NFP teams have an assigned NFP Supervisor 68%* of reflective supervision sessions conducted. *data covers the period April 2020 – December 2020. January – March 2020 was covered in the previous report.	Both teams have started having regular reflective supervisions. One challenge has been the lack of full-time CL to conduct regular reflective supervisions with SVs. Another challenge, which has affected the number of conducted reflective supervisions, has been the fact that some of the nurses also had COVID 19 and were on sick leave in the reporting period.
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform	No benchmark. Data is collected through an online based custom-build platform. Monitored/assured by: Data collection is	Progress: Within last reported period new regular quarterly based procedures were established to utilize data for fidelity of implementation and quality improvement purposes. Data reports are prepared by the DA on	So far, the quarterly meetings on all levels have proven successful in monitoring and guiding implementation of the program with fidelity and quality improvement. The work on

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.	monitored by automated checks in the IS, Data Analyst, SVs and PM on ongoing basis and through biannual monitoring visits to Site teams.	national, team and individual level and discussed on quarterly basis respectively. New data reports on data points not gathered in the IS were also established and used on quarterly basis in the discussions.	finetuning all abovementioned reports is ongoing to make them more functional and useful for Site teams and national implementing agency.
14. High quality NFP implementation is developed and sustained through national and local organized support	100% of Advisory Boards or equivalents held in relation to expected (8 per year – 6 LABs I the two Sites and 2 NABs). 100% attendance at Advisory Boards held in relation to expected (5 government officials per meeting). Monitored/assured by (including other measures used to assure high quality implementation): attendance sheets; photos of meetings.	38% of Advisory Boards or equivalents - 2 LABs – one in each location and 1 NAB. 127% (19 out of 15 expected) attendance at Advisory Boards	

Domain coverage*

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

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35-40%	52% ↑	14-20%	15%	10-15%	12%
Maternal Role (My Child and Me)	23-25%	22% ↓	45-50%	55%↓	40-45%	48%↓
Environmental Health (My Home)	5-7%	7% ↑	7-10%	8%↑	7-10%	11%

My Family & Friends (Family & Friends)	10-15%	8% ↑	10-15%	10%↑	10-15%	13%
Life Course Development (My Life)	10-15%	11%	10-15%	12%	18-20%	16%↑

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):
In red are the percentages that do not fit within the set benchmarks and the arrows show the tendencies in comparison to the results from last reporting period. The negative trend of increase of the Personal Health domain in pregnancy, which is already well above the set benchmark might be due to the health crisis, which started last year and has marked the entire reporting period. This trend could also be in part because of the high percentage (11%) of new clients enrolled after 28th gestation week, which leaves less time to discuss other topics, and from our experience we know that clients are interested at first in the health-related topics. These might also be the reasons behind the trend of lower percentage in the Maternal Role domain, which has fallen just below the benchmark.
Quarterly discussions of data reports on program and individual level might be the reasons behind the positive trends of lowering and increasing percentages in several domains towards the benchmarks. In both types of discussions, the percentage of time spent on each domain has been one of the central topics and the results are visible on both individual and team level.

PART THREE: PROGRAM IMPACTS

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

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

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

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)**	**Current Period (n/%)**
Age (range and mean)	Range: 13-21; mean 16 13 – 5/3% 14 – 16/9% 15 – 35/21% 16 – 31/18% 17 – 23/13,5% 18 – 23/13,5% 19 – 26/15% 20 – 6/3,5% 21 – 6/3,5%	Range: 12-21; mean 16 12 – 1/0,4% 13 – 7/3% 14 – 19/8% 15 – 47/20% 16 – 45/19% 17 – 38/16% 18 – 28/12% 19 – 32/13% 20 – 11/4,6% 21 – 9/4%
Race/ethnicity distribution	Bulgarian – 7/4% Roma – 141/82,5% Turkish – 23/13,5%	Bulgarian – 12/5% Roma – 165/70% Turkish – 60/25%
Father involvement with client	In 7% of the visits in pregnancy	In 9% of the visits in pregnancy
Income (please state how this is defined)	1/1% of 62% who shared info have income above minimum monthly income.	1/1% of 62% who shared info have income above minimum monthly income.
Inadequate Housing (please define) - **No running water.**	75/45%	90/38%
Educational Achievement	28/16% (have completed or are still in high school or higher education)	39/16% (have completed or are still in high school or higher education)
Employment	5/3%	7/3%

Food Insecurity (please define)	N/A	N/A
Ever in the care of the State (as a child or currently)	4/2%	2%
Obesity (BMI of 30 or more)	3/2%	4/2%
Severe Obesity (BMI of 40 or more)	0/0%	0/0%
Underweight (BMI of 18.5 or less)	41/24%	57/24%
Heart Disease	6/4%	6/3%
Hypertension	5/3%	5/2%
Diabetes – T1	0	0
Diabetes – T2	0	0
Kidney disease	10/6%	11/5%
Epilepsy	1/0,6%	1/0,4%
Sickle cell Disease	0	0
Chronic Gastrointestinal disease	0	0
Asthma/other chronic pulmonary Disease	4/2%	4/2%
Chronic Urinary Tract Infections	4/2% (14/8% - during pregnancy)	5/2% (16/4% - during pregnancy)
Chronic Vaginal Infections (e.g., yeast infections)	8/5% (16/10% - during pregnancy)	11/5% (29/12% - during pregnancy)
Sexually Transmitted Infections	2/1% (4/2% - during pregnancy)	2/1% (5/2% - during pregnancy)
Substance Use Disorder	0	0
Mental Illness	2/1%	2/1%
Other (please define)	1/0,6% (Anemia)	2/0,8% (Anemia)

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

Trends for STAR*

Personal Health:

- There is a negative increase of clients with high and moderate risk about Substance Use and Abuse. We mark the highest increase by 3% during Infancy 8 gestation week, compared to the last reporting period.
- There is a positive decrease of clients with Pregnancy Complication and/or Chronic Illness marked by 5% at Pregnancy 36 gestation week. However, there is an increase by 5% at Infancy 8 and 12 gestation weeks.

- During the 4th visit we observe a decrease by 3% of clients assessed with high or moderate risk with Dev. and Intellectual Disability. However, there is an increase by 9% and 5% during Infancy 8 and 12 gestation weeks.

Maternal Role:

- There is a decrease by 3 of clients assessed with high or moderate risk about Caregiving Attitudes and Behaviours during visit 4.
- In terms of Child Health and Development, there is a decrease by 3% at Toddler 18 gestation week.
- At Infancy 8 gestation weeks, we also mark a decrease by 3 % when it comes to clients assessed with high or moderate risk about Child Care.

Environmental Health:

- There is a decrease by 5% of clients assessed with high or moderate risk at Visit 4 when it comes to Maternal Education and Work.
- There is a decrease by 4% of clients assessed with high or moderate risk at Visit 4 when it comes to Literacy Limitations
- There is no change in the data related to Criminal Justice/Legal Issues.
- When assessing the clients about the risk of Loneliness and Social Isolation, there is a decrease by 3% of clients assessed with high or moderate risk at Visit 4 and Toddler 18 gestation weeks.

My Family and Friends

- According to the data from this period, the percent of clients assessed with high or moderate risk of Intimate Partner Violence have decreased by 2% at Pregnancy 36 gestation week and Toddler 18 gestation weeks compared to the data in 2019 year.
- In terms of the risk of Unsafe Family or Friend Network, the percent of clients assessed with high or moderate risk has increased by 3% and 2% at Infancy 12 and Toddler 18 gestation weeks.

Life Course and Development

- Compared with the data in 2019, in 2020 we observe a decrease by 6% of the girls with a high or moderate risk of Economic Adversity at Toddler 18 gestation weeks. However, we see at Infancy 12 gestation weeks that the percent has increased by 9% compared to the data in 2019 year.
- At Toddler 18 gestation weeks, we observe a decrease by 3% of the clients when it comes to the risk of Homelessness and Residential Instability.
- A decrease by 6% is observed at a risk of Environmental Health at Toddler 18 gestation weeks.

- There is also a decrease by 3% at risk of Home Safety during visit 4.

Health and Social Services

- There is a significant decrease by 5% of clients assessed at the risk of Health Services Utilization at Toddler 18 gestation weeks.
- We observe a decrease by 9 % of clients assessed with high or moderate risk of Use of Other Community Services at Toddler 18 gestation weeks.

*The information above is based on data in 2019 and 2020.

Alterable Maternal Behaviour/ program impacts for clients (please complete for all the time periods where the data is collected)					
	Intake	**36 Weeks of Pregnancy**	**Postpartum**	**12 months**	**18 months**
Anxiety (n, % moderate + clinical range) *mild + severe anxiety	33/15%	16/9%	34/17%	1/1%	4/5%
Depression, (n, % moderate + clinical range) *moderate + moderately severe + severe depression	7/3%	5/3%	7/4%	0/0%	2/3%
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours)	75/32% 6 cigarettes	52/30% 4 cigarettes	N/A	48/43% 6 cigarettes	25/38%, 6 cigarettes *At 24 months
Alcohol, (n, % during pregnancy, units/last 14 days)	8/4% 1 drink	0/0% 0 drink	N/A	3/3% 1 drink	3/5%, 1 drink *At 24 months
Marijuana, (n, % used in pregnancy, days used last 14 days)	4/2% 0 days/0 units	1/1% 1 days/0 units	N/A	1/1% 0 days/1 units	0/0%, 0 days/0 units *At 24 months
Cocaine, (n, % used in pregnancy, days used last 14 days)	0	1/1%, 1 time	N/A	1/1%, 10 times	0
Other street drugs, (n, % used in pregnancy, days used last 14 days)	0	1/1%, 1 time	N/A	0	0

Excessive Weight Gain from baseline BMI - Pregnancy, (n, %)	N/A	N/A	N/A	N/A	N/A
Mastery, (n, mean)	14	14	15	16	17
IPV disclosure, (n, %)	16/8%	7/4%	N/A	10/9%	N/A
	6 Months	**12 Months**	**18 months**	**24 Months**	
Reliable Birth Control use, (n, %)	99/66%	78/68%	58/77%	49/77%	
Subsequent pregnancies, (n, %)	6/4%	15/13%	16/21%	24/33%	
Breast Feeding, (n, %)	65/43%	33/29%	17/22%	11/17%	
Involvement in Education, (n, %)	3/2%	3/3%	¾%	3/5%	
Employed, (n, %)	1/1%	0	4/5%	4/6%	
Housing needs, (n, %)	1. 79/53% 2. 65/43% 3. 49/33%	1. 63/55% 2. 45/39% 3. 40/35%	1. 52/69% 2. 37/49% 3. 30/40%	1. 49/77% 2. 34/53% 3. 24/38%	**1. No running water.** **2. No central sewage.** **3. No inside toilet.**
DANCE (or equivalent), (mean - 2, 9, 15, 22 mos.)	N/A	N/A	N/A	N/A	
Father's involvement in care of child, (n, %)	N/A	N/A	N/A	N/A	
Other (please define)					

Please comment below on the program impacts for clients, as indicated by the data provided (include comparisons where possible e.g. to previous years, to rates achieved in RCT, to equivalent populations etc)**:** *Please see data report for more detailed information.*

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

- There is improvement in terms of clients who smoke.

Compared to the data in 2019, we can see that the percent of clients who smoke is decreased in all phases. The same trend can be seen when it comes to number of cigarettes.

- According to the data from last year, we observe an improvement in term of Mastery skills.

Which are the areas of challenge?

- One of the areas of challenge is the IPV.

The percentage of women who have reported IPV has risen by 1% in Pregnancy 4th visit and by 2% in Infancy 12 gestation week. (please see data report, slide 54)

- The other area we identify as a challenge is related to the subsequent pregnancies. We observe that the number of subsequent pregnancies increase together with the number of graduated clients.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks gestation)	**1**	**0,5%**
Very preterm (28-32 weeks gestation)	**2**	**1%**
Moderate to late preterm (32-37 weeks gestation)	**47**	**24,5%**
Low birthweight (please define for your context) <**2500 grams**	**33**	**17%**
Large for Gestational Age (LGA) (please define for your context)	**N/A**	**N/A**
Other (please define)		

Please comment below on your birth data:

Measure / year	2016/2017 (n, % of all births within the period)	2018 (n, % of all births within the period)	2019 (n, % of all births within the period)	2020/2021 (n, % of all births within the period)
Birthweight < 2500 grams	3/43 (7%)	9/38 (24%)	6/34 (18%)	14/74 (19%)
Preterm birth < 38 g.w.	3/43 (7%)	11/38 (29%)	6/34 (18%)	29/74 (39%)

Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	77/50%	65/56%	41/53%	43/65%
Hospitalization for Injuries	1/1%	0	1/1%	0
ASQ scores requiring monitoring (grey zone)	Communication - 2% Gross motor - 7% Fine motor - 9% Problem solving - 3% Personal-social - 6%	Communication - 0% Gross motor – 9% Fine motor – 18% Problem solving – 3% Personal-social - 1%	Communication - 3% Gross motor – 10% Fine motor - 13% Problem solving - 3% Personal-social - 0%	Communication – 0% Gross motor – 11% Fine motor - 8% Problem solving – 5% Personal-social - 2%

ASQ scores requiring further assessment/referral (black zone)	Communication – 0% Gross motor – 1% Fine motor – 0% Problem solving – 1% Personal-social - 0%	Communication – 1% Gross motor – 2% Fine motor – 2% Problem solving – 2% Personal-social - 2%	Communication – 1% Gross motor – 3% Fine motor – 3% Problem solving – 1% Personal-social - 2%	Communication – 3% Gross motor – 3% Fine motor - 2% Problem solving - 2% Personal-social - 3%
ASQ-SE scores requiring monitoring (grey zone)	0	3%	0	3%
ASQ-SE scores requiring further assessment/referral (**Here the child is either below or above the cut-off.**)	N/A	N/A	N/A	N/A
Child Protection (please define for your context) **Signals to Child Protection Services (CPS) could be by NHVs or other people outside the program. Families can also turn to CPS for support services and the NHVs can encourage them to do so.**	Signal from outside the program – 1/1% Signal by an NHV – 0/0% Family turn to CPS – 2/1% cases NHV encouraged family to turn to CPS - 3/2%	Signal from outside the program – 2/2% Signal by an NHV – 0/0% Family turn to CPS – 3/3% cases NHV encouraged family to turn to CPS - 2/2%	Signal from outside the program – 0/0% Signal by an NHV – 1/1% Family turn to CPS – 1/1% cases NHV encouraged family to turn to CPS - 1/1%	Signal from outside the program – 0/0% Signal by an NHV – 0/0% Family turn to CPS – 2/3% cases NHV encouraged family to turn to CPS - 1/2%
Other (please define)				

Please comment below on your child health/development data: *Please see data report for more detailed information*

Additional analyses

Please insert here any additional analyses undertaken to further explore program impacts: N/A

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.: N/A

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	3	All three cases were within previous reporting periods. All cases were in Site 1 Sofia.
Maternal death	0	
Other - mother lost the custody of the child	2	One case was within last reporting period and one case within this reporting period. One case is in Site 1 Sofia and one case is in Site 2 Plovdiv. In both cases the child continue participation in the program with the grandmother. The program is delivered well with the grandmother as a primary caregiver and nurses had no problem continuing the work with a different person, as they usually already know the grandmother.

Any other relevant information or other events to report:

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

- Briefly describe your system for monitoring implementation quality:

As described in **PART TWO** - section **NFP Information System**, we (DA and PM) continue to perform biannual monitoring on individual basis (each NHV and SV) of the IS data input and the client's paper files keeping. These two types of monitoring help clear any mistakes and misunderstandings, unifies the understanding of all NHVs and SVs, and facilitates the process of sharing of good practices regarding data collection, data input and home visits.

- Goals and Objectives for any CQI initiatives undertaken during the reporting period:

The new quarterly practices introduced within the last year – strategic meetings on national level, team meetings and individual reflective supervisions, all based on data reports prepared specifically for these purposes have the objectives of:

1. Quarterly strategic meetings
- Sharing good practices among the two Site teams.
- Identifying common context-specific challenges in both Sites and sharing ideas on how to effectively manage them among the two Site teams.
- Setting the focus of all team members on the overall goals of the program.
- Identifying common context and time specific goals for all team members to work on quarterly and on an annual basis.

2. Quarterly team meetings (quarterly reports from NHVs and SVs)
- Better planning and implementation of some CME with fidelity: weekly reflective supervisions, observations of RS, group supervisions, accompanied home visits with SVs and CL, training needs assessment, team meetings, case conferences, and educational sessions.
- Timely data collection of data points that are not collected in the IS.
- Creating a log with qualitative data based on NHVs and SVs' reflections to feed into lessons learned report and to keep the central implementation team informed on successes and challenges in the direct work with families.

3. Quarterly reflective supervisions
- Informing individual work of the NHVs and their SV.
- Identifying successes and challenges in the individual work so that good practices can be shared among team members and SVs can support NHVs overcome challenges.

- Outcomes of any CQI initiatives undertaken during the reporting period:

Both individual nurses and teams have been able to modify their work towards more closely following the model in their work with clients and some of these shifts were visible from the trends in data from quarter to quarter (with domain coverage for example). Planning and implementation of some CME has become easier and clearer for all team members through data collection in the quarterly reports prepared by NHVs and SVs, although some of the planned activities have not been implemented due to other factors – COVID 19 situation and lack of a full-time CL.

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

Although these new procedures were set in a participatory manner, they were at first seen as an extra work and a burden by the nurses and the teams. However, as the format of the meetings, reports and supervisions are being reshaped and simplified with the input of the teams, they are getting used to them and are starting to appreciate the teamwork created between the two Site teams and the benefits of the team and individual reflections, which bring more insight and support to their work. The nurses are starting to appreciate the continuous learning and the added value that both the new and the already established procedures bring.

- Goals for CQI in next year:

The main goal for next reporting year would be to continue all the practices mentioned above and to modify them as needed, so that they are as efficient and effective for the Site teams and individual nurses as possible.

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

- Program innovations tested[1]:

To continue delivering the NFP service in a structured and sustainable way during the Covid-19 pandemic, in the second half of 2020 TSA started looking for funding opportunities which could respond to the need of electronic devices for our clients (that could facilitate the Telehealth process). In October and November, we applied for two grants and one of our project applications was approved – we received external funding from Sofia Municipality. The amount of 15 000 BGN has been used for purchasing 60 tablets with a 12-month internet plan for all active clients in Site 1. The devices have been distributed in February and are being used for telehealth consultations (to be used until December 2021).

This innovation has to do once again with the delivery of the program rather that its content – it gives us a systematic approach in communicating with our clients from a distance and will let us accumulate new lessons of whether this kind of support is feasible and sustainable for securing the continuity of the working process in times of crises.

We are now in the process of exploring possible funding for purchasing devices for the Site 2 clients as well.

- Program innovations implemented:

In pursuing our plans for even better need-tailored NFP practice we worked on finding ways to push for early application of our vulnerability criteria to newly enrolled clients. As part of our strategic meetings with the nurses, we defined a procedure for applying the list of vulnerability criteria (shared with UCD in the previous annual report) by the 4th home visit and updating the clients'

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

vulnerability status every 6 months (in March, for the purposes of the UCD annual report, and in September, as it usually marks the end of TSA's financial year).

In the process development nurses discussed the importance of each vulnerability from the list and came up with a rating system. Then, our Data Analyst created a Google Drive file with all NFP clients and all vulnerability criteria – by having access to this file, each nurse assessed initially the vulnerability status of her clients and will continue updating it every six months. The table automatically calculated the score for each client depending on her vulnerabilities and different scored mean low, medium or high risk/vulnerability for the client and her family. By having this important information, nurses can better plan their intervention and scope of work with each family.

This practicality is considered an important innovation already put in practice for the teams in Bulgaria which will expectedly contribute even further to the better quality of the program implementation. It could also allow us to monitor more closely the program results among our most vulnerable clients.

- Findings and next steps:

Our "innovations" have been introduced to the working process relatively recently, so we are yet to assess their impact and summarize our findings. As next steps we do plan to include those findings in the Lessons Learned Report we have prepared but have committed to update in the course of the program implementation. Our first step is to summarize our findings from the Covid-19 work and program adaptations, including the delivery and use of electronic devices by our clients in a more systematic way. After we update the Lessons Learned with the Covid-related findings, we plan to share it with UCD (by mid-2021).

Another upcoming activity in the innovations area is what we have initiated so far in exploring the IPV component of the NFP program. We have been collaborating on this issue on a few occasions with our NFP international consultant and Prof. Susan Jack to see if it is feasible for IPV to be adapted for the Bulgarian context and introduced into the NHVs' intervention. So far, the central team has had 2 meetings with IPV local experts from Animus Foundation to discuss possible adaptations, volume of necessary work and overall applicability of the IPV innovation into the Roma communities' context. Final decisions have not been taken and we plan to further explore this possibility. We expect to have a better idea by mid-2021 of whether we will be able to proceed with all the IPV work.

Temporary Variances to CMEs

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

Additional Approved Model Elements (AAMEs)

Please attach a summary of findings in relation to any Additional Approved Model Elements in Appendix 3 to this document
N/A

Feasibility & acceptability study:

- Goals:

A key aim of the evaluation is to explore whether it is possible to implement the NFP program according to the 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:

The initial plan of the F&A study was to conduct 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 by the end of the study. However, due to slow initial recruitment of clients and changes in the initial survey questionnaire based on feedback from clients, nurses and mediators, the number of quantitative interviews with clients in all three stages of the program will be lower.

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. After discussions with the OSI team the goals of the study were restated, and we agreed that we would have two more preliminary reports – one focusing on nurses and clients and another one focused on the stakeholders. We received the final version of the second preliminary report in June of 2020 and a first draft of the third preliminary report in the beginning in March 2021. We hope to have a final version of the report by the end of the month so we can share it with UCD together with the Annual Report and the ADR. We also agreed with the OSI team to have the final Feasibility & Acceptability Study Report by mid-2021.

Findings from feasibility & acceptability study to date:

- Key findings from our study

Current assessment of the feasibility and acceptability of the adjusted core elements of the NFP program as implemented in Bulgaria by March 2020*

DAC criteria	feasibility					acceptability
Core element	relevance	effectiveness	efficiency	impact	sustainability	
Good community and organizational planning	0	+	n.d	+	+	+
Intensive nurse learning	++	+	+	n.a.	=	+
Visit-by-visit guidelines	++	+	++	++	++	++
NFP data collection and reporting system	+	++	+	++	++	++
Standardized evaluation and reports	n.d.	n.d.	n.d.	n.d.	n.d.	++
Quality improving processes	n.d.	+	n.d.	n.d.	n.d.	++

Health mediators	++	+	+	++	++	++
Full coverage for all medical needs of all clients	++	++	=	+	=	++

Note: The scores to be read as follow: *++ feasible/acceptable, + rather feasible/acceptable, 0 neither-nor, - rather not feasible/acceptable, = not feasible/acceptable, n.a. – not applicable to this indicator; n.d. – no data at the current stage of the research*

- Reflections on our findings/results

The summary table from the third preliminary report on feasibility and acceptability of the program in Bulgaria shows that all evaluated elements are acceptable in our context, with the Community & organizational planning and Intensive nurse learning being scored lower than the other elements but still acceptable.

The research team's comments and recommendations about good community and organizational planning have been mostly related to ability to find a suitable control group in a future RCT for the two chosen Sites as they are unique in their setting. However, the possible Sites for NFP are not that many in the country (about 8), as the researchers have also established, and decisions on Site locations were mostly based on proximity to the central team. This is important for two reasons – close oversight of Site teams is needed especially in the beginning and the organization has limited resources both financial and staff wise.

Previous comments of the research team on acceptability of Community & organizational planning have also been regarding the need to work with local community and religious leader more closely, however, our experience in Plovdiv showed that although a buy in from the leaders is necessary, the close work with them is not always productive, since the model of work establish in these communities is through financial incentives which is not sustainable or productive. What has worked well is hiring and training motivated members of the communities as mediators. Although they are community bound, like the research team has pointed out several times in the F&A study, they manage to establish good rapport very quickly, both with the teams of nurses and with the community members, which makes the program delivery acceptable.

Another recommendation of the research team is to engage former clients and community members such as grandmother and mothers-in-law in additional activities to make the program more acceptable and sustainable in the communities where the program operates. The central team has been working on such ideas and has written a project proposal for additional funding to engage the grandmother and mothers-in-law. The project was not approved and after the COVID 19 outbreak the efforts in this direction have been temporarily suspended.

The Intensive nurse learning is becoming more and more acceptable for the nurses, as researchers also point out. On the one hand, the continuous learning is central principal of the medical professions, but on the other hand this is not well established philosophy in Bulgaria yet. As part of the EU, where the continuous learning throughout the lifetime has been established as one of the

guiding principles, this is becoming more widely accepted in Bulgaria as well and the future developments will be in that direction.

Another aspect of the Intensive nurse learning that has been highlighted by the researchers and we need to address is the sustainability of their training. The need for trained trainers within the teams in the country and having more than one trainer has been recognized considering the staff turnover within the last two years.

The Visit-by-visit guidelines and NFP data collection and reporting system have been both evaluated as very feasible and acceptable and the comments of the researchers are that they are becoming more acceptable and appreciated by the teams, something that we have also noticed. With change in management in Site 1 team in Sofia and replacing almost all initial staff in Site 2 team in Plovdiv, which also had problem with the motivation of the first chosen SV, the attitudes have really turned towards quality improvement of the program delivery. There is more and more understanding within team members that quality improvement goes through the elaborate guidelines and data collection of the program.

The research team has not been able to evaluate thoroughly the Standardized evaluation & reports and Quality improving processes due to lack of data.

The evaluation on feasibility and acceptability of Health mediators shows that this element of the program is central for the work of the program in Bulgaria. The research team has commented previously on the fact that their work is community bound and that steps towards sustainability of this element should be taken and both of these issues can be addressed with the formal training they need to undergo to become trained health mediators who can be then hired by the respective municipalities. Such steps have been taken by the central team and two of the mediators in Sofia have undergone the training. One of the mediators hired in Plovdiv is already a health mediator and is hired by the municipality. The experience of the central team shows that the issue with the community bound work of the mediators cannot be entirely overcome with formal training only and hiring mediators from different communities is also necessary.

The last recommendation of the research team on the Health mediators' element is that the knowledge and experience gained by the working mediators of the program to be collected in a handbook or a manual, which can serve later as a training tool.

Full coverage for all medical needs of all clients is also positively evaluated with the exceptions of efficiency and sustainability, which the central team is aware of and has been working to address through publications and raising the topic in discussions with stakeholders and other allies working on ECD topics in Bulgaria and Europe. There are also several advocacy projects led and implemented by TSA, that aim to address the issues of health insurance for pregnant women.

Another issue related to feasibility of the program in Bulgaria, which the research team is raising in each report and supports with data is the shortage of nurses and midwifes in Bulgaria. In this regard a more strategic action on behalf of the government is needed in order to solve this systematic issue, which threatens not only vulnerable communities in the country, but the sustainability of the healthcare system at large. This is one of the topics that consistently raised in NABs in front of the

government officials from the Ministry of Health, not only by the central team, but by other important stakeholders as well.

- Any actions planned based on results

The central team has taken steps towards training another trainer besides the CL, so that new staff members can be timely and cost-effectively trained.

The central team needs to provide all necessary data and information gathered so far on Standardized evaluation & reports and Quality improving processes with clear instructions for the research team for them to be able to evaluate these two elements in the final F&A report.

The central team will work on collecting practical knowledge and experience of the working mediators in a handbook to be used in future trainings.

The central team continuously works on advocacy projects aimed at solving existing policy barriers to healthcare services for vulnerable communities.

The central team has worked towards resolving the issue of shortage of nurses on a smaller scale by securing funding to provide scholarships for women from Roma communities to study to be nurses and midwives, who would later work as nurse home visitors.

Anything else that would be helpful for the UCD international team to know?

PART FIVE: ACTION PLAN

LAST YEAR:

Our planned priorities and objectives for last year

Last year we had planned the following 17 priorities and objectives for the current reporting period:

- 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 (quasi-experimental study)
- 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.

Progress against those objectives

Out of these 17 objectives, we managed to fully achieve 11:

- 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)
- 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 Lessons Learnt Report based on NFP implementation in Bulgaria up to date
- 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 (quasi-experimental study)
- 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

We have started working and made significant progress on 4 of the remaining 6:

- Finalize Bulgarian methodology of NFP (normative regulation of NFP as a new integrated health service for vulnerable groups)
- Finalize Policy Brief as an advocacy tool for government adoption of NFP
- Provide planned ongoing education modules to fill the gaps in NFP nursing workforce
- Adapt and introduce IPV form, facilitators and pathways into NHVs practice

We have not managed to address 2 of the objectives:

- NFP Toddler Training for Site 2 and new nurses from Site 1 team – due to unavailability of the Clinical Leader (only NFP educator)
- Elaborate client graduation process and celebration (due to Covid-19 which made plans for in-person graduation celebrations redundant)

Reflections on our progress:

Given how unusual and challenging 2020 has been because of the coronavirus pandemic and how these unprecedented circumstances dramatically shifted our priorities to adapt the program delivery process and support both nurses and clients in the most optimal way, we feel good about the great number of initially planned objectives we have managed to achieve.

It is evident from the list of priorities and level of their achievement that the ones we have not been able to fully address are the ones most corelated with external factors, external obstacles or uncertainties we have faced. However, we are committed to continue working on completing the remaining ones as well together with the new set of objectives for 2021.

NEXT YEAR:

Our planned priorities and objectives for next year:

- Continue improving the quality of the service through strategic meetings, data-informed practice, regular reflective supervisions, monitoring, etc.
- Develop a marketing strategy for NFP and intensify communication with stakeholders (more videos, monthly newsletter, new annual book donations campaign, start of roundtable sessions, etc.)
- Deliver Toddler training to Site 2 team and some nurses from Site 1
- Deliver Infancy training to new nurses in Site 2
- Finalize formative evaluation process (final F&A report submitted, info disseminated)

- Finalize impact evaluation design and select implementing agency
- Adapt the most used facilitators for Site 2 context (more pictures, less text in Turkish)
- Explore further feasibility to adapt and use the IPV innovation
- Finalize the NFP policy brief
- Finalize Bulgarian NFP methodology
- Provide planned ongoing education modules to fill the gaps in NFP nursing workforce
- Update Lessons Learned Report with findings from the Covid-19 period
- Update IS reporting and functionalities (according to actions described in data sections above)

Measures planned for evaluating our success:

- 4 QSM with teams conducted, 2 monitoring activities performed
- Marketing strategy developed as a final product; one longer video with testimonials as a final product, at least 4 newsletters drafted and sent out; at least 2 NABs and 6 LABs held
- Toddler training is conducted
- Infancy training is conducted
- Final F&A report is submitted
- Study design and finalized, agency is selected (TOR, contract)
- Materials are available in Turkish
- Decision is taken on the IPV innovation
- Policy Brief is ready as a final product
- At least 5 ongoing trainings are provided to team members
- LL Report is updated and sent to UCD
- IS is updated and new functionalities are reported in the next UCD annual report

Any plans/requests for program expansion? No.

FEEDBACK FOR UCD INTERNATIONAL TEAM:

The most helpful things we have received from the International team over the last year have been:

- Regular guidance on program delivery with fidelity to the model
- Regular guidance on adapting the service delivery to the complicated Covid-19 context
- Regular updates on what other NFP countries do to adapt the service (shared learning)
- Connecting to experts and facilitating meetings to explore IPV
- Shared learning for NFP education
- Guidance on the initial steps of the impact study design

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

- More opportunities for sharing knowledge with NFP teams in other countries
- More NFP events such as the international RCT seminars

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

- Provision of mentoring and coaching
- Monitoring of license and oversight of fidelity, including annual report and review

- Expert guidance re design and outcome measures for research methodology and plans
- Feedback on final formative evaluation content
- Support for Bulgarian expert in understanding the IPV intervention; review of suggested adaptations in intervention and nurse/supervisor education.

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

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

I agree to this report being uploaded onto the restricted pages of the international website [X]

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

PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following annual review meeting)

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

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

Identified strengths of program:

- The commitment, talents and resourcefulness of the leadership team in TSA, resulting in continued adaptation and development of program implementation and an exemplary annual report
- The ability of the leadership and local teams to adapt to the challenging environment created by the COVID pandemic and to continue to provide a service to clients in times of great challenge, whilst at the same time continuing to build the service
- The ability of the nurses to develop and maintain purposeful relationships with clients and their growing ability to adapt the program to their individual needs
- The collaborative approach to program adaptation, in which learning from the frontline is developed and thoughtfully integrated into processes and program adaptations.
- The success of the mediator role and the approaches taken to upskilling this important workforce
- The continued development of the Information system and the high-quality analysis of data evident in the annual data report

- The use of data to inform and drive Quality Improvement projects and the collaborative way in which this has been taken forward, leading to the teams investing in both data and improvement work - The continued development of local client recruitment pathways so that there is now a reliable flow of potential recruits to the program in both sites - The tenacity and creativity shown in the development of strategic support for NFP at a national level - The ability to attract funds and external supporters for taking the program forward into phase three.
Areas for further work: - We agree that it is important to develop educator capacity to ensure sustainability in this important area and it will be important to update the curricula for all staff groups over time.
Agreed upon priorities for country to focus on during the coming year: - None in addition to the priorities and objectives identified in Part 5
Any approved Core Model Element Variances: - No additional Variances required
Agreed upon activities that UCD will provide through Support Services Agreement: - As agreed in SSA for 2021.

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

Appendix 2: Evaluation of temporary CME variances

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

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

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

Appendix 3: Additional Approved Model Element (AAME)

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