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Nurse-Family Partnership® (NFP) International

Phase Two Annual Report | 2019.03.29

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

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

PART ONE: PROGRAM OVERVIEW

Name of country: Bulgaria

Dates report covers: March 2018 – February 2019

Report completed by: NFP Bulgaria team

The size of our program:

	# Who work exclusively in NFP	# Who have additional assignments in implementing agency	**Total**
Fulltime NFP Nurses	**5**	**0**	**5**
Part time NFP Nurses	**3**	**0**	**3**
Fulltime NFP Supervisors	**2**	**0**	**2**
Part time NFP Supervisors	**0**	**0**	**0**
Full time Health mediators	**3**	**0**	**3**
Part time mediators	**1**	**0**	**1**
Total	**14**	**0**	**14**

- We have two teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse (+ other staff) ratio: 1:6
- We have enrolled 94 NFP clients as of 26.02.2019

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

Clinical leadership, support and guidance:
Maria Evgenieva has kept her role as the NFP clinical leader for Bulgaria. She received ongoing consultations from NFP International.

The implementation team has negotiated support from experts from the National Center for Public Health and Analysis (the research unit of the Ministry Health) for further adjustment of the Program to the Bulgarian system of health services. The cooperation will have the aim to produce a description of the Program methodology in line with the requirements of the Ministry, as well as to provide supervision of the work of the team and support for quality assurance and improvement.

Description of our National implementing capacity and roles:
Service / implementing agency development

TSA holds the position of central implementation agency for NFP in Bulgaria.

In light of Maria Evgenieva's upcomming maternity leave, we have engaged a new full-time employee as a Project Manager, who has taken on responsibility for the management and coordination of the project since January 2019. Maria will remain involved on a part-time basis and provide purely clinical support. We recruited Ivanka Puleva for this position. She is responsible for the quality of the technical implementation and reaching the strategic goals of the program. Ivanka manages the NFP teams and leads on communicating the program with partner organizations, local and national stakeholders.

Prior to joining TSA, for about 5 years, Ivanka has worked in the field of migration – as a part of the management team of the Refugee-Migrant Service within the Bulgarian Red Cross. She has coordinated projects on a national and international level, related to providing consultations, social assistance services and integration of refugees. She has a significant experience in Child Protection of migrant children, as well as in the media sector. Ivanka has participated in a Fellowship Program by the US State Department, focused on Refugee Resettlement. She holds bachelor's degrees in political science and International Relations, and Journalism and Mass Communications from the American University in Bulgaria. Her Master's Degree is in Public Relations from Sofia University.

Starting January 2019, the NFP team included Dena Popova as evaluation expert. Her role is to work on the key performance indicators that were specifically developed for the Bulgarian context – reduction of anaemia, improvement in feeding practices – and to ascertain that collection of this information is feasible as part of the work of the nurse home visitors. She will also have the aim to collect and describe the insights/lessons learnt from the nurse practice as a foundation for further adaptation efforts. In addition, she will work on development of a monitoring plan that will focus on the quality aspects of the work and will provide evidence for keeping the fidelity to the Program.

Prior to joining the Trust, Dena worked for the International Organization for Migration, Animus Association Foundation and BEST Foundation as research officer and project

coordinator on the issues of migration, labour exploitation, trafficking in human beings, citizenship education and public speaking.
Dena holds Rhetoric, Film Studies and Politics in Whitman College, WA, USA. Following, she pursued a M.Sc. in Political Science at Pompeu Fabra University, Spain, where she got sound in-depth knowledge on the issues of multiculturalism, federalism and diversity. During her studies, Dena was an Abshire grant fellow researching Traditional birth practices in the Highlands of Ecuador, as well as Labor Trajectories for Latino Farmworkers in Washington State; Collective and Postmemory in Argentina and Multilingualism across Europe.

The central implementation team continues to include a data analyst and project coordinator.

Information system and analysis

The information system (IS) is already in use by our NFP staff - nurses, supervisors, clinical leader and data analyst to record and analyze gathered data on home visits and clients' status. All data for all visits has been uploaded in the system. We still need to improve the utilization of reports from the system to inform the work of the teams.

Senior Nursing Leadership

Maria Evgenieva has been engaged part-time (at first 6 hours and in the last six months - 7 hours work day) as NFP Clinical Leader and Project Manager up until March 2019. She will be a part-time Clinical Leader during her maternity leave – we anticipate that she will invest 10 hours per week for the next six months, possibly one year.

License holder

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

Other (please describe)

- TSA has subcontracted HESED to provide services for supervisory support for the HV team in Sofia.
- The supervisory support team consists of:
- 1 developmental psychologist– part-time
- 1 social worker – part-time

Starting April 1 2019, TSA will subcontract the National Alliance for Volunteer Action (NAVA) to provide services for supervisory support and continuous learning for the team of HVs in Plovdiv. NAVA is a well-established NGO that has extensive experience in working with vulnerable groups and with Roma in Plovdiv in particular. The team will consist of:

- 1 developmental psychologist – part-time

- 1 social worker – part-time (to provide also administrative/site development support to the team)

Description of our local and national NFP funding arrangements, including plans for funding for a randomized controlled trial:
TSA has committed to funding Phase 1: Adaptation and Phase 2: Feasibility and Acceptability through Pilot Testing and Evaluation of the NFP replication in Bulgaria. TSA also commits to continuously work throughout these two phases to ensure the program sustainability and build Government support for funding of Phase 3: Randomized Control Trial and Phase 4: Replication and Expansion.
In March 2018, TSA's Board of Directors reviewed our proposal for funding of the NFP Program in the period 2018-2020 and the proposal has been approved. This period will be extended upon renewal of TSA's mandate in 2020.

It is expected that we will continue to enroll clients in Site 1 – i.e. when a child graduates from the program, his/her place will be taken by a new expectant mother.

For Site 2, we anticipate that the last client of the cohort participating in the piloting phase will graduate in 2022.

Description of our research team and capacity to conduct quantitative and qualitative evaluation:
The formative evaluation is assigned to a research team at OSI-Sofia. The research team consists of:

Boyan Zahariev, PhD – senior sociologist, project manager
Boyan has a PhD in sociology from Sofia Univeristy „St. Kliment Ohridski" with specialization in urban studies and a master degree in economics. Boyan has more than 15 years of experience in managing projects targeted at the integration of vulnerable groups, conducting various surveys including large scale household surveys and surveys among students. Boyan has authored or co-authored more than 30 policy analyses for the European Commission, the World Bank and UNICEF among others.

Alexey Pamporov, Ph.D., Associate Professor – research supervisor
Alexey is an Associate Professor in Sociology at the Bulgarian Academy of Sciences since June 2014 and a member of the Asylum Committee at the President of the Republic of Bulgaria since October 2017. He lectures on Roma History and Culture as an adjunct professor at the Culture studies department of Sofia University and at the Ethnology department of Plovdiv University. He has about ten years of experience in the non-governmental sector as a Head of Research Unit at the Open Society Institute – Sofia (2007-2016) and about year and a half at the governmental sector as a Project Manager at the National Commission for Combating Trafficking in Human Beings (Aug. 2016-Feb. 2018).

Ralitsa Dimitrova – sociologist and project coordinator
Ralitsa was coordinating the training and the fieldwork for the „Data collection for the TSA Bulgaria pre-school randomized control trial" and „Follow up data collection for the

impact evaluation „Bulgaria: springboard for school readiness“ projects, with regard of the settlements in Northern Bulgaria. She has moderated numerous focus groups and interviews since she joined the team in 2014. Ralitsa has a bachelor degree in sociology from Sofia University „St. Kliment Ohridski“ and is currently studying in a master‘s program in statistics and econometrics.

Ilko Yordanov – senior research expert in education and inclusion of minorities
Ilko is a policy researcher in the Open Society Institute – Sofia and Expert Analyses Group. Since 2003 he has worked on Bulgarian public policy reforms in the field of: decentralization, early school leaving, early childhood development, evaluation, monitoring and transparency of education and health services, hosing and living conditions and development of comprehensive national and local ethnic minorities' inclusion policies. He has accumulated experience as coordinator and expert on program and project implementations, research design, data analysis, evaluation and reporting.

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

We have continued strengthening the connections with the Ministry of Health and the Ministry of Labor and Social Policy. Two National Advisory Boards hosted by the Ministry of Health took place in March 2018 and December 2018 and were chaired by the Deputy Minister of Health. The Ministry was represented by five members, including the head of the department of 'Medical Activities' and the director of the National Center of Public Health and Analysis adjacent to the Ministry of Health. The Advisory Board in March was co-chaired by the Deputy Minister of Labor and Social Policy. Unfortunately, due to the unstable political environment the Deputy Minister of Labor and Social Policy has resigned. We are currently in the process of reestablishing the same level of representation with the discussed Ministry.

The Ministry of Health is presently working on a national model for home visiting care. It is envisioned that the model will take as basis the service developed and piloted in two regions by UNICEF. It is a universal access service that is offered to all interested beneficiaries with varying degrees of intensity depending on the needs of the family. At the same time, there is growing recognition of the need for a targeted service that will address the needs of the most vulnerable populations and the Ministry of Health has expressed interest in considering the NFP Program as a complementary service that could be incorporated into the national home visiting model.

Along with that, we are in the process of signing a Cooperation Agreement with the National Center of Public Health and Analysis (Ministry of Health) in support for the implementation of the National Strategy for Improvement of Maternal and Infant Health 2014 - 2020. The goal is to ensure advisory assistance in the preparation and implementation of measures that would guarantee the quality of the Nurse Family Partnership service and to engage the government into the preparation of the methodology of the service.

On local level we have proved successful in involving the municipal institutions. Representatives from the Directorate of Health and Directorate of Social Policy have been regular attendees to our Local Advisory Boards. Our last Board was hosted by the Directorate of Health at the Sofia Municipality. We are committed to preserving the municipal hospitality. The Directorate has been a friend and support to the program from the moment we got in touch. Thanks to our good cooperation, we are negotiating the employment of the NFP mediators within the municipal structures.

The government in general has been open to the idea of re-implementing the nurse home visiting service. In cooperation with UNICEF, the Ministry of Health has developed a methodology and provided funding for a similar service until the next EU budget starting in 2021. Disagreements are starting to appear between the two parties involved as the government has made changes to the UNICEF developed methodology. So far it is unclear what the service would include and the way it would operate nationally.

The government demonstrates some interest in the NFP program mainly in terms of achieved results and data retrieved from the segregated communities we operate in. The political environment at the moment discourages a focus on public policy and there is negativity toward specific funding that targets disadvantaged and minority groups. Our initial impression is that the Ministry of Health is interested in certain NFP components. The challenge will be to convince the policy makers to embrace the whole program regardless of the political sensitiveness, the lack of medical specialists and the substantial financial constraints that NFP would cost to the national budget.

Description of our implementing agencies/sites:

High level description of our implementing agencies/sites:

SHEYNOVO HOSPITAL

In 2018 we continued our fruitful cooperation with Sheynovo Hospital which is formally employing the NFP Site 1 team in Sofia.

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. A School for Pregnant and Future Parents has been opened in the hospital. The medical establishment has the following wards:

• Maternity ward - the department's goal is to provide high quality services for pregnant women in the period of labor.
• Neonatological department - monitoring and follow-up of healthy new-born children and treatment of premature babies.
• Gynecology and endoscopic surgery - endoscopic surgery has been practiced in the hospital since 1998 and is currently leading in the field of so-called bloodless operations in gynecology.

• Anesthesiology and intensive treatment - highly specialized activities and care during the period of birth, during and after gynecological operations and manipulations are performed by a qualified anesthetist team of doctors and midwives.
• Risk pregnancy department - The following treatments are performed in the compartment: discontinuation of pregnancy; abrasio residuorum; NST; planned Caesarean sections and birth inductions.
• Diagnostic consultative department - The Diagnostic-Advisory Unit is the hospital's polyclinic unit, which first meets the patients and provides preventive, prophylactic, consultative care and treatment in the field of gynecological and reproductive health.
Given its profile, the Sheynovo Hospital has proved to be a suitable match for the base of our NFP Site 1 team. The project coordinator and accountant on the hospital side are now well into the habit of the administrative work around the team management and the program implementation. The communication and coordination with the TSA national unit is smooth and on a satisfactory level.

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

ST. GEORGE HOSPITAL
St. George University Hospital is the largest hospital in Bulgaria with a total staff of 2641. It is in Bulgaria's second biggest city – Plovdiv and has two bases: Base 1 (Therapeutic Clinics) and Base 2 (Surgical Block), with a 24-hour logistical connection for transporting patients and doctors/consultants. The hospital has 1435 beds.

In connection with the implementation of the national emergency medical assistance, the hospital has established itself as a major centre for emergency care in the city of Plovdiv and the districts of Southern Bulgaria as a whole. St. George Hospital is one of the medical establishments approved to be included in the organ donation and transplantation program.

St. George Hospital is the first hospital in the country to be certified according to ISO 9001: 2015 standards. It is a regional hospital for Plovdiv; district hospital for the municipalities of Asenovgrad and Parvomay; inter-regional hospital for the districts of Pazardzhik, Smolyan, Kardzhali and Haskovo.

In both facilities of the hospital there are reception-consulting offices for: surgery; cardiac surgery; urology; neurology; obstetrics and gynecology; nephrology; internal diseases; Orthopedics and traumatology; endocrinology; gastroenterology; otorhinolaryngology; neurosurgery; rheum cardiology; infectious diseases; hematology; skin-venereal diseases; pediatrics; psychiatry; ophthalmology; cardiology, etc.

The hospital team which facilitates the administrative support for the NFP program consists (same as in Sheynovo Hospital) of a project coordinator and an accountant.
As the hospital was unable to offer a space for the NFP Site 2 team, an office was rented in the central part of Plovdiv, closer to other service providers.

Current number of implementing agencies/sites delivering NFP: 2

How we select and develop new sites:

In the beginning of 2018 we had shortlisted two potential cities for NFP Site 2: Plovdiv and Stara Zagora. These two options were finalized based on the statistical data about size of target groups, existing infrastructure, services and nurse workforce, etc. Our approach for selecting the Site 2 was focused on finding and recruiting a strong nurse supervisor as we believe this is the most crucial factor for having a successful local NFP team. The recruitment process started in March 2018 and in April we had already chosen what we considered the most suitable applicant – in Plovdiv. This is how the final decision was made to have the NFP Site 2 in the second largest city in Bulgaria. Its highway connection to Sofia where the National Unit and the Site 1 are based made it very convenient as well in terms of traveling between the sites for development purposes.

In May 2018 we proceeded with contracting a research agency for conducting the baseline study for Stolipinovo neighborhood – the largest Roma neighborhood in Europe with nearly 50 000 inhabitants.

After we had our local nurse supervisor, we started the recruitment of NHV as well. By the end of 2018 we had a full team of 1 SV and 5 NHV (on temporary contracts due to the ongoing at that time negotiations with the implementing agency for Site 2 – St. George Hospital).
In terms of site development, we established connections with local Roma leaders who helped with providing a temporary office space for the team and gave some insight on the neighborhood dynamics as well as the client recruitment strategy.

Successes/challenges with delivery of NFP through our implementing agencies/sites:
Both implementing agencies are well-known and renowned medical establishments whose reputation contributes to the credibility of the team and the program as a whole – both in terms of field service delivery but also when it comes to meetings with state institutions and other stakeholders.

Both hospitals provide some beneficial conditions for their employees in terms of paid annual leave, additional benefit packages, etc. This, combined with the support coming from the national unit, has contributed to the fact that 3 years after the start of the program in Sofia no team members from Site 1 have resigned. This we consider one of the great successes.

Another major success is the fact that current or graduated clients refer other potential clients to the program. They obviously see the great NFP impact from their own experience and it becomes a driving force for recommending it to friends and relatives. This has become one of the main ways of recruiting new clients into the program and a waiting list of potential clients has formed at various moments throughout the year.
In terms of challenges, we have experienced quite a few with the implementing agency for Site 2. After our initial plans to contract another medical institution for the role – a Diagnostic Consultative Centre in the area of Stolipinovo, have failed because of a political

resistance, we started the negotiation process with St. George Hospital. This proved to be a very long and complicated interaction mainly because the large administrative body of the institution – a series of meetings were held with various leading administrators until we managed to successfully finalize the process with a contract in January 2019. Because of this exhaustive period of communication, which the NHVs spent on temporary contracts without being able to go through the NFP Foundations training and start their actual field work, some of the team members decided to quit – one NHV and the SV as well.

Now that the Site 2 team consists of just 4 people – 1 SV and 3 NHV (2 full time and 1 part time), we face the challenge of recruiting and training new staff. This is due mostly to the lack of nurses and midwifes in Bulgaria as a whole.

Overall, we still see as a challenge the reluctance from medical professionals to refer new clients and to medically examine Roma people.

We have a new team members that joined the NFP National Unit in December 2018:

Ivanka Puleva – Project manager (full-time for NFP)

Ivanka Puleva joined our team as a Project Manager of the Nurse-Family Partnership Program (NFP) in Bulgaria. She is responsible for the quality of the technical implementation and reaching the strategic goals of the program. Ivanka manages the NFP teams and leads on communicating the program with partner organizations, local and national stakeholders.

Prior to joining TSA, for about 5 years, Ivanka has worked in the field of migration – as a part of the management team of the Refugee-Migrant Service within the Bulgarian Red Cross. She has coordinated projects on a national and international level, related to providing consultations, social assistance services and integration of refugees. She has a significant experience in Child Protection of migrant children, as well as in the media sector.

Ivanka has participated in a Fellowship Program by the US State Department, focused on Refugee Resettlement. She holds two Bachelor Degrees – in Political Science and International Relations, and Journalism and Mass Communications, from the American University in Bulgaria. Her Master's Degree is in Public Relations from Sofia University.

Other relevant/important information regarding our NFP program:

PART TWO: NFP CORE MODEL ELEMENTS (CMEs)

Core Model Element	Success and challenges in meeting each CME
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	All the clients enrolled in the program participate voluntarily.
2. Client is a first-time mother	All the clients enrolled in the program are first time mothers.
3. Client meets socioeconomic disadvantage criteria at intake	Our socioeconomic disadvantage criteria are: (To be eligible, clients must meet all four criteria) Expectant mothers up to 22 years old; No previous live births; Pregnancy by 28 week gestation; From neighborhoods that are visited by the nurses.
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	100 % of our clients receive their first home visit no later than the 28th week of pregnancy. Thirty-four percent (32 clients) received their first home visit before or during the 16th week of pregnancy. This is a negligible increase of 1% in the last year and we are still far from the benchmark of 60%. As we have discussed several times, the lack of a pregnancy register in the country and the widespread and still prevalent superstition that a pregnancy shouldn't be announced outside of the immediate family before the third month, make meeting the benchmark almost impossible. However, we prefer to keep this benchmark as we are starting a new site. Although we anticipate a similar outcome as those two main reasons will be still present in the new community that we will be serving, it has different characteristics and the situation might vary. Clients' average gestation week at enrolment is 19 weeks.
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	Each client has an identified NFP nurse. When a nurse is on a long sick leave or in one case on a maternity leave, the clients are visited by another nurse identified and appointed by the supervisor.
6. Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when	- 93% of home visits are conducted in the client's home and the most common alternative is a friend/relative's house. - 52% of the home visits are one-to-one, which is a drop of 4% since last year. The living situation of most clients makes it difficult to have one-to-one meetings

this is not possible.	with clients. A lot of our clients live with the extended family in small dwellings. Most often the third person in the meeting is the mother or mother-in-law, the husband/partner or another family member. According to the nurses after the initial 3-4 visits some privacy is allowed for them to work with the client. When the baby is born the whole family is involved with taking care of him/her and in the first months it is again difficult for them to have some alone time with the client.
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.	There is only 1 client on an alternate visit schedule at the moment. The data shows that clients receive 3% more than the prescribed dosage of visits in the pregnancy stage. More elaborate reporting on visit cancelation will allow for clearer picture on visitation schedule and trends for all phases of the program. The average visit takes about 73 minutes. Some of the clients do not have phones and the mediator visits the client to remind for the scheduled visit with the nurse. Those who have phones are usually using smart phones, even if the device is not personal and used by multiple family members. They use them to communicate with nurses through Messenger and Viber, especially when they have an emergency questions regarding their own health or the health of the child. Most nurses like this type of communication, although it might sometimes interrupt their free time outside of work.
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	One of the NFP nurses has a bachelor's degree, two have 3.5 years of training (a professional bachelor's degree) and five have 2.5 years of training (a professional bachelor's degree). One supervisor has a bachelor's degree and the other one has 3 years of training (a professional bachelor's degree). Nurses in Bulgaria only began to be able to access Bachelor degree-level education in 2008. In addition, many professionals in Bulgaria are reluctant to work in Roma communities and nurses do not often practice autonomously, making recruitment challenging. Initial recruitment efforts for NFP nurses and supervisor encouraged, but did not require, bachelor degree level qualifications. Our experience in recruiting nurses in Plovdiv confirmed our initial observations, however, the shortage of nurses and midwifes in Bulgaria as a whole is a problem that only seems to be getting worse. It took us 9 months to form a team there, only to lose one of the

	nurses and the supervisor before the Foundation training, because they had plans to work abroad. This long recruiting process poses even more challenges, as the nurses have too much time before starting their work in the field and some of them lose motivation. The long recruitment process of clients in Sofia had a somewhat similar effect on the Sofia team, which we now plan to avoid with specific and elaborate recruitment strategy for Plovdiv. Our efforts to recruit more nurses in Plovdiv continue and we aim to have at least four full time nurses, and the new nurses to undergo the Foundation training, so that we have a full capacity team before the Infancy training.
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	All of our nurses and the supervisor from Site 1 Sofia have completed the core NFP education program with the exception of the newly hired nurse, who has completed the Foundation training and will complete the other two core trainings together with the nurses and the supervisor from Site 2 Plovdiv. All of the nurses continue their learning process with the ongoing trainings.
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	Nurses have gained experience and confidence in their work and are now reflecting on areas in which they need more support and the lessons they have learned so far. The data collection forms have been updated also based on this experience. They have gained substantial insight on which materials should be further adapted and how they can be adapted to better serve their clients. However, there is still need for the supervisor and the clinical lead to be involved in this process, as nurses have somewhat narrower point of view and are likely to sometimes disregard some of the materials due to their personal experience with a group of only 10-25 clients they have worked with so far. There is peer learning and exchange of good practices, as well as standardizing responses to some difficult cases and crisis situations through case conferences, team meetings and group consultations with the social worker and psychologist. This can be further facilitated through more case conferences. So far the team meetings have outnumbered the case conferences, due to the long absence of the supervisor. This should be balanced out now that she is back full time. Their learning needs assessments have not happened yet and they are just starting to work on that and to make it a standard procedure in their work.
11. NFP nurses and	The fact that there aren't any abandoned children who

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.	were born in the program, the low attrition rate of clients, and a number of clients have expressed their interest to continue their education or to find suitable jobs gives us the confidence that the nurses are using successfully their theoretical knowledge gained in the core NFP trainings.
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	We have two supervisors assigned to each team. The supervisor of the new team in Plovdiv has started performing reflective supervisions with the nurses and mediators, although there is some resistance from some of the nurses. This was also the situation with the first team when it first started operating in Sofia as the supervision practice is not usual practice within the medical field in Bulgaria. The nurses in Plovdiv will start having group psychological supervisions and individual as needed by a psychologist. The supervisor will also have individual psychological supervisions with the psychologist working with the Sofia team and 1:1 reflective supervisions with the clinical lead. We hope that this will facilitate and help the process of 1:1 reflective supervisions of the nurses with the supervisor. The experience with the first team shows that although they were reluctant at the beginning, when their caseload size increased the nurses started requesting and insisting that they have these reflective supervisions. However, the supervisor in Sofia and the clinical lead have not had regular reflective supervisions. The supervisor is also not conducting regular reflective supervisions with the nurses and mediators. The nurses have raised the issue with the central team and after a monitoring visit to their office it became clear that the supervisions are not performed as regularly as they are supposed to and even not all of the performed supervisions have been documented properly. The reluctance of the team to have the supervisions at the beginning and the long absence of the supervisor, due to a sick leave in the last year, can explain some of the gaps in this regard. Still, supervisions are less than expected. We have had a strong conversation with the supervisor and agreed to a plan of action to correct this shortcoming in the next month, at which point we will assess the extent to which she is fully performing her expected tasks and whether she remains suitable for the

	position.
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.	All gathered data on standard paper forms has now been inputted in the IS. Common mistakes in the input of the data have been discussed and the IS functionalities have been modified, so that most of the mistakes are now detected before the submission of the forms, which saves time both for the nurses and the data analyst. A training has been conducted with the Sofia team on the use of reporting in the IS, which is readily available for the nurses, supervisors and clinical lead to use live after every data input. The Plovdiv team has gone through the initial training for using the IS and have started using it already with their first clients. The trainings have also led to ideas for some new reporting items that will be helpful for the teams' work. The IS is undergoing constant changes and adjustments to better reflect, help and support the field work of the nurses and supervisors. The monitoring visit to the office showed that the nurses in Sofia have all paper data forms and documents. New data forms have been developed for tracking feeding practices and anemia indicators. The anemia data form is still being remodeled to fit the work of the nurses and the needs of the clients. These forms will booth gather information on important indicators and will help the nurses pay more close attention to these issues in the served community, which have been identified both by national research and by the work of our nurses. We have also identified the need for continuous support for the supervisors to use and inform their work with the available reports in the IS.
14. High quality NFP implementation is developed and sustained through national and local organized support	Local advisory board (LAB) for Site 1 Sofia and National advisory board (NAB) have been set up in the beginning of the implementation of NFP in Bulgaria. There have been 4 LAB and 4 NAB meetings so far, where 3 LAB and 2 NAB meetings took place in 2018. There is a part time project coordinator hired by TSA, who organizes the LAB meetings in Sofia and the NAB meetings. A partner organization will help with the support of the second team in Plovdiv and will be responsible for organizing the LAB meetings there with some oversight from the central team project coordinator. For more details see "Current policy/government support for NFP" section in PART ONE of this report.
15. Mediators will be included within NFP teams to promote	An additional element was signed in January 2019 to include the work of the mediators as an important and integral part of the teams in Bulgaria. Mediators have

engagement of the community served, ensure cultural sensitivity in program delivery and support client access to other services.	played a central role in the client recruitment process from the very beginning, as well as ensuring cultural sensitivity of the team of nurses and in the program delivery. They are now starting to take on new responsibilities, as the capacity of the team is full and the nurses need assistance with some of their responsibilities, such as accompanying clients to various health and social services. The mediators of Sofia team have undergone the Medical University of Sofia's training March 19 – April 1, 2018 and have achieved competence as health mediators. As this training requires at least a high school diploma the recruitment in Plovdiv is still in progress. The two mediators who were hired and trained will not be able to undergo the training, however, they will be assisting the recruitment process and the nurses' work with clients. We anticipate that because of the great diversity in the neighborhood in Plovdiv and because the dominant language there is Turkish, we will need more mediators in the team.

Any requested CME variance(s): ☐ No ☑ Yes (please attach completed variance request form)

PART THREE: PROGRAM IMPLEMENTATION

Reflections on clients, family members, and the community

- # of NFP clients participating in the program over the last year: 94

In total 94 clients have been enrolled in the program since October 2016. Twenty-five of them have been enrolled in the last 12 months. Seventeen clients have discontinued the program and 3 have successfully graduated the program. With regards to program stage for the active clients, 5 are at the pregnancy stage, 56 at the infancy stage, and 13 at the toddlerhood stage. Eighty-four children were born to women enrolled in the program, of whom 72 are still in the program.

- % of those eligible clients offered the program who have enrolled over the last year: 66%

Our initial reflections regarding the characteristics of our NFP clients: Clients have been recruited mainly by our health mediators. In the last year we haven't had any referrals in Sofia from clinicians and social workers and a strategy was adopted, for the supervisor and the newly hired nurse initially and afterwards the nurse to present the program to health practitioners. Our initial idea was to gather all of the GPs, pediatricians and obstetricians and present the program to them, however, this plan is unrealistic as they are all extremely busy and would be difficult to gather them all at the same time and place. This new approach aims to present the program and at the same time to establish more close working relationship with the health professionals. The newly hired nurse will have the time in the next couple of months, while she still has only few clients, to meet

with the doctors, present the program and establish these useful working relationship with them. We hope that this effort will also help us recruit some non-Roma clients, as we have been unsuccessful to do so and this is the most feasible channel for referrals that we have identified. The recruitment process has become easier in Sofia, now that the program is established and recognizable in the served communities and we receive a lot of referrals from clients already in the program. Sometimes these potential clients are referred directly to the nurse and sometimes they turn to the health mediators. The number of eligible clients among these women is high, because the clients who are already in the program are knowledgeable of the enrollment criteria and the rate of enrollment is also very high. There are still great disparities even among our clients and unfortunately there are not many services in the social system to be referred to. The municipality has destroyed a lot of illegal houses in the Faculteta neighborhood and the only alternative available only for some of the people there is to use the existing public housing. Some people from the neighborhood have shared that they are afraid to live there because of the drug dealing and drug addicts in those apartment buildings. This is also not a long-term solution, since the municipality has announced their plans to tear down those buildings as well. Most people in these situations rent a room in someone else's house or add a shack to a relative's house. This makes for an overcrowded living environment with bad hygiene.

- Client engagement in the program (including client retention): 17 clients have discontinued the program. Two of them due to the death of the baby (one baby has died due to an illness at 4 months and another baby has died from a congenital heart malformation at 3 months). Some of them have left because of pressure from the family to discontinue and some because they have moved to a different town or abroad (7 clients). The overall retention rate is 82% - 95% for pregnancy phase, 86% for infancy phase and 82% for toddler phase. The low attrition rate is an indicator of the need of the served community for our services. Not all of the clients are equally engaged with the program and that is due to the difficult living conditions and the multiple challenges that some of our clients face, as well as the low literacy rates. Further adaptation of the materials and more close collaboration with professionals providing health and social services can mitigate some of these challenges. The overall involvement in the program, understanding of the materials and acceptance of the materials by the clients has been assessed as relatively high by the nurses at respectively 90%, 91% and 95%. The high acceptance rate of the materials by almost all of the family members involved in the visits is also very encouraging fact. This means that some of the traditional practices, which are regarded as unhealthy in comparison with the up to date standards, might be actually changing.

- Engagement of fathers: The husband/partner is more involved in the pregnancy stage than later in the infancy stage and their involvement dramatically drops at the toddler stage. When present in the visit their overall involvement is assessed at 74%. This is an area where the Sofia team might want to pay more attention and to try to involve the husband/partner or rather to maintain their interest.

- Engagement of other family members: The nurses still rank the involvement of the mother-in-law as the most significant one, since she is the authority in the family when

it comes to raising a child. We have discussed previously and should focus on involving mothers-in-law in support of the program's goals through information campaigns and advocacy efforts targeting feeding practices for example. The nurses have shared that when the girl is living with her own parents she is given more freedom to make decisions about her future related to school and employment. This is an area where we need to think strategically about in order to have some effect on the lives of girls living with the family of her husband/partner.

- Engagement of community, in particular primary care providers and child welfare agencies: We still do not have much success in persuading doctors to provide the one free prenatal check-up, which under law all women without health insurance should be entitled to receive. Even if women have health insurance, often the obstetricians see them as non-profitable and refuse to include them in their list of patients or to perform the medical exam. We have used the services and assistance of Dr. Velev, the head of Sheynovo hospital, in emergency situations. We are paying for medical examinations, laboratory tests and medicines for full pregnancy monitoring and care for all uninsured women, and for the ones under 18 who are insured we are providing prescribed medicines when the family cannot afford to buy them. Babies/ toddlers are insured, but even when medical check-ups occur, medicines are not covered so we are providing them also. We had an intern over the last summer, who did desktop research on health systems and in particular on access to medication for children and we are using these findings for our advocacy efforts for free medication for children at least up to the age of 3. All clients and their babies have access to vitamins and contraception paid again by the NFP budget. All mothers are provided with breastmilk pumps and bottles when requested.

  Our nurses in Sofia re collaborating with the local Child protection department. Number of our NFP clients receive services from state funded service providers, such as rehabilitation for children with developmental delays.

- Success/challenges with receiving referrals

  Our biggest success has been the multiple referrals from existing NFP clients. This indicates that our clients perceive our services as valuable and would recommend them to other family members (sister, sisters-in-law, cousins etc.) The referrals from other services, however, has been a challenge that we are working on. We have now taken a more direct approach to contacting and informing health professionals about the program and ways in which we can cooperate.

  The Plovdiv team has used the time before training and starting their field work to contact all the health and social services providers, who also work with the community that they will be serving. They have presented the program and established working relationships with them, which we expect to make their work easier and more effective. The local coordinator in Plovdiv is an active social worker, who has deep knowledge about the available social services and will support the team in establishing a working referral system.

Program Implementation

- Any adaptations, changes, enhancements made to: Visit-to-Visit Guidelines, Nursing Assessment/Data Collection Forms etc.: We have made small changes and adaptations to the data collection forms used to better reflect the work in the field. For example, the name of the client is not used in the forms, instead the nurses are using the number assigned for the client by the IS, which protects the data even further by making it anonymous and also helps the work with IS. Some clarifications have been made on some of the questions in the data forms, so that all nurses have the same understanding about the data that is collected. We have an agreement on the use of the Relationship assessment form, which will be used only when the nurse is sure that it would be safe for the client and would not be traumatic for the client. We asked them that they still use the form when appropriate, so that we have some information on IPV, and meanwhile we will start the process of adapting the new IPV forms and the nurses pathway.

- Brief description of our nursing education program: The assessment of educational level and skills of nurses and of their ability to achieve competencies required for NFP nurse and supervisor roles have shown the need for extended training and a training plan has been developed for both sites for 2019. Sofia team has gone through most of the trainings and for those that have not happened yet, they will receive them in 2019 either together with the Plovdiv team or separately.

  <u>Undergone trainings for Sofia team:</u>

  1. Communication skills, including body language; Part 1
  2. Cultural particularities of Roma community in general – historical background and traditions;
  3. 2. Basic knowledge of obstetrics/midwifery (including course of normal pregnancy and early signs of risk pregnancy, false and true signs of birth process, normal birth, operative birth, early/late complications of pregnancies);
  4. Breastfeeding;
  5. Care for healthy newborn;
  6. Complimentary feeding – when, how, what to eat? – According to International and Bulgarian recommendations;
  7. Growth charts – WHO for exclusive breastfed infants and Bulgarian growth charts;
  8. Bulgarian immunization calendar;
  9. Cultural particularities of Roma community in children rearing;
  10. Intimate partner violence;
  11. Basics of home visiting;
  12. Pre-natal psychology – using the theory of attachment in creation of mother-fetal relationship; Part 1
  13. ASQ training.
  14. Communication with the extended family;
  15. Case management. Part 1
  16. Field work. Part 1

17. Working with the NFP IS
18. Using reporting in the NFP IS

Planned trainings for Sofia team for 2019:

1. Communication skills, including body language; Part 2
2. Contemporary guidelines for early child development – how to make early diagnosis (to detect early signs of delay in psycho-motor development);
3. Case management; Part 2
4. Child protection;
5. Attachment parenting; Part 2
6. Depression and anxiety scales;
7. Field work; Part 2
8. Embracing diversity (April)

Undergone trainings for Plovdiv team:

1. Cultural particularities of Roma community in general – historical background and traditions;
2. Basic knowledge of obstetrics/midwifery (including course of normal pregnancy and early signs of risk pregnancy, false and true signs of birth process, normal birth, operative birth, early/late complications of pregnancies);
3. Intimate partner violence.
4. Pre-natal psychology – using the theory of attachment in creation of mother-fetal relationship; Part 1
5. Turkish language course
6. Working with the NFP IS

Planned trainings for Plovdiv team for 2019:

1. Embracing diversity (April)
2. Trainings - Burnout prevention & conflict resolution (May)
3. Identification of addictions (May)
4. Breastfeeding training (June)
5. Care for healthy newborn;
6. Complimentary feeding – when, how, what to eat? – According to International and Bulgarian recommendations;
7. Growth charts – WHO for exclusive breastfed infants and Bulgarian growth charts;
8. Bulgarian immunization calendar;
9. Depression and anxiety scales; (October)
10. Working with an interpreter in a home visit
11. Cultural particularities of Turkish community in general – historical background and traditions;

12. Pre-natal psychology – using the theory of attachment in creation of mother-fetal relationship; Part 1
13. Contemporary guidelines for early child development – how to make early diagnosis (to detect early signs of delay in psycho-motor development); (November)
14. Attachment parenting; Part 2
15. Using reporting in the NFP IS

Unfortunately there are no trainers in Bulgaria, who can provide the Dyadic observation training and as a result the nurses cannot use these NFP materials. As it can be seen from the lists of trainings above, there are some differences in the trainings needed in the two teams which stem from the differences of the served communities.

<u>Mediators from both teams have taken part in some of the training activities of NFP team:</u>

1. Communication skills
2. Cultural specifics of the Roma community,
3. Motivational interview (OARS),
4. Working with clients in pre-contemplation,
5. Strength based working and self-efficacy theory in NFP,
6. Client recruitment for NFP,
7. Client engagement and challenges to this,
8. Human ecology theory and application in NFP.

- Any enhancements we have made to the program: The new additional element for mediators, which outlines more specifically their role and responsibilities, as well as the benchmarks which will be used to measure their success, was approved in January this year.

Program Fidelity

- Our assessment of program dosage patterns and length of visits in relation to client strengths and risks to date: At the moment there is only 1 client on an alternate visit schedule. This client receives less visits than the prescribed dosage due to the high economic standing, good living conditions and support from the family. The plan has been mutually agreed by the nurse and the client and approved by the supervisor. For the 84 clients who have finished the pregnancy stage (5 clients are still at pregnancy stage and 5 clients have discontinued during this stage), the recommended dosage amounts to 980 visits and they have received 1012 home visits, which is 3% more than the recommended. 40 clients have been visited more than the recommended with an average of 3 extra visits per client. 35 clients have

been visited less than the recommended, with an average of 2.5 visits less. Nine of these cases can be explained with premature birth. One hypothesis for this lower dosage for the other 26 clients is that clients are not always at home for the scheduled visit or cancel the visit very often, which nurses have shared with us. We will soon have more detailed data on cancellation rates by clients and nurses which will give us more insight. In the rest 9 cases, the clients have received the recommended dosage of home visits. The average length of visits is 73 minutes. The range is 291 with the shortest visit being 9 minutes and the longest - 300 minutes. The short visits can be explained by the interruption of visits by family members, which does not happen very often but they have been reported on several such occasions. The longer visits can be explained with accompanying clients to receive health or social services. The number of such long or short visits is limited. Most visits are within the range of 60 to 90 minutes.

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

Domains	Total	Pregnancy	Infancy	Toddler
Personal Health	**30 %**	57 % (35-40%)	15 % (14-20%)	14 % (10-15%)
Maternal Role	**44 %**	24 % (23-25%)	58 % (45-50%)	50 % (40-45%)
Environmental Health	**6 %**	5 % (5-7%)	6 % (7-10%)	10 % (7-10%)
My Family & Friends	**7 %**	4 % (10-15%)	8 % (10-15%)	11 % (10-15%)
Life Course Development	**13 %**	10 % (10-15%)	13 % (10-15%)	15 % (18-20%)
Total	**100%**	**100 %**	**100 %**	**100 %**

There are several domains that are either more or less prevalent in the different stages of the program. In the pregnancy stage a lot more time is spent on Personal health than the prescribed and this is mostly taking of the time for topics from the My Family & Friends domain. The same is true for the Maternal Role domain in the infancy stage, where topics from Environmental Health and again from My Family & friends domains are overlooked. In the toddler stage the Maternal Role domain continues to be the most explored one, but here this takes up time from the Life Course Development domain, which should be given more time and focus as the client is also preparing to leave the program. Since we still do not have separate reports for each nurse, we will give recommendations to the supervisor, to work with each nurse separately and go over her reporting and the ways each one is following the recommended distribution of time between the domains. There have been several discussions on this topic in the previous year and we have received feedback from Ann Rowe on the questions that the nurses had regarding distribution of time. They noticed that the clients were most interested in one or two domains, different

for the different stages. They agreed that it is their responsibility to shift the clients' focus and to help them get a wider perspective on their lives. However, they have found it difficult to do this with the most impoverished clients, who can't meet their most basic needs and who have very limited resources but also options, as there is not much support they can get from the municipality or the government. We will explore various hypothesis for the shifting focus among the domains:

- Clients having limited access to health services take the opportunity to discuss all kinds of health topics with the nurses
- Clients might be reluctant to discuss family matters with the nurses, on one side because it is early in the program and they might not trust them yet with this topic. On the other hand, clients might feel that family roles are predefined and hierarchical and they cannot be challenged.
- Some of the materials pertaining to the My family and friends and Life course development domains are not relevant for the local context (tax returns, credit card etc.) and no new materials have been developed to address the more general topics within the domains.
- Nurses might feel more comfortable presenting and discussing health related topics with the clients due to their education and practice. They might need more support, guidance and training to feel more confident in working within the other domains.

NFP program innovations

- We are using/plan to use the following program innovations/enhancements (e.g. STAR Framework, DANCE, IPV, Mental Health, other): The nurses are using the STAR Framework and see it as an extremely helpful tool. We have enabled the form to be printed directly from the information system after it has been filled in on the computer, which has further encouraged and made easier the use of the framework.

  As it was mentioned earlier, during the last visit of Ann Rowe it became clear that the introduction of the new IPV forms and the related documents, developed specifically to be used by NFP nurses, needs to be very well thought process. We will take steps to approach the specialists who have trained our nurses on IPV and will collaborate with them to adapt these documents for use in Bulgaria.

  The ASQ:3 and ASQ:SE have been translated and adapted to be used in Bulgaria and the Sofia team was trained to use them in March 2018. They have been using the tools for a year now.

- Assessment of our successes/challenges in implementing/adapting these program innovations: The adaptation of the IPV documents might take some time and we cannot use any other instruments at the moment other than the Relationship assessment form, which has potential risks for the clients experiencing IPV, as stated by the NFP international researchers.

We received permission to be trained and use the ASQ:3 and ASQ:SE tools in their last phase of adaptation and the nurses are finally able to assess the children's development, however, not all of the children have been screened from the very beginning since the training came well into the implementation of the program.

Our information system and analytical capacity:

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

  The Sofia team has caught up with inputting data in the information system since it was launched in October 2017, and are maintaining good speed of inputting the new data. They have received an initial training on use of the IS. This initial training was also done with the Plovdiv team, however, they will be using the system without the backlog of paper forms that the Sofia team had and there might be difference in the use of the IS in terms of attitudes towards its use, accuracy of data input, different time to get used to the IS, etc. The Sofia team has also had training on using the readily available reporting that updates after every data input and can be used to see trends in their own work. This type of training will happen for the Plovdiv team as well, as soon as each nurse has at least two or three clients so that they can see how the reporting works. The trainings with the Sofia team have also led to ideas for some new reporting items that will be helpful for the teams' work. There was an extensive and very productive discussion with the nurses from Sofia team in August 2018 on data forms, different components in the forms and their use. All ambiguities surrounding some of the questions, the use of the gathered information and the schedule for using the data forms, which nurses have raised, have been cleared out. In result, the data forms have been updated in their paper versions and most of them have been updated in the information system as well. The data collection manual has also been updated and the Plovdiv team is able to start using the new versions from the very beginning. Common mistakes in the input of the data were also discussed and as a result the IS functionalities have been modified, so that most of the mistakes are now detected before the submission of the forms, which saves a lot of time for the nurses and the data analyst. The clinical lead uses the reporting to provide feedback to the supervisors and the nurses and to make informed decisions on program implementation. We use gathered information to inform our discussions at the LAB and NAB meetings, to present the program and to report on progress to our board members and donors.
- Our reflections on our information system and what we need to do to improve its functionality, usefulness and quality:

  Several changes have already been made in terms of functionalities (auto detection of missing data points has been developed to save time for the nurses and the data analyst in sending back and forth incomplete data forms); reporting (several new reports are readily available for the nurses, supervisors and clinical lead and there are more reports under development, which will improve the work of the team); usefulness (the nurses can now print out some of their filled in forms directly from the system, like the STAR framework, which saves time from filling in the paper form too).

Individual monitoring on each nurse' data forms input was also performed after they caught up with the input of paper forms in the IS and this proved to be an useful process for detecting missing or double input of forms and has given ideas on improving the IS by adding notifications and filters for a better use of the system.

- Our plans to develop a Continuous Quality Improvement process:

  We plan to set up meetings on a 6 months basis in which the data analyst will work individually with each nurse to ensure quality and completeness of gathered data. We also plan to have another training/discussion on the use of the IS and its reporting functionalities to discuss what can be improved in the work of the IS. These trainings/discussions will also be done on 6 months basis. Through this bidirectional feedback the nurses can improve their work with the data forms and the system and at the same time we can improve the IS in support of their work.

- Please provide:
  A copy of the annual data report is attached at the end of this report.

Nursing Workforce

- Reflections on NFP nurse/supervisor turnover/retention during reporting year:
  Currently we have two NHV teams (plus health mediators/field assistants) – one for each NFP site.

  The Site 1 team in Sofia has stayed the same since the start of the program 3 years ago – no staff member has resigned. However, there are some changes due to a maternity leave of one of the nurses (part-time). She was replaced by a newly recruited full-time NHV who was trained together with the Plovdiv team (Site 2). In addition, one full-time nurse decreased her working hours from 8 to 6 hours and is now part-time.

  As for Site 2, a few major team transformations happened just before the NFP Foundations training late January 2019. One NHV and the team supervisor decided to quit because of other professional opportunities abroad. Thus, the supervisor position was offered to another team member (the deputy supervisor) who accepted it and took part in the supervisor training with the NFP international consultant. These developments, however, reduced the team and its capacity significantly - 1 SV and 2.5 NHV with a total capacity of 54 clients. This is the reason for renewing the recruitment process for Site 2.

- Successes/challenges with NFP nurse/supervisor recruitment:
  In 2018 we managed to find and hire what we considered a strong nurse supervisor for Site 2 who got deeply involved in the recruitment of the rest of the team (5 NHV). Despite the challenges in the negotiation process with the implementing agency for the new site, having the whole team already on board was a huge success for us. However, the resignation of the SV and the NHV set things back a bit.

Our efforts to build a full team for Site 2 so far has shown that recruiting nurses/midwifes outside of the capital city of Sofia is particularly challenging. There is an acute lack of such professionals in general in the whole country but outside of Sofia the deficiency is even deeper. Few candidates apply to our job offers and most of those applying are either in retiring age or exploring our program as an opportunity for a second part-time job. Because of this serious situation we decided that along with the recruitment process in Plovdiv we will continue with the same in Sofia, too. As the program is already well known and sought after by potential clients in Sofia, we think it might be useful to further expand the Site 1 team outreach and compensate for the smaller Site 2 team.

- Successes/challenges with delivery of core NFP nurse/supervisor education:
  The new team in Plovdiv and the new Sofia nurse completed the NFP Foundations training in January 2019 and gave a very positive feedback afterwards (50% were very satisfied and 50% were satisfied with the content, the way of teaching and the practical exercises). There was also a supervisor's training for the new nurse supervisor and her deputy together with their counterparts from the Sofia team. The latter shared their own experience, good practices and practical advices with the new colleagues.

- Successes/challenges with ongoing (integration phase) NFP nurse/supervisor education:
  Our Site 2 team has started completing the ongoing education components we have envisioned for the NFP field staff. In January and February, they passed a few trainings on Monitoring of normal and pathological pregnancy, Giving birth, Prenatal and postnatal depression. The trainings were delivered by a professor from the Medical University in Varna.

- Successes/challenges with delivery of NFP nurse reflective supervision:
  There has been a decrease in the number of weekly supervisions in Site 1 team because of the long absence of the nurse supervisor in 2018 due to medical issues. However, since November the supervisions have been renewed but are still infrequent and poorly documented.

  As for the Plovdiv team, they are still getting into the supervision practice and habit. There is a strong commitment on the supervisor's side who is regularly inviting the NHV to participate into this NFP component. However, the nurses feel some resistance as they link the supervision directly to the phase when they have a growing number of clients and consider it to be unnecessary in this early stage of their work. The central team has planned some discussion sessions on the essence and importance of the NFP supervision for further clarification.

- Successes/challenges with delivery of reflective supervision to our supervisors:
  We still have challenges in the supervision of the supervisors, which we are addressing. The psychological supervisions of the Sofia supervisor were interrupted for several months due to a sick leave of the psychologist. Regular supervisions by the clinical lead were never established because of resistance from both parties. Monthly

supervisions with a psychologist, who has worked with the Sofia team from the beginning of the implementation of the program, are planned for both supervisors. Weekly supervisions with the clinical lead are also planned for both supervisors.

- Any plans to address nursing workforce issues:
  In 2019 we have planned a few trainings focusing on the psychological and emotional wellbeing of the NHV. Both teams will have a chance to know more about burnout prevention, conflict resolution and mechanisms for coping with loss/grief. The nurses themselves have identified and stressed on the need for such trainings because of cases and situations they have faced in their work either with clients or with colleagues.
- We have also planned to regularly meet both teams for exchange of experience and good practices. Team buildings are also on the schedule for 2019 in effort to create better team environment and address emerging issues.

Summary

- What have we achieved this year:
  We have successfully expanded the program implementation to a second site – Plovdiv. The negotiation process with the implementing agency there was successfully completed with a partner and respectively with labor contracts for the NFP team members. The SV, NHVs and mediators successfully passed the first part of the NFP core education and officially initiated the client recruitment campaign in the beginning of February 2019.

  One new NHV was recruited for Site 1 team. The two mediators in Sofia have achieved the competency of health mediators and are eligible for state funding. An additional element was developed and signed to outline the role of the mediators in the NFP program in Bulgaria.

  There were two NAB meetings and three LAB meetings in Sofia, and the state authorities express more interest now in home-visiting services in general and NFP in particular. We have started negotiations with the Ministry of Health to partner with their research institute to adapt the description of NFP program according to the requirements for medical service methodologies.

  We have received the first F&A study report with recommendations on improving and adapting further the implementation of the program.

  We now have fully functioning IS with up to date information and we are continuously working to improve the program and make it a working tool for quality improvement.

  Most importantly, based on the growing number of referrals from NFP clients, the high retention rate and the first indications from the F&A report we can conclude that so far we have achieved high acceptance of the services provided by the NFP program in the Roma community.

- What challenges do we face?

Bulgaria faces a critical shortage of qualified nurses, a problem that has persisted in the past 30 years and has been interlinked with the ongoing healthcare reform.

According to data from the National Statistical Institute of Bulgaria, the number of nurses in the country in 2017 has dropped to 30 955, the lowest number in the past 7 years.

The main factors that have been aggravating the context of the nursing workforce are the pendent structural reform in the health care system and the hospital sector, resulting in waves of staff reductions affecting nurses; low financial remuneration and heavy workload resulting in emigration.

Furthermore, data from BAHNP shows that there is unequal distribution of nurses across the 28 administrative regions in the country leaving certain regions at a critical low level of nurse: population ratio. The unequal distribution of the nursing workforce on the organizational level creates a misbalance between primary and secondary health care with 61% of all nurses working in hospitals and only 39% working in out-patient care contexts (such as home-visitors).

Lack of maternity care for uninsured mothers and difficult access to maternity care for insured mothers due to discrimination are still an issue.

High levels of illiteracy of clients may cause limited use of Program materials and this issue will only get more challenging with the new site in Plovdiv as the baseline report shows that about 78% use Turkish as a primary language and so far we have only adapted the materials in Bulgarian. Further adaptation in Turkish will not solve this problem as most of the potential clients use a specific dialect of the language and only for oral communication.

The reflective supervision practice remains a challenge in Bulgarian context due to the lack of traditions in psychological support of medical staff, the lack of autonomous practice of nurses and midwifes, and the hierarchical structure of the health sector, where nurses and midwifes have a secondary role.

The central team did not have administrator until December 2018 and the functions have been assigned to the clinical lead, which has decreased the amount of time devoted to clinical work and has slowed down the process of program adaptation and limited the clinical support for the supervisor and the nurses.

Any other relevant information:

PART FOUR: ASSESSMENT OF PROGRAM TESTING AND EVALUATION

Our feasibility & acceptability study:

- Goals:

A key aim of the evaluation is to explore whether or not it is possible to implement the NFP program according to these core model elements within the Bulgarian context and to identify barriers and enablers to implementing the NFP model, and to inform policy and practice around its future development.

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

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

- Methods:

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

- Sample:

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

with regard of the existing social work policies and early childhood development programs in Bulgaria.

- Progress to-date: We have received the first Preliminary Field Report draft in the beginning of December 2018. The report was due in August of 2018 but due to delayed data export development from our data base, we were unable to provide the needed data from our IS, thus their report was significantly delayed as well. This first draft of the report sparked some useful conversations between TSA and OSI-S. We have had several meetings to clarify again the aims of the report and to reestablish our expectation for this report. The research team at OSI-S was changed, to better suit the needs of the research process, however, the core team has remained the same, so that the gained knowledge and progress so far can be transferred in the next steps of the evaluation. The provided draft had to be revised in the light of these conversations and at the end of February we received the new version. We have provided feedback and will receive the final version by the end of March 2019. For more details see the Preliminary Field Report.

Data from feasibility & acceptability study:

- Key findings from our data

1. Community and organizational planning

- The NFP program is a complex intervention, which should be tailored to the community needs and cultural standards in more clear and transparent manner. An organogram in informational leaflet may be elaborated, which reflects the roles and responsibilities of all stakeholders involved is one of the possibilities. If an organigram is made, the research team recommends the usage of circular/radial infographic with "client" in the center (i.e. not hierarchical with TSA core team on the top and client at the bottom). The participatory brainstorm and designing of the organogram would help in clarifying the roles and interrelation of the stakeholder and serve as "a manual" of good community and organizational planning. Another way to work out the community communication problem is to incorporate information about the research part of the project in the informational consent and to train the mediators and nurses so that they would know how to answer the most frequently asked questions that the clients might have regarding the research.
- Continuous sensitivity training of the core team and local teams is needed, which includes training in participatory planning, advanced training in diversity management and culture of poverty (i.e. the segregated urban areas are not homogeneous as an ethnicity culture but could be similar in some everyday coping strategies). Currently both the core team and the local team (including the mediators) tend to assign some milieu side effects to the ethnicity of the clients while those effects are not a matter of ethnicity but an effect of poverty and therefore it's not a sensitive "ethnic" issue but phenomenon due to the social segregation.
- Independent psychological supervision of the nurses, health mediators and the local team management is needed, to prevent the burnouts and to improve the community planning.

2. Intensive nurse learning
Better training in diversity management and combating the race prejudices is needed. A change of the "Roma culture" trainer or recruitment of a complementary one is probably needed, since some social phenomenon are considered ethnically based. A testing of an alternative service provider – a para-professionals or social/health mediators – is highly recommended if NFP is aiming at being a program of national coverage, since there is a significant shortage of nurses in the healthcare system.

3. NFP data collection and reporting system
Improvement of the data gathering is needed in order to close the gap of missing data on income and living conditions. One possible solution could be an additional training of the nurses and mediators on data gathering and evaluation. A second possible solution is the change of the approach and instead of income; an expenses based budget matrix may be elaborated (to be filled in on a daily/weekly basis). A zero income per household is unacceptable and non-valid information.

4. Health mediators
The current health mediators are very much community bound. They need a series of capacity building trainings in order to be able to work with different communities in Sofia, and in order to overcome their own prejudices towards the macro-society (i.e. suffer of "being native" effect). At the moment they act rather as community members than as a project staff members. Proper mediation needs more balance in that regard. Some participatory empowerment of the mediators should be encouraged.

5. Full coverage for all medical needs of all clients
It has a booster effect for recruitment but may negatively bias the postpartum dropout rates. A factorial internal RCT in the future may properly measure this hypothesis.
Instead of covering all medical needs of all clients, the TSA may try to achieve a change in the state regulations by developing alternative (i.e. not so expensive) advocacy strategies.

6. Unexpected findings
In order to be able to establish a proper RCT model with a valid impact and efficiency assessments, additional information about the refusals and the drop outs is needed. The research team recommends an elaboration of a log file or database with all refusals and dropouts by reasons and with a contact addresses in order to conduct some additional interviews and to run a meta-analysis (if possible). Bulgaria is a lower and middle income country. Since 2013, the MH and UNICEF have elaborated and implemented a model of home visiting services, which does not require a license payment and which seems to be cheaper at the moment.

- Reflections on our findings/results:

- Since we received the first draft of the preliminary field report we have had several meetings with the OSI-S team to clarify again the aims of the report and to reestablish

our expectation for this report, which also needs to be useful for our ongoing work on adapting the program. We have cleared all misunderstandings in these meeting and started a process of closer collaboration.

- It also became clear from the report that our team has failed to communicate some changes and adaptations we have made so far.

The need for better instruction of the interviewers and participation of NFP team member in their training has been identified and addressed. We have collaborated closely with OSI-S to make the interviewing process as effective as possible and have come up with a procedure to avoid further misunderstandings with our clients and nurses.

- We do not plan to test the program with paraprofessionals and mediators as primary program delivery agents at this point.
- As for the mediators, they have expressed some reluctance to go to one of the Roma neighborhoods in Sofia, where we have several clients that have been directly recruited by the nurses. One client was referred to the nurse by social services and this client has referred several other clients from the same neighborhood to the program. We believe that after receiving their training from Medical University of Sofia the mediators have been empowered to broaden their role in the program and in their neighborhood as well. The diversity training we have planned for the NFP teams will further help with the fact that they are "community bound", which we agree with to some extent.
- We have payed close attention to the UNICEF, which has made a great progress on the testing and implementation of their program but more importantly on putting the topic of early childhood development and in particular home-visiting on the agenda with the government. We have had useful communication and collaboration with them, however, more recently the national implementation of their program has been delayed or rather put on hold because of the lack of nurses in the country. This recent development has somewhat disturbed the close communication with them and we anticipate that they now see the NFP as a competitor, not a complementary home-visiting program, targeted to a specific group of vulnerable population, way in which we have always presented the program.

- Any actions planned based on results:

- We have already included information about the F&A study in the informed consent for the clients and have worked out a procedure, were the nurses will introduce the interviewers to the clients as part of the team and the program, in order to make the clients more comfortable and cause them no additional stress.

- We have organized meetings between the nurses and the OSI-S team, where the nurses got a better understanding on the need and usefulness of the F&A study and to accept it as part of the program. We have received feedback from them and developed a procedure on the work between the nurses and the interviewers so that this process introduces as little stress and discomfort for the clients as possible.

- We have already had an internal diversity training for TSA and the NFP team has undergone this training. We are also planning to organize diversity training for the nurses from both sites based on the OSI-S recommendations.

- We will be working on changing the questions about income in the Client intake and Client intake Update form, so that we can have consistency in the gathered data and we will take into account the recommendations of OSI-S to make the questions more sensitive towards clients, so that they are more willing to share such information. We will consider a training for the nurses on gathering such data.

- We are also working with the OSI-S team to add questions about refusals to enroll in the program in the Potential client form and the Initial contact visit form, which will allow us to follow the whole process from approaching a potential client to enrolling her in the program and will be able to see the trends of changing attitudes from the very beginning of the recruitment process.

- We have already established closer collaboration with OSI-S team and more regular communication in which important decisions and changes are shared with their team, so that they can take those into account in the process of ongoing research.

Anything else that would be helpful for UCD to know?

PART FIVE: ACTION PLANNING FOR NEXT YEAR

Our planned program priorities for next year:

- Reach full capacity of Site 2 team (4-5 full time nurses); NFP Infancy Training
- Orient of Site 2 local site developer and psychologist of the team
- Implement client recruitment strategy ins Site 2
- Recruit non Roma clients in Site 1
- Strengthen the collaboration between NFP nurses and health service providers
- Develop and implement M&E plan, lessons learnt, further adaptation
- Draft a proposal for normative regulation of NFP as a new integrated health service for vulnerable groups
- Plan first steps of RCT phase
- Establish links with other TSA initiatives (employment opportunities, exploration of narratives on maternity in the Roma community, advocacy to enable access to health services, training of professionals on embracing diversity)

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

- Explore available instruments in Bulgaria for tracking speech development and introducing them in the NFP implementation
- Adapt IPV forms and documentation for use in the NFP

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

- To address the quality improvement aspect, we plan to engage the new evaluation expert within the NFP central team. She will devote time and efforts on drafting a Monitoring and Evaluation Plan with the aim to reinforce the innate quality improvement system and assess the quality of the program implementation. This step, together with strengthening the knowledge and skills of the supervisors to use and analyze data from the IS reporting to inform their work should impact the overall quality of the program implementation. At this stage of the program, with the start of a second site, the graduation of the first Sofia clients and the RCT phase on the horizon in just a few years, it is crucial that we pay more attention to quality improvement.
- In addition, we plan to focus on the ongoing nurse education for both Sites – the Sofia team still needs to complete some essential training modules and the same holds for the Plovdiv team. We believe that strengthening the knowledge and competency of the nurses in key areas will improve the quality of the program implementation.
- The supervision practice will also be strengthened within both teams. Site 1 team had some challenges with this NFP component for various reasons and Site 2 team is still getting used to having the supervision sessions. However, the central team will now monitor more closely the implementation of this particular program element and will provide timely support.
- Based on the feedback from our NFP nurses and clients we will introduce further adaptations of the program materials.

Our research/program evaluation priorities for next year:

- Continue with implementation of F&A study in both sites and receive and review the second report. As in 2018 we have started seeing clients graduating the program, meaning that we have completed the full NFP cycle, we can now adequately explore what the strengths and weaknesses are, what needs to be further adapted or improved. We will ensure to close communication and collaboration with the OSI-S team, that the planned methodology (interviews with clients while they go through all 3 phases of the program) for the F&A study is implemented as planned for both sites.
- For next year we plan to work on summarizing the lessons learnt from the program implementation so far.
- Research the potential for enhancing the role of the graduated mothers to become ambassadors of the program and disseminate key health messages.
- Research available data, which is reliable to be used in preparation of an RCT, and also the feasibility to collect data against particular measures like speech development for example. Research the options for setting NFP sites on the territory of Bulgaria based on geographical distribution of potential clients.
- Assess the feasibility of using measures on anemia and healthy feeding practices and adapt present methods of data collection and evaluation.

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

- Site 2 team reaches full capacity
- Established and effective referral system and operating LAB in Site 2
- Recruit 50 clients in Site 2
- Recruit 5 non Roma clients in Site 1

- More referrals are done by clinicians/medical specialists and increased interactions in cases of addressing of health problems of clients
- M&E indicators show quality improvement
- Comprehensive list of lessons learned to be shared with Site 2, public institutions, NFP international community
- Updated materials that more adequately reflect clients' needs
- Submission of a proposal for normative regulation of NFP as a new integrated health service for vulnerable groups to the Ministry of Health
- List of measures which allow feasible data collection for impact evaluation through RCT or quasi-experimental research; list of geographical locations for potential NFP sites; agreement on research design
- Through established links with other TSA initiatives, NFP clients have access to more opportunities for employment; NFP nurses have better understanding of maternity role in the Roma community; NFP clients will potentially have improved access to health services and face less discrimination from health professionals

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

- Leading of Infancy training – for new nurses, supervisor and health mediators in both sites
- Ongoing support for supervisors and central implementation team
- Review of RCT plans

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

- We eager to share our experience in developing and operating with database in NFP (information system).
- We hope to learn more about the family dynamics in settings where several generations live together, about involvement of elders and how these affect the implementation of the NFP program.

PART SIX: ANNUAL REPORT FROM UCD

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

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

- Advice and guidance to Clinical lead through regular mentoring and consultation calls
- Support to further consider the role of the NFP mediators and complete the 'Additional Approved Model Elements' proforma
- Support with development of curricula for supervisor and nurse education for Plovdiv site
- Collaborative planning and delivery of the 'Foundations' education for new NFP nurses and mediators
- Collaborative planning and delivery of the SV education
- Responses to ad hoc questions and requests for documents etc
- Access to NFP International website and resources, Clinical Advisory Group and other International collaboration.

Identified strengths of program:

- The commitment, talents and resourcefulness of the leadership in TSA to ensure that NFP is given the best opportunity to be tested within the Bulgarian context.
- The additional resources that have been committed to the central leadership team, enabling a diversity of areas of work and development.
- The implementation of the Information system and the analysis of data that is now supporting the shaping of improvement projects.
- The understanding of the program that is now embedded in the clinical leadership and the Sofia team
- The tenacity and creativity shown in developing and establishing the second site in Plovdiv
- The commitment of the nurses, mediators and supervisors
- The development and growing success of the Local Advisory Boards
- The ongoing strategic work with the aim of creating a sustainable future for the program in Bulgaria
- The willingness of all involved to continue to learn, adapt and improve the program and work towards phase three.

Areas for further work:

- Continued development of the Plovdiv site, including nurse education
- Continued adaptation of program materials
- Development of understanding and implementation of reflective supervision within both teams
- Development of understanding and implementation of learning needs assessment practice and tailoring of individual learning within both teams
- Further refinement of the NFP educational curricula for future NFP nurses and supervisors

• Further development of the Information system so that regular reporting can be developed • Consideration of further adaptations that are needed for clients in the most challenging contexts
Agreed upon priorities for country to focus on during the coming year: • Priorities identified by TSA team are agreed (see part 5) • Addition of project to explore how nurses can address environmental health and housing within context of the program
Any approved Core Model Element Variances: • No new /additional variances requested
Agreed upon activities that UCD will provide through Support Services Agreement: • Additional meeting with Dr Olds and Ann Rowe to explore interim feasibility report in more detail and discuss progress to phase 3. • Dr Olds to provide details of appropriate speech /language assessments that have been translated into Bulgarian • AR to provide ongoing consultation to TSA leads (clinical and implementation) • AR to provide infancy training for new nurses and supervisor. • AR to provide ongoing support to NFP supervisors as requested.

