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International Nurse-Family Partnership® (NFP)

PHASE TWO ANNUAL REPORT

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

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

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

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

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

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

PART ONE: PROGRAM OVERVIEW

Name of country: Norway

Dates report covers (reporting period): 01.01.2021 – 31.12.2021(18.10.2021)

Report completed by: RBUP and Bufdir

Date submitted: 08.02.2022

The size of our program:

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

- We have 2 (+3 new partly from December 2021) _____ teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:4

- Current number of implementing agencies/sites delivering NFP: ____2_____
- Number of new sites over the reporting period_____3_____
- Number of new teams over the reporting period____3____
- Number of sites that have decommissioned NFP over the reporting period: 0
- Successes/challenges with delivery of NFP through our implementing agencies/sites:

This year, the team from South-west has been in a prolonged process of transfer to local employment. The team has encountered some challenges in the process, but as of September 27 they have been employed by the host municipality. Five new municipalities have joined the South-west region in 2021 and the host municipality is working on the necessary agreements for them to be included. Two new Family nurses have been recruited to strengthen the existing team and will start by mid/late February. The team has not started to recruit from the new municipalities, as signed contracts with the respective municipalities need to be in place.

There have been delays in Oslo to strengthen the team and to expand the geographical outreach due to Covid-19. However, the host township made great efforts and succeeded to transfer the team by January 1st. Organizing these transfers is complicated, but in Oslo the process has been facilitated faster and the team is cooping well. They have also kept up the recruitment pace. There are 3 new townships which agreed to join phase 3 in addition to the existing 2. Four new Family nurses have been recruited to the team and will be the largest NFP-team in Norway. The new nurses will start early in February and mid-March. The recruitment of clients in the new townships has not yet started.

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There are 3 new NFP implementing sites in addition to the 2 existing sites. All teams are employed by their host municipality or host township as of November/December. A couple of Family nurses and team coordinators will begin by early 2022. None of the new sites have started to recruit clients in 2021.

Due to covid-19 restrictions it has been challenging for the exiting teams to work as usual. Still, they have to a large extent managed to follow up the clients through home visits. But as for team-meetings and supervision face to face, meetings have been limited. Also, meetings with local advisory boards have mostly been held digitally and some have been cancelled.

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

License holder name: The Directorate for Children, Youth and Family Affairs

Role and Organisation: Official directorate reporting to the Ministry of Children, Youth and Family Affairs (Bufdir). The Directorate is in charge of the up-bringing sector and to facilitate a safe up-bringing for children, as well as leading the child protection services at national level and providing certain specialized services for local authorities targeted at particular vulnerable children and their families. In relation to the NFP Program in Norway the Directorate is the license holder and is responsible vis a vis the Ministry of Children, Youth and Family Affairs for the assignment to test NFP in Norway. The Directorate is also responsible vis a vis UCD to ensure that the license requirements and core elements of the program is complied with, as well as following the phases of the program. The program is funded by the Government.

Description of our National implementing capacity and roles:

1. Clinical Leadership:

Norway's Clinical Lead draws on her clinical background as a midwife from two different municipalities when planning clinical adaptations, implementation support to sites and training of the NFP teams. During many years she contributed to the training of midwives at the Institute of Nursing at Oslo Metropolitan University. She also has a history of engagement in the Midwives' Association.

The Senior Advisor has her clinical background from child welfare and has ample experience from work with vulnerable pregnant women, children, and families. Her skills and knowledge about dyadic assessment and tools, especially about Emotional Availability Scales (EAS) and video feedback of Infant-Parent Interaction, has been particularly beneficial in the process of developing the DANCE (Dyadic Assessment of Naturalistic Caregiver child Experiences) "substitute."

The other Senior Advisor has her clinical background from Public Health working as a Public Health nurse and as a Family therapist. She has broad clinical and theoretical knowledge, in infant and toddler development, parent and child interaction and mental health. She has in-depth knowledge of the various municipal services and interdisciplinary collaboration. The Senior Advisor has been Supervisor for the NFP team in Oslo since the beginning of 2016 and joined the National Office in January 2021.

The Project manager has her background as a Librarian and has expertise in systematic overviews, knowledge-based practice, literature search, as well as methods for summarizing knowledge and research design. She has worked with summarized research since 2006, when she was employed by the National Knowledge Center for Health Service. She worked fulltime at the National Office until October 2021 when she started in another department at RBUP.

The Network of Infant and Toddler Mental Health at RBUP, offers technical and clinical support to the Clinical Lead and Senior Advisor, and facilitates expert discussions and guidance throughout the country on relevant topics.

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2. Data analysis, reporting and evaluation:

Our research coordinator has a master's degree in health and social psychology and a bachelor's degree in psychology from the University of Oslo. She also has a one-year study program in Economics and Management from Oslo and Akershus University College. This year she went on maternity leave in April and her substitute as Research Coordinator started parttime from March and full time from May.

She has a bachelor's degree in social work with intercultural specialization from NTNU, experience in social work from NAV, substance abuse care and prison care, and a master's degree in interdisciplinary health research from the University of Oslo.

As a Research coordinator, one works full time and is responsible for overseeing the data collection and data input process, analyzing the data, and making the data reports. This year, there has been a high focus on the development of a new digital data collection system in collaboration with the research team. The research coordinator at RBUP manages the data system and develops monthly data reports. This year the position has had more responsibilities both in document development and the development of the new website. The research coordinator has regular meetings with each supervisor to hand over data reports and discuss data findings. The administrators/team secretaries in both sites are trained in data input and data quality, and reports are being run on a regular basis. The Family nurses collect data on paper forms, and the administrators handle the data system input/plotting into SPSS.

3. Service development/site support:

As mentioned above, there has been a transfer of both teams from RBUP to local employment throughout this year. It has been quite comprehensive and has demanded a high degree of cooperation between NFP Clinical Lead and the local leaders in addition to high level support from other support services at RBUP. The project manager together with the Clinical Lead, was responsible for preparing the agreement documents for the South-west site. The process took about 9 months. The transfer of the team to the host township in Oslo was a much quicker process.

The support to the two existing sites has mainly been handled by the Clinical Lead and the project manager. As for the 3 new sites the cooperation started shortly before the summer. The sites were given information both through sharing a short version of the management manual and through information meetings. It has been s challenging in the way that the sites varied widely in The new sites readiness for the NFP have varied and it has been challenging for the national office to accommodate their different needs due to competing priorities. The national office had to give priority to the recruitment and establishment of the new teams and to secure foundation training before the end 2021. Therefore, the leaders in the new sites did not get the information and training which we would have liked to offer them in order to support them in the best possible way. This will be addressed and given priority in 2022.

4. Quality improvement:

As we prepared for the new teams to have the foundation training, we undertook a comprehensive quality improvement and adaptation of the material to the Norwegian context.

5. NFP Educators:

Through phase 2 it has mainly been Clinical lead and Senior Advisor who had managed the education with important help from the research coordinator when needed. As a result of the expansion this year, everyone in the National Office has contributed greatly to the development and teaching of the new teams based on their respective areas of competence. We also have an agreement with a psychologist who is a specialist in Motivational Interviewing.

6. Other (please describe)

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Description of our local and national NFP funding arrangements:

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

Current policy/government support for NFP:

The Directorate is pleased that it was stated in the national budget in October 2021 that the program is to be funded for the period of 2021-2027.

Organisation responsible for NFP education: Not relevant

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

Continued work has been invested in bringing the health sector at national level on board in the program implementation. Their collaboration is needed especially with regard to the following two issues; 1) Where and how to organize the program beyond phase 3 (health sector versus child protection services or in collaboration between the sectors) and 2) Health sectors interest in the NFP- effect evaluation. Unfortunately, it is still challenging to get the Health Directorate and its Ministry of Health on board.

Other relevant/important information regarding our NFP program:

Also 2021 has been a very intense year, especially for the National office overseeing the implementation of the program on the ground. The recruitment process and collaboration with the implementation sites has demanded a lot of work for all parties involved.

At the level of the directorate there has been various legal issues around the program which has demanded the Directorates attention and dialogue with the Ministry, as well as the National Office for handling personal information.

The program continues to be referred to in several new strategic government papers and action plans which is considered as positive.

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PART TWO: PROGRAM IMPLEMENTATION

Clients

of NFP clients participating in the program at any point over the last year: 145

- Current clients: Pregnancy phase: 18% (N=19), 26.10.21
- Current clients: Infancy phase: 42% (N=44), 26.10.21
- Current clients: Toddler phase: 40% (N=42), 26.10.21

Nursing Workforce

- Average nurse caseload: 12 (26.10.21)
  Most of the nurses had a caseload between 11 and 15. One nurse, who started in March, had a caseload of 7.
  The average supervisor caseload was 4.

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

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

The numbers of staff who left during the reporting period include the transfer of the Supervisor from the team in Oslo, to the National Office as a result of moving into phase 3. An experienced Family nurse from the team took over the position as Supervisor and a new Family nurse was engaged from March 2021.

- Successes/challenges with NFP nurse/supervisor recruitment:

The interest for the NFP program and the posted positions have been very high in all the new sites.

- In “Trøndelag” region with Trondheim as host municipality, there were 118 applicants for the position as Family nurse and 12 for the Supervisor position
- In “Vestland” region with Bergen as host municipality, there were 26 applicants for the position as Family nurse and 13 for the Supervisor position
- In “Agder” region with Kristiansand as host municipality, the were 108 applicants for the position as Family nurse and 17 for the Supervisor position
- In Oslo for the 4 positions as Family nurse the number of applicants were 24
- In Rogaland for the 2 positions as Family nurse the number of applicants were 20

An important experience with the recruitment to the NFP teams is the use of former program participants named as experienced consultants in speed-dates. All applicants who came to the

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first interview met two former program participants. They got 5 minutes together and afterwards we arranged for feedback from all the meetings/speed-dates and the experiences were used in the overall assessment of each applicant. We found it very useful as our former program participants were very serious and respectful in their assessments and provided thorough, well-considered feedback.

- Any plans to address workforce issues: Since the number of implementing sites have expanded from 2 to 5, as well as the strengthening of existing sites the risk of turnover is even higher than before. This is something that we will monitor closely and is included in our risk assessment of the program for year 2022.

NFP education

- Briefly describe your NFP education curricula

NFP training modules. For the first time, the National Office has delivered the Foundation week for new Norwegian Family nurses. We have previously delivered education curricula for Infancy and Toddlerhood, but never for as many as 30 at the same time, and not in the first introduction week. We are satisfied with the delivery of Foundation week, and the feedback from the new nurses have been positive.

Newborn Behavioral Observation training (NBO). All the nurses already have the NBO-observer certification or get it through the program. This year, the Senior Advisor at the National Office, is joining the NBO-training with the new nurses, to develop the dyadic tools . This can assist us in bringing the NBO-curricula to be better integrated with the rest of the NFP-curricula.

Motivational Interviewing (MI). There is one day of basic MI training in the Foundation week, and regularly follow up sessions including case studies when the teams are gathered on regular basis. MI is also included in the weekly supervision with supervisors, to help them focus on MI in their supervision with nurses in the teams. The program collaborates with the same psychologist specialist, Tom Barth, as we have done since the start in 2015., We will continue the collaboration in the coming years. He helps to highlight the theoretical framework of MI and guide the nurses in how to implement MI in practice, by bringing up useful cases in the supervision.

Intimate Partner Violence (IPV). This include two separate days of basic training, led by Clinical Lead, Tine Gammelgaard Aaserud. The family nurses use the specific developed clinical pathway and the material developed for this intervention. It is structured and helps the family nurse to follow up as written in the clinical pathway.

- Changes to NFP education since the last report

A major step in this regard is our newly developed Video Home training which we call VIS (Video Interaction for Sensitive care). To make it more realistic to implement Video Home training in the new teams, we have made an adaptation and adjustment, based on the Marte Meo method and Video feedback of Infant-Parent Interaction (VIPI) which we used during phase 2. Our intention has been to develop a more easily accessible video guidance, without the requirement of several years of education. Video Interaction for Sensitive Care (VIS) is based on topics which our collected data over the past years have shown to be most relevant. The intervention is focused on two fundamental themes: 'Following the child' (child-initiated) and 'Leading the child' (parent-initiated). We intend to translate the training plan to English, which includes the

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knowledge base for the approach. We have also made a parent booklet where VIS is described. Let us know if UCD would like to receive the translation any of these resources. The training to become a Marte Meo Therapist lasts for 1-2 years.

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

As already mentioned, in December 2021 we delivered our first Norwegian Foundation week, with 30 new nurses. Luckily, we could conduct a live training, without being delayed by Covid. Everything went well, and the feedback from the nurses and supervisors were positive.

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

The conducted trainings and the revised training material have been adapted based on the experiences made in phase 2 and our Norwegian context. This applies to both training of NFP nurses and supervisors. We believe that this will improve the quality of the training an better align with what is relevant for the program participants in Norway.

The 3 new supervisors completed their first training in November 2021. This was followed by one day in December focusing on the theoretical background and implementation of individual supervision and team conferences. The National office continue to be in close contact with supervisors in meetings twice a week. There is a lot for the new supervisors to learn and integrate, in addition to learning to know the new municipalities, relevant leaders, host municipality and the sites as a whole. The National office need to strike the balance between providing them with a good understanding of the program and at the same time helping them overcome local challenges or obstacles. This is more challenging in some of the implementing sites than for others.

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

Each team has a Team coordinator (earlier called administrator). In phase 2, their role and work mainly consisted of plotting data from paper forms. Due to the digitalisation of the data collection, the work tasks for our 2 established Team coordinators will change as from 2022.
As part of the expansion of the program we have hired 3 new Team coordinators for the new teams. We need to develop a specific training for the 5 Team coordinators to give them a better and broader insight into the program, as well as an understanding of the work the Family nurses do. We hope this will enable them to assist the nurses in a better way. The Team coordinators will also have a greater responsibility to support and help the supervisors in establishing a good local interdisciplinary collaboration.

Reflective Supervision

- Successes/challenges with NFP nurse reflective supervision:

The nurse reflective supervision is going well. Also these documents have been revised and adjusted. As a result, the supervisors and the nurses find them even more useful. They also find it easier and more meaningful to prepare for both individual supervision and team conferences.

Due to corona, joint visits between supervisor and nurses at home visits have been a challenge to carry out according to the plan for this year.

- Successes/challenges with reflective supervision to our supervisors:

There is still less reflective supervision and more supportive and cooperative supervision in order to handle unpredictability's and different preparatory work linked to the transition to local employment..

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

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The Team coordinators work closely with the supervisor. They have not received reflective supervision during phase 2, but as described above, their role is changing. We have observed the need, especially for our established Team coordinators, to receive closer follow-up and support in the transition to new tasks. The supervisor and the NFP National Office will work together to make this transition as smooth as possible.

NFP Information System

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

Until the 18th of October the nurses collected the data on paper forms and the administrators/team secretaries plotted the data into the SPSS data program, developed for NFP data management by our research team.

On the 18th of October, we launched our new digital data collection system ("NFP-portalen"). All the data forms have since been filled out by our nurses with their new personal iPad. The transition from paper to digital plotting is more demanding that foreseen and there are also several technical challenges. Hopefully, the digital solution will in the long run free up time for the nurses and enable them to have a bigger caseload than they have today.

- Commentary on data completeness and/ or accuracy:

As mentioned above, until the 18th of October this year, all our data forms were filled out on paper and then manually plotted into SPSS. This led to some mistakes and missing data forms and the research coordinator did a lot of quality assurance to improve the data quality.

We have just started to look at the data since launching our new digital collection system. It´s still too early to measure data completeness and accuracy, but the new digital collection system gives our nurses an overview of every data form, as well as reminders when each form should be completed. We believe this will decrease the chances of mistakes and missing data. We look forward to further analyze data in 2022 to check if the digital system meets our expectations.

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

The research coordinator develops data reports for the supervisors, focusing on different data forms and various topics. We usually do this monthly, but less often this year due to Covid-19, the increased workload due to the expansion of the program and the development of our digital collection system.

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

The research coordinator also develops reports for the Advisory Boards in each site. Reports and data are in addition provided for Bufdir upon request, usually to be used vis-à-vis the Ministry.

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

As mentioned above, we launched our new digital data collection system in October. A lot of credit should be given to RBUPs "research support"-team, who helped us develop the system. The NFP teams (Family nurses, Supervisors, and Team secretaries) have also been involved in the process, at different stages, to enable the data collection system to become as good as possible and to serve different needs. We have also incorporated valuable experiences which we have gained over the past five years.

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Our research coordinator Frida (Marte has been on maternity leave in 2021) and RBUPs "research support"-team are still developing and adjusting the digital data collection system in cooperation with our nurses. We will continue to develop our new system to make it as easy and user-friendly as we can, secure data accuracy and completeness, as well as optimizing the way the system aggregate reports. In 2022 we will focus specifically on reports and how we can make data more available for our nurses and the National Office, to better inform and adjust our clinical practice. As well as providing needed information to the municipalities and local Advisory Boards.

Description of our implementing agencies/sites:

High level description of our implementing agencies/sites:

- At the level of the Directorate, we are very pleased that the existing teams finally have been transferred to local engagement. This is an important milestone for the program. We are also pleased to see how effectively the three new sites have taken the responsibility for the teams, though one of the sites will need to be worked on in 2022.

- It has also been interesting to observe the impatience and eagerness of the new sites to get started with the program. The National office have done an amazing job in 2021, this is especially true for the recruitment process which they have facilitated in the best way including the use of experience consultants.

- The establishment of well-functioning Local Advisory Boards will be paramount to focus on during 2022, as well as sound collaboration with other services at each site which play an important role in referring potential participants to the program/effect study.

Current number of implementing agencies/sites delivering NFP: _____5_____

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

It has been a complicated process to organize the transfer of the teams to local employment in the South-West region. There are municipal laws and regulations which defines these forms of cooperation's between municipalities and the transfer of teams like the NFP-Team. This implies that there are many agreements which will have to be revised and reviewed by the political leadership of all the involved municipalities before agreements finally can be signed off. This is also delaying the recruitment process of participants in the new implementing sites and in the municipalities/townships which are joining existing implementing sites.

The fact that local services and relevant leaders, have been involved in these processes is positive since the NFP program gets known beyond those being directly involved in the program. The challenge has been less meetings in the existing AB. In general, we experience that there is a local eagerness to establish the AB in the new sites.

It has been important to secure ownership of the NFP program delivery at the central City council level in Oslo. As a result, the program implementation in the new i townships has been a bit stagnant pending clarifications from the City council department. Due to these necessary

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clarifications, the AB in Oslo has not conducted any meetings in 2021. At the end of 2021, it was decided that an advisor at the City council, should have a direct contact with the NFP Clinical Lead, to stay informed about the progress in the five townships which are included in the program. A priority this autumn and towards the end of the year for the Clinical lead were meetings with administrative leaders in the existing implementing sites to discuss the arrangements for the transition of the teams to become locally employed. The selected host-township in Oslo facilitated the formal transfer and expansion of the team in the best possible way when considering the strict timeline.

The Oslo NFP team is the only team that counts 8 Family nurses. The National Office and the Supervisor in the Oslo team were leading the employment process in agreement with the host township. There will be a change of leader for the AB and the new leader is coming from the other township which was part of phase 2. The township is engaged and positive to have the leadership role of the AB.

We are much looking forward to gathering experience about the teams being locally employed, and to gather experience and data from five bigger and diverse geographical sites. One might expect that local leaders will take a higher degree of responsibility for the team, the program and how the recruitment and cooperation works. So far, the experiences with the local AB highlight the importance of working closely with the sites to develop a sustainable organization for the AB and to develop an effective way of information-flow to the right decisionmakers.

Program adaptation

- Brief description of our program adaptation processes:

During phase 2, we have experienced the need to adapt the material to the Norwegian context. We have in 2021 in collaboration with the Family nurses adapted and adjusted the overall structure of the program s, and the content (documents and facilitators) have been revised and adapted. Within the new structure, we have a stronger emphasis on helping the families to set goals and to explore their individual challenges and needs. We believe, this is improving the follow-up and the daily work in each family.

Linked to the larger program structure revisions we have also changed and revised the use of the STAR structure since we developed a new document for assessing the resources and risks/challenges the individual family has. This assessment document is (as STAR) linked to our 5 program areas. The document is being filled in by the Family nurse when setting the goals- with the client. We have also developed new facilitators, adjusted, and adapted previous facilitators for the nurses to use in the conversations about her risks, resources, goals and her challenges. It is being used at least at the start of the pregnancy, infancy, and toddler phase. It will also be revised as needed when changes, risks, or worries in the client's situation occurs. This document is completed in collaboration with the client, as often as possible.

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

This new structure and the materials were presented to the teams in November 2021. Despite the considerable changes and the work this entails, it was positively received. The nurses appreciate that the work in the families will be clearer and more directed towards their individual needs and

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challenges. The nurses also find it easier to adapt the revised materials and tools individually, based on the family's needs and goals.

- Adaptations planned for next 12 months.

Continue and complete the materials. We plan to gather our 5 teams to share experiences in using the new material.

In autumn 2021 we hired a design and communication agency to create a new visual profile for the program, including templates and a designated NFP website. The project will hopefully be completed and launched during spring 2022.

Reflections on successes and challenges with our adaptation approach:

As always, we include our Family nurses and supervisors in the process of proposing changes and necessary adjustments in the program delivery. Their input is invaluable, since they know the families and the challenges out there, better than anyone. In 2021 we have made major changes in the program structure, including reducing the program areas from six to five, and to sort it by topics, and not based on pregnancy-, infant- and the toddler-phase. This has been well received by our two existing teams, and the three newly started teams find the structure logical and are eager to learn and to use the program in this way. The National office recognize that 2021 has implied major changes for the Family nurses. It has been, and still is, a lot of new things to get acquainted to: changes in the program structure, digital data collection and the transition to local employment.

Any other relevant information: Described in part 4

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

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

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

Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% voluntary participation Monitored /assured by: (e.g. by signed informed consent) Family nurse	100 % voluntary participation	
2. Client is a first-time mother	100% first time mothers enrolled Monitored/assured by: Family nurse	100 % first time mothers	
3. Client meets socioeconomic disadvantage criteria at intake	The eligibility criteria for inclusion in the program in our country are: 1. Perceived neglect, physical/mental, violence/abuse or bullying 2. Contact with welfare in your own upbringing 3. Little social support in family and network 4. Persistent or serious conflicts in your relationship with partner or others 5. Difficulties in utilizing relevant	100 % clients enrolled who meet the country's eligibility criteria The average number of eligibility criteria that the clients meet is 3,5.	We have started to use our new eligibility criteria this year. Potential clients must go through an exploration process. To ensure that we include those who make the best use of the program and who meet our inclusion criteria. The nurses have become very skilled at conducting these interviews. Everyone must have a minimum of 2 conversations and between these the matter must be discussed with the supervisor or/and the team.

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
	services being offered 6. Not in work, education, and a low level of education 7. Persistent low income/difficult economy 8. Mental difficulties 9. Drug problems 10. Young of age There must be two or more criteria present for inclusion Application of these criteria are assured and monitored by: Supervisors and Family nurse in collaboration with the National Office		
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	94 % of NFP clients receive their first home visit no later than the 28th week of pregnancy 86 % of eligible referrals who are intended to be recruited to NFP are enrolled in the program 39 % of pregnant women are enrolled by 16 weeks' gestation or earlier	Two clients (6%) received their first home visit later than the 28th week of pregnancy. They were both included late (week 28 and 25).

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned a single NFP nurse.	100 % clients are assigned a single NFP nurse	
6. Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.	Current National benchmark is: ____% visits take place in the home We have not developed benchmarks on this.	71 % visits take place in the home % breakdown of where visits are being conducted other than in the client's home: Family/Friend's Home: 0 % Public Health Office: 0 % NFP-Office: 10 % Doctor/Clinic: 1 % Telehealth (phone): 5 % Telehealth (video): 4 % Café: 2 % Meeting outside/walking: 3 % Other: 4 %	In 2020 58 % of visits took place in the home. The Covid-19-situation was better in Norway in 2021, and more visits took place at home. The percentage is still a bit lower than pre-covid (79 % in 2019).
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	Current National benchmarks for: a) Length of visits by phase country benchmarks are: • Pregnancy phase: • Infancy phase: • Toddler phase:	• _____% of clients being visited on standard visit schedule • Average number of visits by program phase for clients on standard visit schedule is _____ • _____% of clients being visited on alternate visit schedule • Average number of visits by	We do not collect data on how many clients are visited on standard or alternate visit schedule.

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
between the client and nurse.	b) Client attrition by program phase country benchmarks are: _____% attrition in Pregnancy phase _____% attrition in Infancy phase _____% attrition in Toddler phase	program phase for clients on alternate visit schedule is_____ Average number of completed visits for clients who have completed each phase: • Pregnancy: 8. Range: 1 – 26. • Infancy: 20. Range: 8 – 35. • Toddlerhood: 14. Range: 2 – 35. • Length of visits by phase (average and range): • Pregnancy phase: Average: 78 minutes. Range: 15 – 150 minutes. • Infancy phase: Average: 79 minutes. Range: 10 – 180 minutes. • Toddler phase: Average: 80 minutes. Range: 10 – 160 minutes. <u>Client attrition by phase and reasons:</u> 1 % attrition in Pregnancy phase (of the 145 clients active this year) 2 clients left the program in pregnancy phase in 2021. • 1 client moved to an area where NFP is not available • 1 client left the program for other reason	These data are based on all clients, from 2016 – October 2021. The average number of visits in pregnancy is the same as last year. The average number of visits in infancy increased from 19 to 20, and from 13 to 14 in toddlerhood.

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
		5 % attrition in Infancy phase (of the 145 clients active this year) 7 clients left the program in infancy phase in 2021: • 1 client moved to an area where NFP is not available • 1 client refused NFP following report to Child Protective Services • 2 clients perceived that they had sufficient knowledge or support • 1 client left due to infant death • 2 clients left the program because the babies are no longer in mothers' custody 3 % attrition in Toddler phase (of the 145 clients active this year) 4 clients left the program in toddler phase in 2021: • 1 client moved to an area where NFP is not available • 2 clients refused new Family nurse • 1 client perceived that she had received what she needed from the program	

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by (eg standardized job description); Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc.	100 % NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree	
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula _____% of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	83 % of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities 92 % completion of team meetings, 90 % completion of case conference and 83 % completion of education sessions	In 2021 we had two Family nurses who was supposed to have the toddlerhood education according to the educational curricula. Due to the transfer of the existing teams to local employment, the expansion process, and the challenges related to Covid -19, we have scheduled the education for early 2022 (February). The new Family nurses and Supervisors received the Foundation week in December 2021 as planned. The team meetings and case-conferences have been held, though some of these meetings have been digital
10. NFP nurses, using professional knowledge, judgment and skill, utilize the	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.			
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	100% of 4-monthly Accompanied Home Visits completed (against expected).	30 % of 4-monthly Accompanied Home Visits completed	It has also in 2020, been challenging to implement Accompanied Home Visits this year due to Covid-19
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100% of NFP teams have an assigned NFP Supervisor 100% of reflective supervision sessions conducted against expected (calculated by time – working weeks- and number of nurses).	100 % of NFP teams have an assigned NFP Supervisor 72 % of reflective supervision sessions conducted	Following the expansion of the program with three new NFP teams and NFP Supervisors in 2022, we will especially focus on frequent contact with our NFP Supervisors through counseling, teams-meetings and NFP Supervisors gatherings.
13. NFP teams, implementing agencies, and national units collect/and utilize data	No benchmark. Monitored/assured by:	Progress: Please be referred to p. 9 (NFP information system) about our new digital data system (“NFP-portalen”).	Please be referred to p. 9 (NFP information system) about our new digital data system (“NFP-portalen”).

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.			
14. High quality NFP implementation is developed and sustained through national and local organized support	_____% of Advisory Boards or equivalents held in relation to expected _____% attendance at Advisory Boards held in relation to expected Monitored/assured by (including other measures used to assure high quality implementation):	_____% of Advisory Boards or equivalents _____% attendance at Advisory Boards	We have not collected data on this CME. We hope to be able to develop the AB and the reporting system fin order to gather this data. . In 2021 there has been fewer AB meetings in South-west than usual, due to the local transfer process of the teams and covid-19. There have been two AB meetings in South-west and the attendance has been good. In the AB in Oslo there has not been any meetings in 2021. The reason for this has mainly been because of to Covid-19 which hit Oslo hard. The conduced AB meetings have been devoted to discussions about the transfer of the teams to local employment. There have also been meetings at the City council

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Core Model Element	National Benchmarks and how these are being monitored	Progress against Benchmarks	Challenges + suggested actions to address these
			department to secure ownership and support of the mentioned transfer and the inclusions of three new townships.

Domain coverage*

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

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35 – 40 %	28 %	14 – 20 %	18 %	10 – 15 %	19 %
Maternal Role (My Child and Me)	23 – 25 %	30 %	45 – 50 %	46 %	40 – 45 %	43 %
Environmental Health (My Home)	5 – 7 %	11 %	7 – 10 %	9 %	7 – 10 %	10 %
My Family & Friends (Family & Friends)	10 – 15 %	18 %	10 – 15 %	18 %	10 – 15 %	17 %
Life Course Development (My Life)	10 – 15 %	15 %	10 – 15 %	12 %	18 – 20 %	13 %

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

In the infancy and toddler phases, our domain coverage is mostly within the benchmarks. In the pregnancy phase, the personal health-average is below the benchmark and the rest of the domains are above the benchmarks. We think this is because the clients also get pregnancy follow-ups from the universal services, and that they focus more on personal health there.

We are pleased that, even in 2021 with the Covid-19 challenges, our nurses seem to have delivered program content and covered all the domains in a good way.

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PART THREE: PROGRAM IMPACTS

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

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

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

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%) (2016 – 2020)**	**Current Period (n/%) (2021)**
Age (range and mean)	Range: 16 – 42. Mean: 27	Range: 18 - 40 Mean: 28
Race/ethnicity distribution	64 % (N= 154) of clients are Norwegian/Scandinavian. 36 % (N= 88) of clients have another ethnicity than Norwegian/Scandinavian.	70 % (N= 23) of clients are Norwegian/Scandinavian. 30 % (N= 10) of clients have another ethnicity than Norwegian/Scandinavian.
Home visits where father/partner is present	27 % (N=1834)	27 % (N=377)
Home visits where other family members are present:	2 % (N=158)	1 % (N=17)
Income (please state how this is defined) The average gross income in Norway in 2020 was around 65,000 USD.	92 % (N=184) of clients earned less than 65,000 USD.	93 % (N=26) of clients earned less than 65,000 USD.
Inadequate Housing (please define) • Staying with friend(s) temporarily • Residential care (treatment center, maternity home) ➔ Residential care can be both inadequate and adequate housing. Housing for the homeless is e.g. inadequate, but a client that currently lives	Staying with friend(s) temporarily: 2 % (N=5) Residential care (treatment center, maternity home): 2 % (N=4) Other arrangement: 2 % (N=6)	Residential care (treatment center, maternity home): 3 % (N=1)

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at a treatment center, can normally have an adequate housing alternative • Other arrangement		
Educational Achievement	Primary school: 30% (N= 71) High school: 28% (N= 67) Vocational school: 0% (N= 1) One-year program at university or college: 6% (N= 15) Bachelors' degree: 19% (N= 46) Masters' degree: 13% (N= 31) PHD: 1% (N= 3) Other: 2% (N=4)	Primary school: 18% (N= 6) High school: 39% (N= 13) Vocational school: 9% (N= 3) One-year program at university or college: 0% (N= 0) Bachelors' degree: 27% (N= 9) Masters' degree: 6% (N=2) PHD: 0% (N= 0) Other: 0% (N= 0)
Employment	52 % (N= 124) of clients were in employment.	52 % (N= 17) of clients were in employment.
Food Insecurity (please define)	Not Applicable	Not Applicable
Ever in the care of the State (as a child or currently)	Foster Parents: 8% (N=18) Residential Care: 10% (N=25) (as a child)	Foster Parents: 12 % (N=4) Residential Care: 12 % (N=4) (as a child)
Obesity (BMI of 30 or more)	8 % (N=17)	25 % (N=8)
Severe Obesity (BMI of 40 or more)	1% (N=2)	0 %
Underweight (BMI of 18.5 or less)	11% (N=24)	9% (N=3)
Heart Disease	4 % (N= 9)	6 % (N=2)
Hypertension	2 % (N= 4)	0 %
Diabetes – T1	1 % (N= 3)	0 %
Diabetes – T2	1 % (N= 3)	3 % (N=1)
Kidney disease	1 % (N= 2)	3 % (N= 1)
Epilepsy	3 % (N= 6)	0 %
Sickle cell Disease	0 % (N= 1)	0 %
Chronic Gastrointestinal disease	6 % (N= 15)	8 % (N= 3)
Asthma/other chronic pulmonary Disease	15 % (N= 35)	6 % (N= 2)
Chronic Urinary Tract Infections	10 % (N= 23)	6 % (N= 2)
Chronic Vaginal Infections (e.g., yeast infections)	7 % (N= 16)	8 % (N= 3)

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Sexually Transmitted Infections	20 % (N= 48)	17 % (N= 6)
Substance Use Disorder	9 % (N= 22)	28 % (N= 10)
Mental Illness: Anxiety	46 % (N= 111)	44 % (N= 16)
Mental Illness: Depression	47 % (N= 112)	56 % (N= 20)
Eating Disorder	17 % (N= 40)	22 % (N= 8)

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

We do not collect data based on STAR, but other data indicates that our client population is very vulnerable when it comes to mental illnesses. The number of clients who have anxiety and depression are very high, both last year (44 % and 56 % respectively) and the years before that (46 % and 47 % respectively). In addition, the number of clients who have an eating disorder is also quite high (22 % in 2021 and 17% in 2016-2020). This is further emphasized by the fact that 80% of the included clients in 2021 met the criterion of mental difficulties.

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Alterable Maternal Behavior/ program impacts for clients (please complete for all the time periods where the data is collected)					
	Intake	**36 Weeks of Pregnancy**	**Postpartum**	**12 months**	**18 months**
Anxiety (n, % moderate + clinical range) Generalized Anxiety Disorder 7 (GAD-7)	N = 206. 17 % moderate anxiety. 9 % severe anxiety.	N = 117. 14 % moderate anxiety. 3 % severe anxiety.	N = 198. 16 % moderate anxiety. 5 % severe anxiety.	N = 91. 7 % moderate anxiety. 5 % severe anxiety.	N = 76. 20 % moderate anxiety. 4 % severe anxiety.
Depression, (n, % moderate + clinical range) Patient Health Questionnaire-9 (PHQ-9)	N = 206. 24 % moderate depression. 16 % moderately severe or severe depression.	N = 117. 21 % moderate depression. 6 % moderately severe or severe depression.	N = 194. 19 % moderate depression. 8 % moderately severe or severe depression.	N = 89. 18 % moderate depression. 8 % moderately severe or severe depression.	N = 77. 17 % moderate depression. 11 % moderately severe or severe depression.
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours) We changed the questions about smoking and drug use in June 2020. We have added the question "Do you smoke now/at the moment"? It will be interesting to see how these numbers change/develop when more data forms are filled out. This data form is now being filled out at four times during the program: pregnancy intake, 36 weeks of pregnancy, 12 months and 18 months.	25 % (N= 67) of clients have been smoking in the pregnancy, including before they found out that they were pregnant. 5 % (N=3) of clients are smoking daily. 5 % (N=3) of clients are	11 % (N=11) of clients have been smoking in their pregnancy. 6 % (N=2) of clients are smoking daily. 0 % (N=0) of clients are		32 % (N= 21) of clients have been smoking since their baby was born. 4 % (N=1) of clients are smoking daily. 16 % (N=4) of clients are	 6 % (N=1) of clients are smoking daily. 12 % (N=2) of clients are

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	smoking sometimes. 90 % (N=54) of clients are not currently smoking.	smoking sometimes. 94 % (N=33) of clients are not currently smoking.		smoking sometimes. 80 % (N=20) of clients are not currently smoking.	smoking sometimes. 82 % (N=14) of clients are not currently smoking.
Alcohol, (n, % during pregnancy, units/last 14 days) Same changes in the data form as mentioned above.	44 % (N=120) of clients have been drinking in the pregnancy, including before they found out that they were pregnant. 100 % (N=59) of clients are not currently drinking alcohol.	100 % (N=35) of clients are not currently drinking alcohol.		56 % (N=18) of clients are currently drinking sometimes. 44 % (N=14) of clients are not currently drinking alcohol.	56 % (N=10) of clients are currently drinking sometimes. 44 % (N=8) of clients are not currently drinking alcohol.
Marijuana, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	6 % (N=12) of clients have been using marijuana in the pregnancy, including before they found out that they were pregnant. 100 % (N=58) of clients are not	100 % (N=37) of clients are not		3 % (N=1) are using marijuana once a month or less frequently 97 % (N=28) of clients are not	7 % (N=1) are using marijuana once a month or less frequently 93 % (N=14) of clients are not

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	currently using marijuana.	currently using marijuana.		currently using marijuana.	currently using marijuana.
Cocaine, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	1 % (N=3) of clients have been using cocaine in the pregnancy, including before they found out that they were pregnant. 100 % (N=55) of clients are not currently using cocaine.	100 % (N=33) of clients are not currently using cocaine.		100 % (N=25) of clients are not currently using cocaine.	100 % (N=11) of clients are not currently using cocaine.
Other street drugs, (n, % used in pregnancy, days used last 14 days) Same changes in the data form as mentioned above.	1 % (N=2) of clients have been using other street drugs in the pregnancy, including before they found out that they were pregnant. 100 % (N=56) of clients are not currently using any other street drugs.	100 % (N=34) of clients are not currently using any other street drugs.		100 % (N=31) of clients are not currently using any other street drugs.	100 % (N=12) of clients are not currently using any other street drugs.

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Excessive Weight Gain from baseline BMI - Pregnancy, (n, %)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Mastery, (n, mean) Low Mastery = 19 or under. Not Low Mastery = 20 or more.	Intake: N = 256. Mean = 21.8 Low mastery: 26 % (N= 67) Not low mastery: 74 % (N=189)	6 months: N = 144. Mean = 22.7 Low mastery: 16 % (N= 23) Not low mastery: 84 % (N=121)	12 months: N = 125. Mean = 22.2 Low mastery: 18 % (N= 67) Not low mastery: 82 % (N=102)	18 months: N = 86. Mean = 22.0 Low mastery: 21 % (N= 18) Not low mastery: 79 % (N=68)	24 months: N = 70. Mean = 22.6 Low mastery: 17 % (N= 12) Not low mastery: 83 % (N=58)
IPV disclosure, (n, %)	Pregnancy: 21 % (N= 15)	Infancy: 22 % (N= 16)	Toddler: 17 % (N= 8)		
	6 Months	**12 Months**	**18 months**	**24 Months**	
Reliable Birth Control use, (n, %) Reliable Birth Control: Condoms, birth control pills, patch, quarterly birth control injection, hormonal implant, IUD Hormonal and IUD Non-Hormonal	46 % (N= 73)	50 % (N= 66)	47 % (N= 44)	53 % (N= 40)	
Subsequent pregnancies, (n, %)	3 % (N= 5)	11 % (N= 14)	20 % (N= 19)	32 % (N= 24)	
Involvement in Education, (n, %)	25 % (N= 39)	24 % (N= 30)	27 % (N= 23)	31 % (N= 23)	
Employed, (n, %)	53 % (N= 56)	54 % (N= 59)	67 % (N= 50)	53 % (N= 37)	
Housing needs, (n, %)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
DANCE (or equivalent), (mean - 2, 9, 15, 22 mos.) Emotional Availability Scales (EAS) - At 6, 12 and 24 months	EA Zones – Adult Sensitivity at 6 months:	EA Zones – Adult Sensitivity at 12 months:		EA Zones – Adult Sensitivity at 24 months:	

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	Emotionally available: 61 % (N=75) Complicated: 32 % (N=39) Detached: 7 % (N=8). EA Zones – Child Responsiveness at 6 months: Emotionally available: 67 % (N=82) Complicated: 25 % (N=31) Detached: 7 % (N=9).	Emotionally available: 47 % (N=39) Complicated: 46 % (N=38) Detached: 7 % (N=6). EA Zones – Child Responsiveness at 12 months: Emotionally available: 48 % (N=40) Complicated: 47 % (N=93) Detached: 5 % (N=4).		Emotionally available: 77 % (N=27) Complicated: 20 % (N=7) Detached: 3 % (N=1). EA Zones – Child Responsiveness at 24 months: Emotionally available: 77 % (N=27) Complicated: 20 % (N=7) Detached: 3 % (N=1).	
Father's involvement in care of child, (n, %) During the past three months, how often did the baby's biological father spend time taking care of and/or playing with the baby?	He does most/all of the care: 2 % (N= 3) Every day: 61 % (N= 94) 3-6 times a week: 10 % (N= 16)	He does most/all of the care: 4 % (N= 5) Every day: 61 % (N= 80) 3-6 times a week: 5 % (N= 6)	He does most/all of the care: 2 % (N= 2) Every day: 59 % (N= 54) 3-6 times a week: 13 % (N= 12)	He does most/all of the care: 3 % (N= 2) Every day: 49 % (N= 36) 3-6 times a week: 12 % (N= 9)	

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	Once or twice a week: 6 % (N =9) 1-3 times a month: 3 % (N= 5) Less than once a month: 4 % (N= 6) He has not spent time caring for or interacting with the baby: 14 % (N= 22)	Once or twice a week: 6 % (N =8) 1-3 times a month: 3 % (N= 4) Less than once a month: 5 % (N= 6) He has not spent time caring for or interacting with the baby: 17 % (N= 22)	Once or twice a week: 7 % (N =6) 1-3 times a month: 1 % (N= 1) Less than once a month: 8 % (N= 7) He has not spent time caring for or interacting with the baby: 10 % (N= 9)	Once or twice a week: 10 % (N =7) 1-3 times a month: 5 % (N= 4) Less than once a month: 8 % (N= 6) He has not spent time caring for or interacting with the baby: 12 % (N= 9)	
Breast Feeding, (n, %) We changed the question "Have you been breastfeeding the baby exclusively since the birth?" to "Have you breastfed your baby?" in June 2020. The results from both questions are presented here. We also added a question "How are you currently feeding your baby?"	**First postpartum visit:** <u>Exclusive breastfeeding:</u> 57 % (N=99) of clients had breastfed their baby exclusively. <u>Breastfeeding:</u> 96 % (N=50) have breastfed their baby.	**6 months:** 26 % (N=43) of clients are exclusively breastfeeding. 34 % (N=56) of clients are breastfeeding non-exclusively. 41 % (N=68) of clients are not breastfeeding.	**12 months:** 53 % (N=51) of clients are breastfeeding non-exclusively. 47 % (N=46) of clients are not breastfeeding.	**18 months:** 32 % (N=20) of clients are breastfeeding non-exclusively. 68 % (N=42) of clients are not breastfeeding.	**24 months:** 11 % (N=6) of clients are breastfeeding non-exclusively. 89 % (N=47) of clients are not breastfeeding.

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	Currently feeding their baby: 60 % (N=30) are exclusively breastfeeding. 32 % (N=16) are not exclusively breastfeeding. 8 % (N=4) are currently giving their baby pumped breast milk.				
Other (please define)					

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

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

We assess the interaction between mother and child at three points in time (at 6, 12 and 22-24 months), based on a 20-minute video recording in the family's home. The mother's sensitivity and the child's response are considered the primary sources of information, and it is referred to as EA-Zones in the manual. Scores below 4 are considered below the limit value. In our figures, we find that there is generally "good enough" interaction in our families (scores from 4 and above). It is important to emphasize that we already have supported these families in NFP since pregnancy. The scores at 6 months of age in EA reflect the qualitative follow-up that has already been given.

It is positive to see that we find the same percentage as last year, regarding mother- child interaction. The EA scores shows that mother's sensitivity and child's responsiveness increase from T1 (6 months) to T3 (24 months), as it also did last year.

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It is challenging to pinpoint exactly which areas of the program that have the greatest impact on maternal behaviour, as this varies from mother to mother and their individual needs. The fact that the client has been supported in her role as a mother by a Family nurse for over two years is described by most mothers as a positive factor. The Family nurse appears to be a reliable professional who can provide important input and perspectives to the mother and support her in making good choices for her child and family. A topic that is referred to by several clients is the Family nurse's emphasis on family strengths. Working on the role as mother based on her competence and level of mastery is highlighted by several mothers as positive. The mothers are experiencing that the nurses believe in them, and that small changes have ripple effects, which is benefitting the child and the family. The principle that a small change is enough, and that small steps can do wonders, both for the child and the family, is repeated as good experiences when we have asked the mothers. A strong statement from one of the mothers when she had finalized the program is a good illustration of the emphasis of the nurse's role. She said that even though her daughter may not remember the Family nurse when she grows up, her contribution to the family will certainly affect her child in the future.

Which are the areas of challenge?

Mental health is an important area. The percentage of clients with severe anxiety decreases from 9 % to 4 % from intake to 18 months. But at the same time, the percentage of clients with moderate anxiety increases from 17 % to 20 % in the same time frame. When it comes to depression, moderately severe or severe depression decreases from 16 % to 11 % from intake to 18 months. Here, moderate depression also decreases from 24 % to 17 %. But the numbers are still quite high. It is important to remember that mental difficulties are one of the most common eligibility criteria for our clients. 80 % of the clients recruited in 2021, had mental difficulties as one of their eligibility criteria.

30 % of the clients were neither in education nor in employment at intake. At the end of the program delivery, this applied to 33 % of the clients. In the annual report from 2020, we reported that 34 % of the clients were neither in education nor in employment at intake. At the end of the program delivery, this applied to 32 % of the clients.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks gestation)	0	0 %
Very preterm (28-32 weeks gestation)	1	0.4 %

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Moderate to late preterm (32-37 weeks gestation)[1]	12	5.4 %
Low birthweight (please define for your context) Low birthweight: below 2500 g	16	8.0 %
Large for Gestational Age (LGA) (please define for your context)		
Other (please define)		

Please comment below on your birth data:

Generally, there is a good follow up of preterm births in Norway. The numbers in NFP are close to the national numbers regarding preterm births. When it comes to low birthweight our numbers (8.0%) are higher than the Norwegian average (4,2%).

Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	98 %	98 %	99 %	100 %
Hospitalization for Injuries	0 %	1 %	0 %	0 %
ASQ scores requiring monitoring (grey zone)	Communication: 1 % (N=2) Gross Motor: 1 % (N=1) Fine Motor: 5 % (N=9) Problem Solving: 3 % (N=5) Personal Social: 2 % (N=3)	Communication: 1 % (N=1) Gross Motor: 4 % (N=4) Fine Motor: 2 % (N=2) Problem Solving: 5 %(N=5) Personal Social: 1 % (N=1)	Communication: 5 % (N=4) Gross Motor: 1 % (N=1) Fine Motor: 1 % (N=1) Problem Solving: 4 % (N=3) Personal Social: 5 % (N=4)	Communication: 6 % (N=4) Gross Motor: 5 % (N=3) Fine Motor: 5 % (N=3) Problem Solving: 8 % (N=5) Personal Social: 3 % (N=2)

[1] https://www.who.int/news-room/fact-sheets/detail/preterm-birth

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ASQ scores requiring further assessment/referral				
ASQ-SE scores requiring monitoring (grey zone)	Social Emotional: 3 % (N=5)	Social Emotional: 1 % (N=1)	Social Emotional: 1 % (N=1)	Social Emotional: 2 % (N=1)
ASQ-SE scores requiring further assessment/referral				
Child Protection (please define for your context) Referrals to Child Protective Services – Concerns regarding suspected abuse or neglect of child	8 % (N=12) of clients had been referred to the Child Welfare Organization by other than the Family nurse. 3 % (N=5) of clients had been referred to the Child Welfare Organization by the Family nurse.	6 % (N=7) of clients had been referred to the Child Welfare Organization by other than the Family nurse. 3 % (N=3) of clients had been referred to the Child Welfare Organization by the Family nurse.	12 % (N=10) of clients had been referred to the Child Welfare Organization by other than the Family nurse. 2 % (N=2) of clients had been referred to the Child Welfare Organization by the Family nurse.	9 % (N=6) of clients had been referred to the Child Welfare Organization by other than the Family nurse. 1 % (N=1) of clients had been referred to the Child Welfare Organization by the Family nurse.
Child Protection (please define for your context) Referrals to Child Protective Services – Voluntary support services	7 % (N=11) of clients had been referred to the Child Welfare Organization by other than the Family nurse. 3 % (N=5) of clients had been referred to the Child Welfare Organization by the Family nurse.	9 % (N=11) of clients had been referred to the Child Welfare Organization by other than the Family nurse. 2 % (N=2) of clients had been referred to the Child Welfare Organization by the Family nurse.	12 % (N=10) of clients had been referred to the Child Welfare Organization by other than the Family nurse. 4 % (N=3) of clients had been referred to the Child Welfare Organization by the Family nurse.	12 % (N=8) of clients had been referred to the Child Welfare Organization by other than the Family nurse. 3 % (N=2) of clients had been referred to the Child Welfare Organization by the Family nurse.

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Please comment below on your child health/development data

Referrals to Child Protection Services due to suspected abuse or neglect of a child and/or similar concerns:

We observe that the percentage of clients referred to the Child Protection Services by the Family nurses due to suspected abuse or neglect of a child at 12 months has increased this year (from 1 % in 2020 to 3 % in 2021). Furthermore, it has been observed that the number of referrals decreased when the child is 18 and 24 months compared to previous year. This may reflect that the Family nurses are more confident in their professional role, to make referrals earlier when needed. It may also reflect the fact that the Family nurses work with challenging families who need comprehensive follow-up in addition to NFP. We found that the number of families referred to the Child Protection Services for voluntary support services by other welfare services than the Family nurse has decreased from respectively from 16 % and 14 % at 18 and 24 months to 12 % (both 18 and 24 months) in 2021. This may reflect that the local welfare services rely more on the quality of follow up in NFP, and therefore consider that referrals to the Child Protection Services may not be as necessary.

ASQ:

We would have liked to compare ASQ data from the population study of ASQ conducted by RBUP in 2017, with NFP data in 2021. Unfortunately, we have not been able to do that yet. When we compare our NFP data from 2020, we find very little difference. Similar to last year, there are more children in the grey zone (requiring monitoring) at T4 than in T1 (except for fine motor skills). We do not know why, but one reasonable explanation might be that the nurses are more occupied with interventions related to socio-emotional development than the development areas measured in ASQ. In 2021 we have experienced that the ASQ-SE scores requiring monitoring (grey zone) decreased from T1 to T4.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts
Client experiences
Please insert here any materials you would like to present regarding client experiences of the program. This can include collated client feedback, a case study or by clients providing video evidence etc. Throughout 2021, we have been in close contact with both former and active clients in the program (called experience consultants).

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We find it very important to include and use their perspectives in several contexts:

- Linked to recruitment and expansion of 3 new teams and employment of 3 supervisors and 24 Family nurses. In the interviews they made an invaluable contribution as described earlier in this report.
- As members in the local advisory boards
- In meetings with Bufdir to inform the effect study and how they experience that the program has influenced them as parents and their child, and as a family. They brought in important perspectives, but not necessarily effects easy to measure in an RCT.
-

We have also developed a data form about the clients' experience participating in the program. The data form is completed 3 times during the program cycle, after each phase.
The data indicates that the clients find the program useful and that they learn from the different tools.
At 12 months, 61 % of the clients report that they have learned a lot from video feedback. 13 % have learned some and 26 % have no experience with video feedback. 65 % of the clients feels that they have learned a lot from using ASQ at 12 months, 30 % have learned some and 4 % have no experience with ASQ.

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	1	Due to congenital/chronic disease
Maternal death	0	
Other		

Any other relevant information or other events to report:

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PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

Briefly describe your system for monitoring implementation quality;

As described above, we have adapted and adjusted the overall structure of the program. The best way to describe this, is to look at the six focus areas in the NFP program:

1. Personal Health (Health Maintenance Practices; Nutrition and Exercise; Substance Use; Mental Health)
2. Environmental Health (Home; Work; School and Neighbourhood)
3. Life Course (Family Planning; Education and Livelihood)
4. Maternal Role (Mothering Role; Physical Care; Behavioural and Emotional Care of Child)
5. Friends & Family (Personal Network Relationships; Assistance with Childcare)
6. Health and Human services (Linking families with needed referrals and services) (Dawley et al., 2007)

Our new structure contains all the areas, except that we combined no. 2 and 5, therefore the Norwegian structure now looks as follows:

1. Personal Health (Health Maintenance Practices; Nutrition and Exercise; Substance Use; Mental Health)
2. Family and network (Personal Network Relationships, culture)
3. Maternal Role (Mothering Role; Physical Care; Behavioural and Emotional Care of Child, Child development, Childcare)
4. Life Course (Family Planning, Home environment, Work, Education, Economy and Livelihood)
5. Health and Human services (Linking families with needed referrals and services)

This allows us to compare our statistics with the US benchmarks, as the domains contain the same. Additionally, we have revised the facilitators to better ensure that they are suitable for Norwegian clients and their needs. These revisions also include the goal setting materials. The emphasis on helping the families set goals and explore their individual challenges and needs are addressed more specifically in the new program structure, as well as in the facilitators. In collaboration with the design and communication agency which has previously been mentioned, we hope to get our unique visual profile and identity as a common thread throughout the revised facilitators and program materials.

Here is a quick overview of the new program structure:

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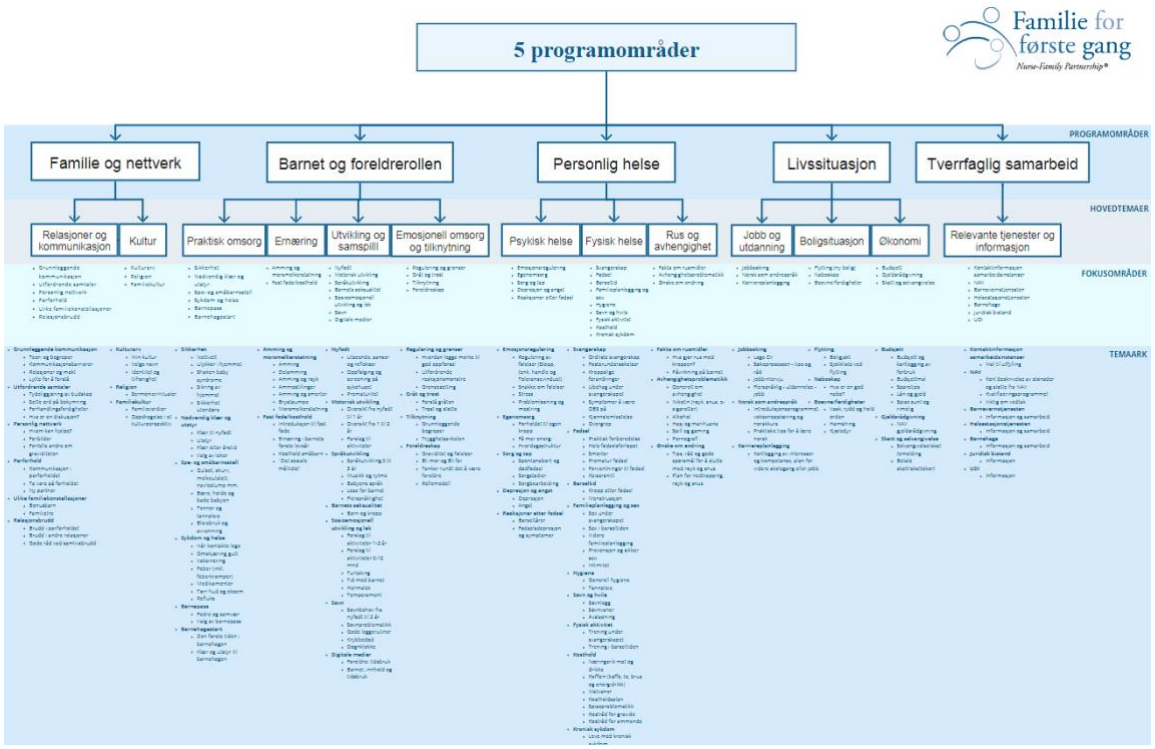

PIPE training and maintenance. Our NFP nurses have positive experiences with PIPE when working with the families, and using dolls to share activities with clients. We like the PIPE theoretical framework, and the topics it covers are very relevant, and overlap with what we see as helpful to our clients in Norway. We plan to continue to use PIPE in selected ways, so it better fits the Norwegian context and the clients, since the program differ from other countries (with no age restriction, but rather focuses on challenges related to mental disorders, difficult upbringing, and other forms of risks among pregnant first-time women). The use of PIPE in selected ways was discussed with Jody Perkins from How to read your baby.org in October 2021, and she replied that they are delighted that we continue to find the curriculum useful.

During the last year we did not have any basic training in PIPE, but we did have regular maintenance days for our two teams. For our new nurses, we plan to make an easier entrance to the PIPE curricula and integrate the PIPE training into other parent – child interaction training. We are doing a revision and simplification of the PIPE materials that we use, to make it easier for our new nurses to learn the PIPE curricula.

Emotional Available (EA) Scales. As last year, we still have a challenge related to the assessment of mother-child interaction, especially now that we are going to expand. Training and maintenance of EA certification is extensive and complicated, especially related to privacy rules in Norway, which prevent us from sharing video material over Zoom / other network platforms. The Family nurses have been satisfied with the collaboration with external coders, who can give a second opinion when it comes to the mother – child interaction. As of today, we have three external coders, one for each measurement time. Now that we are expanding from 2 to 5 teams, and with an increased number of Family nurses in each team, the clients will also multiply. We realize that we will not have access to additional qualified and reliable coders, and if we did it would become too costly. EA is therefore no longer a sustainable tool for the program in Norway. Another important point is that we believe that the Family nurses can receive more training and knowledge to enable them to assess the quality of the interaction themselves. In this way, the thinking behind the assessments will come from the Family nurses, and their professional

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competence will increase. However, this will require investment in training and maintenance, which we hope to find a good solution for soon. Senior Advisor and Supervisor in one of the teams, did attend a DANCE online training and got useful information and learning relevant to this process. In 2021, we had coding participants in a training called Coding Interactive Behaviour (CIB). We believed that the training and coding would take less time. Unfortunately, we did not find this tool to fully fit with our needs, especially when it comes to clinical use. The system is mostly used as a scientific tool, so CIB could not be a qualitative replacement for EA.

The Parent - Child Early Relational Assessment, brief version (B-ERA). We are still looking at an assessment which is used in other parts of the specialist health service in Norway. These days, the Senior Advisor and two of our most experienced Family nurses, attends an education in a short version of The Parent - Child Early Relational Assessment, called B-ERA. We really hope to find B-ERA useful, and a tool that can replace Emotional Availability (EA) Scales in the future.
A useful reason for switching to B-ERA is that the nurses themselves can receive training and use the assessment in their own families. To preserve the value of 'second opinion' from an external coder, which EA provides, the Senior Advisor will code a selection of the families, and it will also be possible to create a system where the Family nurses can code each other's families if needed. In this way, the need of a 'second opinion' can be safeguarded. Another reason why B-ERA may be relevant is that we may have the opportunity to run the training of our own Family nurses in the future and avoid to be dependent on trainers from the US.

As previously mentioned, we have developed a Video Home training; VIS (Video Interaction for Sensitive care), based on and adjusted form of Marte Meo and VIPI (Video feedback of Infant-Parent Interaction) which we used during phase 2 in Norway. VIS is a more easily accessible video guidance, based on topics that we have experienced to be most relevant for us in Norway. We have made booklets that contain a training plan and the knowledge base for the approach. We have also made a parent booklet where VIS is described. The existing teams have been given an introduction, as they were trained in the former version. Providing VIS training to the new nurses at the Infant training this autumn will be exciting.

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

We planned to adjust the materials in NFP to the Norwegian context before the new teams were engaged and before we conducted the Foundation training. This applies to both the facilitators and the information documents.

- Outcomes of any CQI initiatives undertaken during the reporting period

When the new program structure and adjustment was presented to the Family nurses it was positively received, as it is better aligned our Norwegian context.
Nevertheless – change is also challenging. And though the Family nurses have wanted these revisions for many years, it will take time to fully learn, understand, and use the new program structure and adjusted material.

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

It has been exiting and very useful to include the Family nurses in the work when working on the material adjustment and adaptation to the Norwegian context. At the same time it is challenging in terms of time consumption, as the are many expectations and opinions which are aired and need to come together.
As the program is growing and we now have 3 new sites and 27 new nurses on board, we realize that it will be important to keep this in mind, and to find a good structure to use when the National Office invite the nurse's to share opinions about material to be developed or revised.

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- Goals for CQI in next year

We work closely with the Supervisors on how to work with the material in each team. This will continue in 2022. We plan to gather the Family nurses to share their experiences – this may result in further adjustments.

Our research coordinators and RBUPs "research support"-team are still developing and adjusting the digital data collection system in cooperation with our nurses. This will continue in 2022. We hope to make it easy and user-friendly, to secure data accuracy and completeness, as well as optimizing the way the system aggregate reports. In 2022 we will focus specifically on reports and how we can make data more available for our nurses and the National Office, so that we can adjust our practice easier as we move forward in phase 3.

-

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

- Program innovations tested:
- Program innovations implemented:
- Findings and next steps:

Temporary Variances to CMEs

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

Additional Approved Model Elements (AAMEs)

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

Feasibility & acceptability study:

- Goals:

For information regarding the feasibility and acceptability study reference is made to annual report for 2019.

- Methods:
- Sample:
- Progress to-date:

Findings from feasibility & acceptability study to date:

- Key findings from our study
- Reflections on our findings/results
- Any actions planned based on results

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

This summer and autumn the Directorate has worked on identifying an agency which could undertake the effect study (RCT) of the program, but had to cancel the bidding process in December due to the lack of qualified agencies. A new bidding process has been planned for in January 2022.

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PART FIVE: ACTION PLAN

LAST YEAR:

Our planned objectives for last year:

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

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

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

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

Measures planned for evaluating our success:

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

Progress against those objectives

RBUP: It has been challenging due to previously described delays, but over all we have managed to reach our plans for 2021. The existing teams have been transferred to local employment. The digital data collection system was up running by October 18th. We have developed and adjusted the education curriculum for the Foundation training and for the Supervisor training. The website will hopefully be up and running by March 2022.

Bufdir: had to cancel the bidding process in 2021 due to the lack of qualified agencies, and a new bidding process is planned for January 2022, it is still challenging to get a functional collaboration with the Directorate of Health and their Ministry. A temporarily legal basis is in place for the program to collect personal information.

Reflections on our progress:

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RBUP: We are proud to have achieved our goals, considering the significant delays in spring 2021 and the challenges posed by Covid-19. Despite these challenges, the expanded team at det National Office have been functioning well and everyone have worked very hard to achieve our plans and goals.

Bufdir: We do hope that we will be able to identify a qualified agency with sufficient experience in conducting RCT in our sector of responsibility. The challenges we are phasing to get our counter parts in the health sector on board is slightly demanding. We can do little more than hope that they slowly see the relevance of the program. We are pleased that we found a temporarily legal basis for collecting personal information in the program, though we understand that we need to find something more permanent. As well as something which better align with other legal aspects.

NEXT YEAR:

Our planned objectives for next year:

RBUP:

- Carry out the Infancy training in week 36 (September 2022) as planned in the curricula.
- Carry out the IPV training in June 2022
- Carry out the New-born Behavioural Observation training which start in March 2022
- Facilitate the establishment of Local Advisory Boards in all sites and to enable them to function well
- Conduct information/education gatherings for local leaders at the implementing sites, especially the new ones
- Develop a good reporting system for the Local Advisory Boards
- Translate the new material and documents into English and some of it into the most used languages at the implementing sites
- Develop and carry out education for the Team coordinators

In connection with changes in the overall program structure and the adaption of the material to the Norwegian context, we plan to arrange experience a conference with the teams. The intention is to develop and meet the needs of the nurses, exchange of knowledge, perceptions, and experiences in using the new material will be important. This will also be of importance to ensure that the new teams and Family nurses gain a broader understanding of the content and delivery of the program as intended.

Hopefully during spring 2022 our new visual profile will be launched, as well as our new website. The launch is pending a decision from the Ministry whether they are accepting the proposed name change or not. We will continue to develop, in cooperation with the design agency, the profile of our licensed material and the content on our website. During 2022 we hope to have time to start writing articles based on our data reports and to publish them, alongside Norwegian Nurse-Family Partnership news, on our new website.

Bufdir:

- Solve the two assignments that we have received from our Ministry regarding NFP:
  1) To develop a legal regulation for the handling of personal information in the program 2) to explore if there will be a need to develop a law or regulation which covers NFP as a service.
- Continue to work on the collaboration with the health sector at the government level
- Identify an agency which can undertake the effect evaluation and start the RCT in 2022.
- Continue to deliver regular updates to our Ministry about the progress and status in the program implementation

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Measures planned for evaluating our success:

RBUP:

- The website is up and running as planned
- NBO, IPV and Infancy training are carried out as planned
- Developed and carried out the team-coordinator training
- Experience conferences have been conducted according to plan
- The program material is adjusted to Norwegian context and translated
- Local advisory boards are implemented in all sites, as well as a good AB reporting system

Bufdir:

- The two assignments are solved
- The collaboration with the health sector at the government level has improved slightly for 2022
- An agency to undertake the RCT has been identified and the RCT has started
- The Ministry have received 4 status report about the status and progress in NFP

Any plans/requests for program expansion?

FEEDBACK FOR UCD INTERNATIONAL TEAM:

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

RBUP:

The help of regular meetings with the international consultant to the Clinical Lead and others from the National Office. We appreciate the availability and support we get from Ann whenever we need. Regular meetings of the Clinical Advisory Group (CAG) are very helpful and useful. We also find the international website useful.

Bufdir:

The availability and readiness to discuss and give advice in difficult questions, especially regarding the effect study is much appreciated by the Directorate. The sharing of relevant documents and other countries is also much appreciated. It is also of great value to receive input and documents directly from other NFP countries so we can learn from each other and do not do the same mistakes all over. The regular updates on the International website is also appreciated.

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

Having worked a lot on the specifications linked to the RCT, especially around recruitment to the study as well as how to best develop relevant outcome measures to be used we think that it would have been useful if the UCD International Team would develop some systematic material about guidance about the collective learnings when preparing for an RCT. For instance, what to consider when selecting primary and secondary outcomes, what measurement instrument to use, as well as reflections about who should be recruiting to the study depending on different inclusion criterias to the program etc. As well as advice about the various steps one should consider when preparing for an RCT. We believe that this would be of great help to NFP countries preparing for

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an RCT. We also realize that when moving to phase 3 there should maybe be a stronger emphasis from UCD that it is smart to run the expansion of the program for a minimum of one year with the new teams fully operational before starting an RCT. But it might be difficult for UCD to be specific about this since the various NFP countries are piloting the program in different ways. As mentioned last year we also see the value if UCD would facilitate a network and a few regular meetings per year between the political focal points in each NFP country like you have for the Clinical Leads.
This is what we would like from UCD through our Support Services Agreement for next year: Ref. is made to signed support service agreement for 2022.

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

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

I agree to this report being uploaded onto the restricted pages of the international website ☐

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

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PART SIX: ANNUAL REPORT FROM UCD

(To be completed by UCD following annual review meeting)

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

- Monitoring of license, oversight of fidelity and agreement of quality improvement plans
- Liaison and expert guidance regarding the development of research design and methodology for phase three study.
- Consultation meetings with Clinical Lead and strategic lead to provide guidance, updates and collaborative problem solving
- Updating and maintaining the international NFP website, including creating opportunities for accessing international program resources, educational materials, and NFP news updates.
- Access to the international website forum for discussion of issues with leads in other NFP implementing countries
- Development and dissemination of international guidance documents on program content and implementation that draw on the experiences of all NFP implementing countries.
- Provision of the international Clinical Leads' Advisory Group meetings.
- Sharing new program innovations developed and researched by PRC and all implementing countries
- Developing additional opportunities for international collaboration and networking, such as the data analytic and research-leads forum and the PIPE education group.
- Facilitating the sharing of good practice between countries on particular topics.
- Sharing new NFP international research outputs from all countries via the website and through the international research seminars.
- Promoting NFP internationally as an example of a program that ensures high quality replication in all contexts and maintains its international reputation for effectiveness and quality.

Identified strengths of program:

- The commitment, talents and resourcefulness of the RBUP Clinical Leadership Team, resulting in continued adaptation and development of program implementation at clinical and organisational levels, alongside site expansion and the development of the NFP curricula for nurses and supervisors.
- The commitment and skills of the data analytical team, who were able to develop the data analysis in an exemplary annual report and produce additional sub analyses for the annual review meeting
- The continued Governmental support for the program, providing the long-term resources necessary for the transition to phase three.
- The skills and commitment of the strategic team in Bufdir, who have been rigorous in their work to secure the best possible outcomes research for the program and continue to work to develop an appropriate context for the program, sometimes challenging the system in order to do so.
- The talents and dedication of the NFP nurses and supervisors, who show commitment to the families they serve and to delivering the program in the best way possible.
- The collaborative approach to program adaptation, in which learning from the frontline is developed and thoughtfully integrated into processes and program adaptations.

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- The ability of the leadership and local teams to adapt to the challenging environment created by the COVID pandemic and to continue to provide a service to clients in times of great challenge, whilst at the same time continuing to undertake a program of quality improvements, adaptations and expansion.
- The complimentary approaches and skills of the strategic and operational leadership teams, whose joint work produced this interesting and insightful report.

Areas for further work:
Several actions for further work were agreed during the meeting as follows

1. More subgroup analysis re:
- clients with higher education
- nurse caseload size
- pregnancy phase visits
2. Follow up and explore with teams re: nurse caseload size and pregnancy phase visits
3. Share latest Norwegian proposals for dyadic assessments and methods for positively impacting on the dyads.

Full details are available in the meeting notes

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

These were agreed as in part five above. In addition:
The RBUP leadership team were encouraged to begin a site annual review process to support sites to feel ownership of the program and engage with the data for quality improvement

The Bufdir team were encouraged to continue to work on the engagement of the Health Ministry

Any approved Core Model Element Variances:
N/A

Agreed upon activities that UCD will provide through Support Services Agreement:
In addition to those agreed in the SSA for 2022, and in line with the requests of this report, the UCD international team will plan to:

- Develop an international network of strategic and Governmental NFP leads
- Develop some additional guidance for countries moving from phase 2 to 3 regarding organizational, administrative, and juridical issues, taking on board Norway's experiences

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

Appendix 2: Evaluation of temporary CME variances

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

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

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

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Appendix 3: Additional Approved Model Element (AAME)

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

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