A comparison of the Well Child Clinic services in Norway and the Nurse Family Partnership programme in the United States

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Aim and objectives. To present a comparison and a discussion of the Well Child Clinic model in Norway and the Nurse-Family Partnership® model in the United States.

Background. The Nurse Family Partnership programme in the United States is voluntary and not universal. The Well Child Clinic programme in Norway is voluntary but universally available for Norwegian families. As the Well Child Clinics are used by the vast majority of the families in Norway, it is difficult to determine the benefits and outcomes for the families who receive universal services.

Design. Qualitative design.

Methods. Authors reviewed the literature on the Norwegian Well Child Clinics and the Nurse Family Partnership programme in the United States and interviewed public health nurses experts on evidence-based home visiting programmes in Minnesota.

Results. The similarities between goals and content of the Nurse Family Partnership programme in the United States and the Well Child Clinic services in Norway are emphases on (1) intensive services, (2) a focus on behaviour, (3) the inclusion of both parents and children and (4) programme fidelity. The major difference in the programmes is the focus on a targeted population for the Nurse Family Partnership programme vs. the universal offer of Well Child Clinics in Norway.

Conclusion. Norway should continue with universal approach to support new families. A model similar to Nurse Family Partnership could be developed in Norway as an addition to the existing universal services, as an offer to the high-risk families.

Relevance to clinical practice. Public health nursing leaders in Norway need to advocate for public health nurse ratios that make it possible for public health nurses to follow government guidelines. A model similar to Nurse Family Partnership could be developed in Norway as an addition to the existing universal services, as an offer to the high-risk families.

Key words: community health centres, family–nurse partnership, health visitor, home visiting, nurse–family partnership, public health nurse, well baby clinic, Well Child Clinic

Accepted for publication: 28 November 2012

Introduction

Public health nurses (PHN) play a central role in supporting the health of the public (Truglio-Londrigan & Lewenson 2011). In the United States, PHNs synthesise knowledge from nursing, social and public health disciplines to promote and protect the health of populations. Throughout history, PHNs have worked to create societal conditions that support health for individuals, families and communities (Green 1993, American Nurses Association 2007). Similarly, the work of PHNs in Norway consists of health promotion and primary prevention, which means promoting mental and physical health as well as social and environmental conditions that contribute to improved health and prevention of
disease, injury and disability (Ministry of Education & Research 2005). However, the target group for PHNs in Norway is primarily individuals and families through the provision of well child health and school health services (Norwegian Directorate of Health 2004) in comparison with a focus on the entire lifespan in the United States.

An analysis of values that are foundational to public health nursing found that core beliefs and values were similar for PHNs in the United States and Norway (K. Glavin et al. 2012, A comparison of the cornerstones of public health nursing in Norway and in the United States, submitted). PHNs in both countries identified important themes of core beliefs and values as: (1) promotion of health and prevention of disease, (2) holistic care including consideration of living conditions, (3) collaboration with clients, government and healthcare organisations, (4) caring relationships, and (5) independence in public health nursing work. PHNs in Norway emphasise to a greater extent governmental responsibility for influencing the health of populations and empowering individuals and families for self-care management.

While public health nursing education in the United States is delivered in baccalaureate nursing programmes through didactic and clinical educational strategies, in Norway public health nursing education is delivered at the postgraduate level, following a minimum of one year of practice. Students integrate public health principles with nursing skills to prepare them to provide health services to children and families in the community setting (Ministry of Education & Research 2005). Norwegian public health services are extended to all pregnant women and families with children (Norwegian Directorate of Health 2004). In 1972, the public responsibility for Well Child Clinics (WCCs) in Norway was established by law; until then, the clinics often were run by voluntary organisations (Glavin & Kvarme 2003). The prevention of ill health is a key principle in the new Public Health Act (Ministry of Health & Care Services 2011). The national goal is to provide Norwegians with good opportunities for quality of life and coping skills, which requires a greater emphasis on early prevention. Municipalities are responsible for managing the services within Norwegian laws and regulations (Norwegian Board of Health 2012). Child health professionals offer routine child health examinations free of charge at a universal level, including detection of a range of environmental and family issues that influence children’s safety and health. The goal of preventive child care is to foster an optimal trajectory for growth and development in children and to provide guidance to parents and communities (Norwegian Directorate of Health 2004).

In contrast, child health services in the United States are a mix of public and private healthcare services and are not universally provided to children and families. Children in families at the lowest socioeconomic level receive health care through Medicaid (a government programme), while children who have employed parents with health insurance coverage also have access to health care. To fill the gap for children in between these two groups, states have a variety of healthcare programmes that may qualify children for health care, but the programmes are not universal. One programme developed to meet the gap in resources available for high-risk families is the Nurse Family Partnership programme. The Nurse Family Partnership (NFP) is a free, voluntary programme that helps high-risk first-time mothers have healthy pregnancies, improve child health and development, and become more economically self-sufficient. A specially trained nurse visits first-time mothers throughout their pregnancy until the baby turns two years old. During these visits, the nurse offers information and support. The programme’s core education and visit-to-visit guidelines are the mechanism by which the theories of self-efficacy, human ecology and attachment are woven together within a professional nursing practice framework to produce a unique programme of great depth, breadth and vitality (Nurse Family Partnership 2012).

In summary, the Nurse Family Partnership programme in the United States is voluntary and not universal. The Well Child Clinic programme in Norway is voluntary but universally available for Norwegian families and used by nearly 100% of the population (Statistics Norway 2012a). As the Well Child Clinics in Norway are used by the vast majority of the families, it is difficult to determine the benefits and outcomes for the families who receive universal services.

Aim

This study addresses how PHNs contribute to healthy children and families. Specifically, the authors compared the characteristics of the Nurse Family Partnership (NFP) programme in the United States with the Well Child Clinic (WCC) programme in Norway. The comparison is followed by a discussion of implications for maternal child health policy.

Background

Evidence supports the effectiveness of early intervention with families by PHN for positive effects on physical health, mental health and development, social health, and accessing healthcare services (Ciliska et al. 2001).
from the United States shows that regular PHN home visits to high-risk families during the child’s first two years contribute to prevention of emotional, language and mental health problems in children, and child abuse and neglect (Kitzman et al. 2000, 2010, Olds et al. 2002, 2007, 2010, Eckenrode et al. 2010). There also is evidence from the UK that home visiting and the detection and management of postpartum depression (PPD) can produce positive effects on parenting and mother–child interaction (Bull et al. 2004).

A recent Norwegian study showed that information and support by a PHN at the home visit two weeks postpartum may have a preventive effect on PPD in women (Glavin et al. 2009, 2010b). Other studies support these findings. Morrell et al. (2009) reported a decrease in depression scores among women who received support from the health visitors in the UK. A study by Brugha et al. (2011) in the UK provided evidence for the prevention of PPD in women in a universal programme. The new mothers in the intervention group received care from a trained health visitor and had fewer depressive symptoms in comparison with the women in the control group at six months postpartum. Dennis and Creedy (2004) also found that home visits after birth by PHN or midwives helped prevent PPD. Several studies indicated that long-term PPD can be prevented by early intervention from primary health services (Elliott et al. 2000, Chabrol et al. 2002, Ray & Hodnett 2004, Glavin et al. 2010a). Findings from these studies suggest that support and information at a universal level provide a preventive effect for decreasing the incidence of PPD.

Research studies support that first-time mothers feel more secure in their parental role when receiving a home visit and support from the PHN (Wilsson & Adolfssson 2011). Home visits may also give the new parents support to develop as a family (Jansson et al. 2003). A study by Iversen and Kjøllesdal (2011) showed that mothers expected the PHN to make contact soon after their discharge from hospital and they desired to have the same PHN follow the family in the WCCs. The women valued the relationship with the PHN as the most important. They wanted to be taken seriously, be taken care of, be seen and have a PHN who was caring and understanding with adequate time. The women wished that the PHNs were more easily accessible and that they had more visits (Iversen & Kjøllesdal 2011).

A survey of PHNs in Bergen, Norway, showed that parents of newborn children in Bergen usually received an offer of home visit two weeks after birth, which is the initial well child visit (Økland & Hjælmhult 2010). However, with time constraints, some of the PHNs prioritised home visits only to first-time mothers. The survey results indicated that not all PHNs made visits to all families of newborns although it was an official recommendation. The way the nurse presents the offer for the visit can play a crucial role in whether or not the parents accept the home visit. If the home visit is omitted, it is not necessarily a time-saving strategy, because parents often compensate with more frequent consultations at the clinic (Økland & Hjælmhult 2010).

There are differences in the infant mortality rate between Norway and the United States. The infant mortality rate in Norway has declined from 13.9–3.0 (infant deaths in first year of life per 1000 live births) from 1970–2010 (Statistics Norway 2012b). The universal offer and the support given to the new families through the WCC model may be one of the contributing factors to this decline. In comparison, for 2009, infant mortality in the United States was reported as 6.39 per 1000 live births. However, the rate for some ethnic groups is higher; for example, infant mortality for non-Hispanic blacks was 13.07 per 1000 live births for the same year (Kochanek et al. 2011).

Immunisation rates are similar between the two countries. Children in Norway are well vaccinated against diseases that are included in the childhood immunisation programme. Vaccine coverage for diphtheria, tetanus, pertussis (DTP), measles, mumps and rubella (MMR vaccine), and polio was 94% in 2011 (Norwegian Institute of Public Health 2012). For the United States, the Centers for Disease Control reported that the immunisation rate for most routine vaccines is at or over 90% (Centers for Disease Control 2010).

Data sources

Literature sources

Authors reviewed the literature on the Norwegian Well Child Clinics and the Nurse Family Partnership programme in the United States, including documents written in English and Scandinavian languages. Databases searched included Medline (2007–2011), PsychInfo (2002–2011), AMED (1985–2011), British Nursing Index (1994–2011), Embase (1996–2011), Ovid Nursing Database (1948–December 2011) and SveMed (1994–2011), which has databases for papers in English, Norwegian, Swedish and Danish using keywords: *well baby clinic*, *well child clinic*, *nurse-family partnership*, *family-nurse partnership*, *health visitor child*, *community health centers child family*, *home visiting child* and *health nurse child*. We also reviewed references from these papers to identify other arti-
Interviews with PHN experts on evidence-based home visiting programmes in Minnesota

The authors conducted interviews with PHN leaders in four Minnesota counties, including rural, suburban and urban settings to explore the implementation of evidence-based nurse home visiting programmes in Minnesota. Three counties provided the Nurse Family Partnership (NFP) programme in addition to other evidence-based family service programmes. One county had adapted many of the key features of the NFP programme for a unique programme model. In addition, the authors interviewed the state PHN consultant for evidence-based family home visiting programmes and the regional coordinator for the NFP programme. Interview questions for PHN experts explored programme features and interventions, funding mechanisms, training, programme evaluation, and rewards and challenges for PHNs. Questions for the state consultant and regional coordinator addressed strategies to maintain programme integrity, supervision and evaluation, and plan for expansion at the state level. Interviews were approximately one hour in length. In addition, interviewees provided written materials about NFP programme features and outcomes. The NFP website was accessed for updated information on programme features, initiatives and outcomes.

Discussion

Home visiting and Well Child Clinics in Norway

All Norwegian municipalities are required to provide health services in maternity care, well baby clinics for the 0- to 5-year-old population, school health and youth health centres. The publicly organised services are offered to pregnant women and to all parents with children and adolescents 0–20 years old. The service keeps a record of physical, mental and social health status and other matters of concern for children’s health and welfare (Norwegian Directorate of Health 2004). PHNs have a central role in this service and are the healthcare workers who meet with the family most frequently.

Public health nurses home visits to families with newborn babies is one of the most traditional services offered in Norway; the home visit provides the basis for future collaboration between the family and the PHN (Jansson et al. 2001, Hjälmhult 2009). All Norwegian families with newborn babies are offered a home visit from a PHN about two weeks postpartum. In 2010, there were 60,000 births in Norway and 76% of all families received a home visit by the PHN within two weeks after birth of the baby (Statistics Norway 2012a). This visit is often the first contact between the family and the PHN, if they have not already met during the mother’s pregnancy (Norwegian Directorate of Health 2004). The home visit after birth has a long-standing tradition in Norway. A central task at the home visit is to support the parents’ mastery of the parenting role (Norwegian Directorate of Health 2004, Hjälmhult 2009). Early contact is even more important currently as mothers are discharged from the hospital after a very short time.

At the home visit, the PHN has the opportunity to get to know the parents and other children in their home setting (Jansson et al. 2001, Hjälmhult 2009). The aim of the home visit is to assess the child’s condition, get to know the family, create contact and trust, and assess what kind of help and support the family might need. The PHN listens to the family’s questions and their need for guidance with the child, that is, questions concerning the birth, breastfeeding, infant care or family situation (Norwegian Directorate of Health 2004). In addition, the PHN assesses important information about the parents’ living conditions and observes the interaction between the child and the family (Jansson et al. 1998, 2001, Norwegian Directorate of Health 2004, Hjälmhult 2009). The mothers were more satisfied at the first meeting with PHN at a home visit than at a well baby clinic (Hjälmhult 2009). As attendance at the well baby clinic and participation in home visits occur on a voluntary basis, it is important to establish a trusting relationship with the parents at the initial visit (Norwegian Directorate of Health 2004, Hjälmhult 2009).

The Norwegian Well Child Clinics offer comprehensive preventive and health-promotion services for children, adolescents and families. Well Child Clinics are staffed by a midwife, public health nurse (PHN), physician and health secretary. The clinics work in close cooperation with other public services in the municipality. For many generations, the vast majority of the population has used these services. Each child has 12–15 visits up to school age, including eight vaccinations by the PHN and five routine examinations by a doctor (Norwegian Directorate of Health 2004). After the first home visit, the PHN sees the family about ten times during the child’s first year at the Well Child Clinic (Norwegian Directorate of Health 2004). For example, in 2010 all children (100%) had their six-week and two-year examinations and 95% had their four-year evaluation (Statistics Norway 2012a). At every visit, the PHN conducts a routine check-up of the child’s growth and
development and asks about the well-being of the child and family. These individual examinations include the detection of adverse child environments and take the broader context into account (e.g., family, social network, social participation). If therapy is necessary, the child or the family is referred to a general practitioner or specialised care or service (Norwegian Directorate of Health 2004). See Table 1 for a description of programme components. In the past, the primary focus was on the child’s physical health and development, but during recent years, greater attention has been given to mental health and the family situation (Norwegian Board of Health 2012).

Typically, a PHN in Norway is responsible for preventive services provided to infants, children, adolescents and their families in a geographically defined area, including work in well baby clinics, school health services and youth health clinics (Andersson et al. 2006). PHNs assist individuals and families to take action to improve their health behaviour choices in their everyday lives. Often, PHN actions take the form of teaching and counselling about healthy lifestyle choices. Collaboration with other health professionals is also an important part of the public health nursing work (Ministry of Education & Research 2005). The organisational and structural factors in the municipality as well as time and place aspects influence how PHNs work with families that have newborn children (Andersson et al. 2006). The PHN workload varies depending on the municipality. The recommendation from the Norwegian Association for Public Health Nurses is 40–60 births per year for one PHN in a full-time position, but the municipalities often do not follow this recommendation. Usually, PHNs are responsible for an area with 80–120 births per year, and in some municipalities, PHNs have responsibility for up to 150 births per year (Andersson et al. 2006). PHNs also may have additional responsibility for school health service in one or two schools with 400–1000 pupils (Andersson et al. 2006). There is variation throughout the country in the content and quality of services provided by WCCs. The municipalities must ensure systematic monitoring of internal control and management of WCCs in order to ensure that the services function as intended (Norwegian Board of Health 2012). PHNs have a strong desire to have standards for workload following the National Guidelines for Well Child Clinics (Norwegian Directorate of Health 2004, Andersson et al. 2006).

Nurse Family Partnership programme and outcomes

The Nurse Family Partnership is a well-researched, evidence-based and voluntary nurse home visiting programme that aims to improve family and child well-being by targeting vulnerable mothers pregnant with their first child. Programme goals include: (1) improving pregnancy outcomes, (2) improving child health and development and (3) improving economic self-sufficiency of the family. An October 2011 snapshot on the programme website shows the programme is offered in 33 states and 412 counties, serves over 22,000 families and involves over 1200 nurse home visitors and more than 200 nurse supervisors (Nurse Family Partnership 2011a). A combination of private and public funding supports programme implementation through a variety of public and non-profit organisations such as local health departments and community health centres. The average cost for providing the programme to a family is $4500 per year (Nurse Family Partnership 2011a).

The nursing focus in working with families is a relationship- and strengths-based model that emphasises empowerment of families. Three theories guide nursing interventions on home visits: self-efficacy, human ecology and attachment (Nurse Family Partnership 2011c). Based on self-efficacy theory, nurses work with mothers to make realistic goals and develop their confidence. From a human ecology perspective, nurses focus on helping mothers to manage their environments of family, neighbourhood, school and community. Nurses use attachment theory to guide interventions that promote responsive and nurturing parenting. Nurses are viewed as advocates and coaches rather than being ‘the expert’.

A report by the Washington State Institute for Public Policy identified five characteristics shared by effective and evidence-based programmes that aimed to improve child welfare. The characteristics are: (1) targeted populations, (2) intensive services, (3) a focus on behaviour, (4) inclusion of both parents and children, and (5) programme fidelity (Lee et al. 2008). See Table 1 for examples of these characteristics in the Nurse Family Partnership programme.

The Nurse Family Partnership Theory of Change Logic Model (Nurse Family Partnership 2008) documents short-term, intermediate and long-term outcomes in conjunction with programme goals. Maternal life course and child outcomes have been rigorously evaluated through a series of randomised control trials that measure long-term outcomes of NFP programmes in three cities: Elmira, New York, from 1977; Memphis, Tennessee, from 1988; and Denver, Colorado, from 1994 (Nurse Family Partnership 2011e). Outcomes include the following: fewer subsequent pregnancies, longer intervals between first and second child births, fewer months of dependency on Food Stamp and welfare programmes, longer relationships with current partner, higher achievement scores for children in school, lower mortality for children due to preventable causes, decreased

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Journal of Clinical Nursing
### Table 1: Characteristics of effective evidence-based child welfare programmes applied to Nurse Family Partnership (NFP) and characteristics of Norwegian Well Child Clinic programme

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<th>Characteristic</th>
<th>NFP programme</th>
<th>Characteristic</th>
<th>Norwegian Well Child Clinic programme</th>
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| **Targeted population** | Targets: low-income, first-time, unmarried mothers  
For Minnesota (25 counties and tribal agencies), median age is 19, 88% are unmarried, and 63% are Medicaid recipients (Nurse Family Partnership 2011b) | Universal offer  
99–100% of all families use the Well Child Clinic (Statistics Norway 2012a) |  
Women should be offered continuity of care during pregnancy, birth and the postnatal period. This means being cared for by a minimum number of professionals, who the woman feels comfortable with, during the whole of her pregnancy. A system with clear routines should be established for antenatal services, so that women who need check-ups in addition to basic care are taken care of and treated by the appropriate healthcare personnel when a problem arises.  
During pregnancy (up to and including the fortieth week of pregnancy) a basic programme of eight check-ups is recommended. This includes an ultrasound examination between the 17th and 19th weeks. Extra check-ups should be carried out in week 41, and after this time, the routines for post-term pregnancy should be followed.  
During postpartum period, home visit 2 weeks after delivery, then 9 visits at the WCC the first year, 3–4 times the second year and then again when the child is 4 year  
During pregnancy  
Effects of smoking, alcohol and drugs on foetal growth  
Nutrition and exercise during pregnancy  
Preparation for labour and delivery  
Newborn care  
Family planning  
Prenatal care  
After birth  
Child nutrition, health, growth and development, and safety  
Sensitive parent–child interaction and assessment  
Building social support networks  
Child care arrangements  
Family planning  
Goals and strategies for education and work  
Connections with community resources | Universal offer |
An analysis of cost savings of the preventive impact of family participation in the NFP programme yielded an estimate of over $17,000 per family when considering benefits minus programme costs (Aos et al. 2004, Olds 2007).

The Coalition for Evidence-Based Policy rated the NFP programme in the top tier of evidence initiatives based on ‘well-designed and implemented randomized controlled trials, preferably conducted in typical community settings, to produce sizable, sustained benefits to participants and/or society’ (Coalition for Evidence-Based Policy 2011).

Comparison of key characteristics of effective programmes that promote child welfare

The similarities between goals and content of the NFP programme in the United States and the WCC services in Norway are emphases on (1) intensive services, (2) a focus...
on behaviour, (3) the inclusion of both parents and children and (4) programme fidelity (Table 1). Although the format and structure for programme fidelity differ between the two countries, both programmes include PHN knowledge development through education and supervision that has components of reflective practice and conflict resolution. In the NFP programme and in the Norwegian WCC, the family’s relationship with the nurse is considered important. The findings in a study by Worth and Hogg (2000) support the value of the nurse client relationship, formed mainly by home visiting, as the cornerstone of successful intervention. Parents in the study appreciated the nurses’ support in helping them to develop their parenting skills. According to Benner (1984), holistic understanding improves nurses’ decision making by enabling them to gain a perspective on which of the many existing attributes and aspects in a situation are the important ones. The NFP nurses in the United States and the PHNs in Norway have additional education that provides holistic understanding and knowledge and skills for working with children and families (Ministry of Education & Research 2005, Nurse Family Partnership 2012). Reflective practice is considered important in both programmes, but is supported to a greater extent in the NFP programme as NFP nurses have regular supervision, which is not always the case for Norwegian nurses. The roles and responsibilities are also different for the nurses in the two programmes. While the NFP nurses have no more than 25 clients, the work load for the Norwegian PHNs differs in spite of national guidelines (Norwegian Board of Health 2012).

The major difference in the programmes is the focus on a targeted population for the NFP programme vs. the universal offer of WCCs in Norway. The political and societal contributions to the structure of the healthcare systems in these two countries have shaped how child health and family programmes are structured. Norway has universal health care for its entire population. In addition, a philosophical difference is an emphasis on choice vs. following expectations. Although Norwegian families do have a choice to use the WCC services, nearly all families participate, which is consistent with a tradition of using healthcare services offered by the government. Individual choice has more often driven healthcare policy in the United States.

In focusing on a targeted population, NFP identifies high-risk families, those who will receive the greatest benefit from the services. The Task Force on the Family from the American Academy of Pediatrics identified the following family risk factors: stress resulting from family structure such as single parenting, parental health and/or social problems, lack of social support, lack of financial access to health care, and poverty (Schor 2003). One of the high-risk factors identified for the NFP programme, low socioeconomic status, is less likely to be a risk factor for Norwegian families. With the universal approach in Norway and nearly all families using the WCC services, an assumption is that nearly 100% of high-risk mothers in Norway are using the service. According to Norwegian guidelines, a family with certain identified risk factors, for example lack of social network, lack of social support, economic stress issues, substance abuse, and child development issues, should have more frequent appointments in comparison with those without risk factors (Norwegian Directorate of Health 2004).

Challenges in documenting outcomes of universal preventive care

As preventive health care is organised in completely different ways in Norway and the United States, it is difficult to compare service content and quality between different countries. The relationship between offering universal health services and effectiveness of prevention or lack of prevention is also challenging to document in short timeframe. This makes it difficult to conduct specific impact assessments of service that can be used to support negotiations for funding and resources (Norwegian Board of Health 2012). However, research findings do suggest there are benefits for all mothers with the universal approach in Norway. Wilsson and Adolfsson’s (2011) study shows that women need help and support in their development as mothers in order to feel more secure in their roles as a parent. All of the mothers in Wilsson and Adolfsson’s study expected to receive confirmation of their baby’s health and development during this first-time visit in the home by the nurse. First-time mothers tended to need more confirmation that they were taking proper care of their infant (Wilsson & Adolfsson 2011). More emotional and informational support to parents both in pregnancy and during the postpartum period has also been a recommendation made in other studies (Wilkins 2006, Deave et al. 2008), and should be considered important to the primary healthcare services. In a preventive programme, it is important to strengthen the resources of the municipalities to provide support to new mothers who are discharged early from the hospital. The infant mortality rate has declined considerably during the last decades in Norway. According to Størdal (2009), simple and inexpensive interventions before, during and after delivery may reduce mortality with more than 50% globally.
Conclusion

Limited research and differences in the municipalities make it difficult to assess the effect of the universal WCC model in Norway, while the NFP programme is well researched and evidence based. Research has demonstrated that benefits are greater for higher-risk groups in NFP. However, for many health problems, a combination of primary, secondary and tertiary interventions is needed to achieve a meaningful degree of prevention and protection, and support to new families should be considered as important to prevent future health and social problems. Information about the dosage of frequency of visits for best outcomes is needed, but evidence is lacking. Although the effect of primary prevention interventions in a universal programme is difficult to measure as all families receive the intervention, research shows that new families need support and counselling and a universal approach might prevent depressive symptoms in postpartum women. Also, the inability to follow governmental guidelines for preventive health care may contribute to reduced follow-up of high-risk families even though the offer was initially universal.

Norway should continue with universal approach to support new families. The target group for NFP is mothers at risk opposed to the Norwegian universal offer. A model similar to NFP could be developed in Norway as an addition to the existing universal services, as an offer to the high-risk families. In this way, high-risk families would be given even more attention as required from the Norwegian Directorate of Health (2004).

Relevance to clinical practice

Although WCC services are universally offered throughout Norway, reports shows that despite National Guidelines, there is a large variation throughout Norway in the content and quality of services in the WCCs; also, the PHNs struggle to find standards for their workload (Andersson et al. 2006, Økland & Hjälmhult 2010, Norwegian Board of Health 2012). The Norwegian Board of Health Supervision and the Norwegian Directorate of Health suggested that more comprehensive data and research about services provided by Well Child Clinics are needed, as existing data are inadequate (Norwegian Board of Health 2012). Public health nursing leaders in Norway need to advocate for PHN ratios that make it possible for PHNs to follow government guidelines. Quality assessment of programmes across country should be carried out regularly to ensure consistency and an equal offer to the population. Standardised interventions across country for prevention of PPD should be implemented.

The universal offer of WCC services is one factor that contributes to healthy child outcomes in Norway. If implemented in the United States, the universal approach with emphases on support and prevention would likely improve child outcomes, specifically for low-income families who fall in the gap of the mix of public and private health care available in the United States. NFP is filling this gap for some families in the United States, but many families who could benefit from the programme are missed because the programme is not universally available. Historically and currently in the United States, values about individual rights and the role of government have prevented a consensus on implementing a universal approach to health care.

Acknowledgements

We are grateful to the PHN experts on home visiting programmes in Minnesota who contributed with their time for our interviews and to the Norwegian Public Health Nurses Association for contributing with funding to this study.

Contributions

Study design: KG, MS; data collection and analysis: KG, MS and manuscript preparation: KG, MS.

Conflict of interest

No conflict of interest has been declared by the authors.

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