MASTER THESIS – HEALTH SCIENCES

EVALUATING VOORZORG-VERDER:

EXAMINING IMPLEMENTATION CHALLENGES AND PROGRAM EFFECTIVENESS

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1. ABSTRACT

VoorZorg-Verder is a program for high-risk mothers, who have finished VoorZorg. VoorZorg-Verder aims to improve the developmental chances for the child and to prevent (severe) parenting problems. The program is based on several scientific theories and is executed by specially trained VoorZorg nurses. VoorZorg-Verder started in 2016 and has not been evaluated since. There are a lot of unclarities about how the program is doing and whether it should continue. This study provides a process- and an effect evaluation of VoorZorg-Verder. Semi-structured interviews were used to find answers to the research question. The questions in the interviews were based on the CDC framework, MIDI framework and the goals of VoorZorg-Verder. The interviews were transcribed, coded, and analyzed. Eventually four VoorZorg nurses participated in the research. The process evaluation showed that there currently is a low degree of implementation, which means that not all planned activities are being carried out. Next to that, the factors that facilitate the implementation are participant satisfaction, staff perceptions, clarity of communication, social support, and self-efficacy. The factors that impede the implementation are alternatives, materials, and money. The effect evaluation showed that all but one goal is being reached with VoorZorg-Verder. The only goal that is not reached is more knowledge about attachment. Based on these conclusions, VoorZorg-Verder should be continued and improved. Not only would it be great for the clients if VoorZorg-Verder continues and improves, but also for the VoorZorg nurses. All nurses who were interviewed were very enthusiastic about the program. They really see the added value and after improvements, they might even be more inclined to offer VoorZorg-Verder to clients. However, there is a consideration to keep in mind while reading the results of this study. Eventually only four VoorZorg-Verder nurses were interviewed, this could have caused response and participation bias.

2. INTRODUCTION

2.1 BACKGROUND

An estimation of the Dutch ministry of Health, Welfare and Sport states that annually around 119.000 children experience maltreatment at home. This includes physical violence, neglect and mental abuse (Alink et al., 2011). Child maltreatment has an enormous impact on the child and the family. In an attempt to help these children, many treatment programs exist. Examples are Families First, Veilig, sterk & verder, Multisystematic Therapy for Child Abuse & Neglect. Based on the Databank Effectieve Jeugdinterventies or the Kenniscentrum Kinder- en Jeugdpsychiatrie these programs show effective results in treating the consequences of child maltreatment (Nederlands Jeugdinstituut, 2024). Even though these programs exist and are effective, the consequences can be severe and permanent. Next to that, child maltreatment is still a taboo, many people who suffered maltreatment are too scared or embarrassed to talk about it and ask for help. Studies show that child maltreatment increases the risk for depression, bipolar disease, and earlier onset of these diseases. It also increases the risk for suicidal ideation, anxiety, posttraumatic-stress disorder, and long-term deficits in educational achievement (Lippard & Nemeroff, 2020)(Gilbert et al., 2009). Next to the mental issues, child abuse can increase the risk of physical injury, growth retardation and obesity (Gilbert et al., 2009). The timing of the occurrence of the child maltreatment plays a role in the consequences. Maltreatment that occurs early in life and continues for a longer duration, can be associated with the worst outcomes (Lippard & Nemeroff, 2020). To prevent child maltreatment and all these consequences, VoorZorg was developed.

The program VoorZorg was developed by Nederlands Centrum Jeugdgezondheid (NCJ), the program is based on Nurse-Family Partnership (NFP). NFP is an evidence-based program for the primary prevention of child maltreatment (MacMillan et al., 2009). This program is focused on high-risk pregnant women, they receive well-structured home visitation from the beginning of their pregnancy until the child turns two years old. High-risk means that there are complex multi-problems occurring in their lives right now or did occur in the past. During VoorZorg, the women receive about 50 home visits by trained VoorZorg nurses. The VoorZorg nurses were specially trained before implementation of the program. During the program the nurses regularly review each other at home visits, and they receive a one-day training session at the national level annually (Mejdoubi et al., 2015). A manual was developed to guide the nurses during each session. Each visit has separate goals, for example teaching parenting skills to enhance the mothers' self-efficacy or to improve the utilization of social and community resources (Mejdoubi et al., 2015). The nurses strive to keep contact between the visits via messaging or social media. The focus of every visit and the extra contact is to establish and maintain an enduring trust relationship between the nurse and the mothers (Mejdoubi et al., 2015).

In 2019, the program was evaluated. This evaluation showed that there was a need for a continuation after VoorZorg. The mothers said that they learned a lot of parenting skills, but that they had other questions about their aging child. The mothers were especially enthusiastic about a continuation of the program because of the good trust relationship

between them and the VoorZorg nurse. Therefore, VoorZorg-Verder was developed (Jansma & van der Hoff, 2019).
Where VoorZorg is focused on preventing child maltreatment, VoorZorg-Verder aims to improve the developmental chances for the child and to prevent (severe) parenting problems, by promoting her self-efficacy, sensitivity, and responsiveness. VoorZorg-Verder consists of guidelines, developed based on scientific theories (Jansma & van der Hoff, 2019). Most of the subjects are age-specific, meaning that this helps the mother during the different phases of the live of her child's development. VoorZorg-Verder is a program of four years, during which there are eight home visits. These can be flexibly planned, although there is an advised schedule based on the development of the child (Appendix A). These visits last 1-1,5 hours. To build a safe space for the mother, the nurse of VoorZorg-Verder is the same as during VoorZorg, so trust is already established. Further, the nurses aim to make visits predictable by having the same structure during each home visit. The home visits start with time for the mother to express how she is feeling. Based on this, the nurse and the mother decide what subject to discuss during the home visit. At the end of every visit, the nurse should use the leaflet 'Neem de tijd, kijk en verwonder', that emphasizes the importance of play for the development of the child. After that, new arrangements are made for the next visit (NCJ, 2018). The components of each visit try to improve the development of the mother herself, by promoting her self-efficacy, sensitivity, and responsiveness.

The Verweij-Jonker institute researched VoorZorg-Verder during the development of the program from 2016 until 2019. This was a process evaluation. This research was done in Amsterdam, Noord-Holland and Breda. Eventually 31 clients participated in the entire research. The goal was to find out what would be necessary for an optimal implementation of VoorZorg-Verder. Eventually, the results were categorized into seven categories. These are (i) the design of VoorZorg-Verder, (ii) the material of VoorZorg-Verder, (iii) training and support for VoorZorg nurses, (iv) support for child and youth health (JGZ) organizations and communication with municipalities, (v) execution of VoorZorg-Verder, (vi) the outcome of VoorZorg-Verder and (vii) conditions and effective components of VoorZorg-Verder (Jansma & van der Hoff, 2019).

There were a few points that were specifically mentioned, that influenced the implementation negatively. First, the time nurses get for the house visits was too little. The nurses only got 1,5 hour per house visit and both the nurse as the client thought that was too little. The clients stated that this was too little time for the child to get to know the nurse, since the first meeting of VoorZorg-Verder is usually a long time after the last meeting of VoorZorg. Secondly, nurses felt that they weren't sufficiently trained to execute VoorZorg-Verder. They did receive a training before VoorZorg-Verder, however they felt like they needed more experience and knowledge about the different ages of the children. Thirdly, the contact between nurses and the designers of VoorZorg-Verder, with JGZ organizations. There was little to no contact, this caused uncertainty about the content and costs of VoorZorg-Verder.

Next to that, the research mentioned the following points (Jansma & van der Hoff, 2019):

- The frequency of the house visits is too little (8 in total)

- The language of the material is not fitting for the target audience.
- The nurses didn't use "Neem de tijd, kijk en verwonder" during each home visit.
- (Mental) burden for nurses was high
- The nurses doubted the added value of the program

2.2 RESEARCH PROBLEM

Since VoorZorg-Verder was developed in 2016 it has not been amended, resulting in an outdated program. The program was evaluated when it first started, this effect evaluation revealed a couple points that could use improvement. There has not been another research to see if these points were improved after the beginning or whether new adjustments should be made. Even though there were points to improve, the design of the program sounded promising, and the nurses and designers were overall enthusiastic after the pilot (Jansma & van der Hoff, 2019). However, it is not known if VoorZorg-Verder is currently achieving its goals.

Because of these unclarities, the NCJ does not know if there is still a need for the program and if the program has added value for the clients and the buyers. The NCJ is therefore on a crossroad, whether they want to continue VoorZorg-Verder or not. If the program would continue, it needs an improvement of its quality. Materials need to be improved and actualized, and the structure needs to be adjusted, since it is outdated. In order for the NCJ to decide about the (dis)continuation of VoorZorg-Verder, information is needed about (1) the implementation of VoorZorg-Verder and (2) the goal achievement. Therefore, this study will focus on whether it is still feasible and needed for VoorZorg-Verder to be continued. This study will do a process and effect evaluation. Eventually an advice will be made on whether VoorZorg-Verder should continue and that there should be a look into improving the program or that VoorZorg-Verder should be cancelled.

Both evaluations will give a good overview of how the program currently is doing. First, a process evaluation focuses on the implementation of the program, it examines the fidelity. Fidelity means 'the degree to which programs … are implemented as intended by the program developers' (Dusenbury et al., 2003). In other words, whether the nurses are executing the program as described in the manuals. The process evaluation will also focus on factors that could influence the implementation. Secondly, the effect evaluation examines whether the goals of the program are reached.

2.3 RESEARCH QUESTION

The main research question is: *should VoorZorg-Verder be continued and improved, or cancelled?* To be able to answer this question, this study will do an effect evaluation and a process evaluation. This led to the following sub questions:

1. Which factors influence the implementation of VoorZorg-Verder? (process evaluation)
2. Does VoorZorg-Verder achieve its goals? (effect evaluation)

3. LITERATURE REVIEW

3.1 VOORZORG-VERDER

3.1.1 Theoretical base

VoorZorg-Verder was specifically designed as a continuation of VoorZorg. The difference is the focus on the aging child; however, the foundation is the same. The methods of VoorZorg-Verder are based on the same scientific research and theories as VoorZorg and some more. One of the theories is the attachment theory of Bowlby. Ainsworth describes attachment as a 'secure base from which to explore' (Ainsworth MD, 1963). The attachment theory states that a higher quality of attachment of the child positively influences the socio-emotional and physical health outcomes of the child (Bowlby, 1988). The sensitivity and responsivity of the mother can improve the attachment. During the home visits, sensitivity and responsivity are improved, so attachment of the child and the mother improves as well.

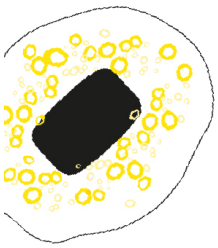
Because of the similarities between VoorZorg and VoorZorg-Verder, another theory of VoorZorg-Verder is the scientific evidence of the effectiveness of VoorZorg. VoorZorg was evaluated and showed significantly effective. The number of child protective services that had to interfere with mothers who joined VoorZorg were lower compared to mothers who did not join VoorZorg. Next to that, VoorZorg improved the long-term home environments and behavior of the child (Mejdoubi et al., 2015). The positive results of VoorZorg are caused by the trust relationship between the mother and the client and the skills and knowledge the mothers gained.

Another theory is the self-efficacy theory of Bandura. Self-efficacy describes how someone's belief in their own capacity is crucial in determining their behavior (Bandura & Walters, 1977). This means that raising the child is easier and more enjoyable for the mother if she beliefs in her abilities of raising the child. During the home visits, the nurse tries to improve the confidence of the mother.

3.1.2 Goals

The main goal of VoorZorg-Verder is to break the cycle of intergenerational transmission of family issues, child maltreatment and developmental challenges, with the focus on developmental challenges (Jansma & van der Hoff, 2019). VoorZorg-Verder tries to prevent (severe) parenting issues and to improve the developmental chances of the child. VoorZorg-Verder stands out with its particular focus on the aging child. VoorZorg-Verder tries to achieve the main goal by focusing visits on these subgoals:

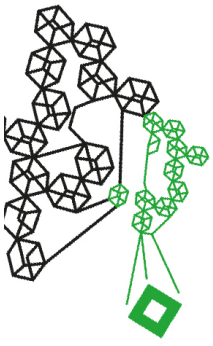
- Safeguard and enlarge the goals achieved during VoorZorg.
- Knowledge about attachment, lifestyle (smoking, alcohol, nutrition), parenting, domestic violence, child maltreatment, debts, work, income, and use of community services.
- Being able to timely identify problems, then provide support conform the methodology of VoorZorg.
- Working with existing facilities, such as neighborhood teams and school.
- Offering a trusted nurse for the mother to contact with questions.



One of the goals is knowledge about attachment, which tries to improve the attachment of the child and the mother. During the home visits, the nurses explain the importance of attachment and how the mother could improve it. A better attachment means an improvement of the health and development of the child. Next to that, the nurse tries to give the mother more knowledge about debts, work, income, and use of community service. The mother can provide a more stable environment if she has a job and knows how to manage money wisely. Next to that, there are usually many options in the use of community services, such as the 'Voedselbank' or a community center. Mothers might not always know these facilities exist, but they can help a lot. More knowledge about parenting could give the mother more self-confidence and self-efficacy, which will improve her parenting skills and the enjoyment of being a parent. Better help can be provided if the VoorZorg nurse can timely identify problems. Then, a problem might be solved before it becomes worse. An important part of VoorZorg and VoorZorg-Verder is creating a trust relationship between the mother and the nurse. This makes sure the mother feels safe to ask all the questions that she wants and that she is not afraid to talk about all things that are going on in their lives.

3.2 CDC FRAMEWORK FOR EVALUATION

In 1999 a paper was published with the "Framework for Program Evaluation in Public Health" by the Centers of Disease Control and Prevention (CDC). This framework was developed to help with the evaluation of public health innovations. Since public health changes so rapidly, the importance of evaluation is high (Milstein et al., 2000). A framework can help to do the evaluation systematically and clear (Milstein et al., 2000). In 2020 a review of different evaluation frameworks was done by Fynn et al. (2020). This showed that the CDC framework was a fitting framework for the evaluation of a public health innovation. The CDC framework is widely used, as there are around 300 citations in peer-reviewed articles (Logan et al., 2003).



The CDC framework is designed to summarize all parts of a program evaluation, which makes it easy to understand each element of the program and their evaluation. The framework consists of six steps and a couple standards for an effective evaluation (Witsel & Markwell, 2023). The steps are:

1. Engage stakeholders,
2. Describe the program,
3. Focus the evaluation design,
4. Gather credible evidence,
5. Justify conclusions,
6. Ensure use and share lessons learned.

In this study the stakeholders are the mothers participating in VoorZorg-Verder, the VoorZorg nurses, the NCJ, the JGZ organizations or GGD involved. The program is described above. The focus of the evaluation design will be a process evaluation and an effect evaluation. Credible evidence will be gathered through interviews with VoorZorg nurses. To justify conclusions, the interviews will be transcribed and coded and the

results will give an answer to the research questions. This paper will share the lessons learned.

To perform the process evaluation successfully, the framework describes six areas to focus on during the evaluation. These are:

- Participant demographics
- Individual participant attendance
- Fidelity to the selected program
- Participant satisfaction
- Staff perceptions
- Clarity and appropriateness of communication

3.3 MIDI FRAMEWORK

The MIDI framework was developed by Fleuren et al. (2004), this framework unites several theories and models, and represents the four main stages in an implementation process (figure 1). The stages are dissemination, adoption, implementation, and continuation. VoorZorg-Verder is in the implementation stage, here the program is put into daily practice by the nurses. The transition from one stage to the other, so from implementation to continuation, is influenced by several factors, or so-called determinants. These factors are divided into four categories, (i) characteristics of the socio-political context, such as rules and legislations; (ii) characteristics of the organization, such as staff capacity or the time available; (iii) characteristics of the person adoption the innovation, such as the expectations or social support; (iv) characteristics of the innovation, such as the complexity or the extent of to which the innovation is clearly described. (Fleuren et al., 2004).

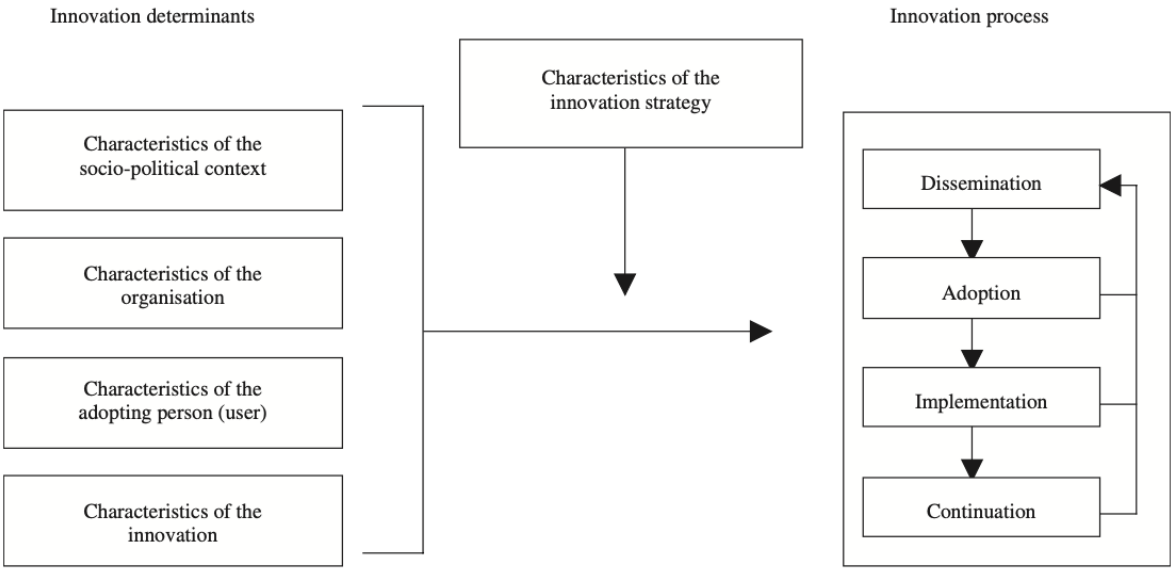


Figure 1. MIDI Framework

Originally, a list of 50 potential determinants was published by M. Fleuren et al. (2004). In 2014, M. Fleuren et al. published another research where they tried to shorten the list, by researching which determinants predict the use of an innovation in preventative child health care and which determinants were seen as relevant by implementation experts (M. A. H. Fleuren et al., 2014b). Eventually, a list of 29 determinants was formed, which can be seen in appendix C.

A study by Konijnendijk et al. (2014) researched which determinants of the MIDI framework would facilitate or impede adherence to a guideline for the early detection of child abuse in preventative child healthcare. Three focus groups were used, during which a semi-structured interview took place. Half of the participants were working with children up to the age of four. Eventually 29 determinants were identified as facilitating or impeding to adhere to the guidelines, of which nine were mentioned in all focus groups by seven people or more. None of these determinants were from the characteristics of the innovation, seven from the characteristics of the adopting person, two from the characteristics of the organization and one from the characteristics of the socio-political context (Konijnendijk et al., 2014).

3.4 CONCLUSION

The theories of the CDC framework and the MIDI framework will be used to answer the first sub-question. These two frameworks form the base of the interview questions and guides the process evaluation, so all important aspects of the program are thoroughly evaluated. The knowledge about VoorZorg-Verder and its goals will be used to answer the second sub-question. The second sub-question is an effect evaluation, this researches whether goals are achieved and to what extent the goals are reached.

4. METHOD & DESIGN

4.1 RESEARCH APPROACH

The aim of this study is to find out if VoorZorg-Verder should be improved and continued or if it should be cancelled. To answer the research question and the sub-questions, this research adopts a qualitative approach with semi-structured interviews. Conducting interviews is widely used in qualitative research, since interviews can provide more in-depth answers. The opinions of the VoorZorg nurses are needed to fully understand how VoorZorg-Verder is doing and what factors are influencing the implementation. The qualitative approach of this study is the best way to answer 'how' and 'why' questions, which are needed to answer the research question (Tenny et al., 2022). The interviews were semi-structured to give some direction and to discuss all the points found in the literature, but still enable the nurses to give as much information as possible (Baarda & van der Hulst, 2021).

4.2 PARTICIPANTS

Participants were selected for interviews based on two criteria:

1. They are trained VoorZorg nurses.
2. They have executed VoorZorg-Verder and/or are currently executing VoorZorg-Verder.

The nurses were recruited through the NCJ, an e-mail was sent to VoorZorg nurses who complied to the criteria, with an explanation of the study and the question whether the nurses would be interested in participating. The contact information of the nurses who wanted to participate was forwarded. Then, an interview was scheduled at a convenient time for both parties. The aim for this study was to interview eight VoorZorg nurses. This amount would be feasible within the given time. The total population of appropriate participants was around 16. Eventually, four VoorZorg nurses were interviewed, this amount was lower than the aim for this study.

4.3 INTERVIEWS

The questions for the interviews were based on several sources and specifically composed to answer the sub-questions and eventually the research question.

The forementioned six areas from the CDC framework were used to answer the first sub-question. The first three areas of the framework; Participant demographics, individual participant attendance, and fidelity to the selected program provide information about the degree of implementation of VoorZorg-Verder. Participant demographics shows who are receiving VoorZorg-Verder, where they live and why they chose to start VoorZorg-Verder. Individual participant attendance shows the number of home visits that are made by the nurses per client. Fidelity shows how closely adherence is to the program (Centers for Disease Control and Prevention, n.d.). The NCJ provides a manual for the entire program, a general manual for the home visits and specific manuals for each of the eight home visits. These state what the nurses should be doing during and between each visit. To measure the fidelity, the nurses were asked if they are doing what is stated in the

manuals. The questions in the interviews corresponding with the fidelity can be seen in the appendix B. This also goes for the questions around participant demographics and individual participant attendance.

The other three areas of the CDC framework; participant satisfaction, staff perceptions and clarity and appropriateness of communication provide information about factors that could influence the implementation. Participant satisfaction and staff perceptions show opinions of either the participant or the staff about the program. Clarity and appropriateness of communication clarifies the communication of the goals of the program with the clients (Centers for Disease Control and Prevention, n.d.). Questions based on these latter three areas can be found in appendix B.

Questions based on the MIDI framework were asked, in addition to the questions based on the CDC framework. The questions are based on results found in the study of M. A. H. Fleuren et al. (2014a) because VoorZorg-Verder is also a preventative child healthcare program. During the interviews, one question was about the characteristics of the innovation since this still might influence the implementation of VoorZorg-Verder. This determinant is procedural clarity, this was chosen because it was already mentioned during the research of Jansma & van der Hoff (2019). The nurses indicated in that study that they sometimes did not know what to do during VoorZorg-Verder.

There are only two questions about the characteristics of the adopting person because the interview should be accessible for the nurses and otherwise it would be too long. These are social support and self-efficacy. Social support means “support experienced by the user from important social referents relating to the use of the innovation”, in this case from the municipality or NCJ (M. A. H. Fleuren et al., 2014a). During the Jansma & van der Hoff (2019) research, the nurses stated that there was little to no contact, so they experienced no support. Self-efficacy means “degree to which the user believes he or she is able to implement the activities involved in the innovation” (M. A. H. Fleuren et al., 2014a). This was also stated by the nurses during the Jansma & van der Hoff (2019) research, the nurses felt that they were not sufficiently equipped to execute VoorZorg-Verder.

Both the determinants that were found during the research of Konijnendijk et al. (2014) about characteristics of the organization were asked during the interviews. These are material resources and facilities, and coordinator. Coordinator means whether one or more people are responsible for coordinating VoorZorg-Verder (M. A. H. Fleuren et al., 2014a).

There are no questions about the determinant within the characteristics of the socio-political context. This determinant is legislation and regulation, and this will differentiate little, if all between Dutch child health care organizations (M. A. H. Fleuren et al., 2014b). The determinants with the corresponding interview questions can be found in appendix D.

To answer the second sub-question, questions for the interview are based on the five goals of VoorZorg-Verder that are mentioned above. This will start with a general

question about the view of the nurses on the goals of VoorZorg-Verder. The goals that were set by the designers of VoorZorg-Verder were formulated before the program started. The view of the nurses on the goals of VoorZorg-Verder can give new insights in the goals. Next to that, the nurses might value goals differently, they are very close to the clients which gives them a unique point of view. The second goal; knowledge about attachment, lifestyle, parenting, domestic violence, child maltreatment, debt, work, income, and use of community services, is split up into four questions. The first question is whether the client has acquired knowledge about the various areas. Knowledge about attachment will be surveyed by asking about the health and development of the child, since that would be the outcome of a better attachment. Knowledge about lifestyle and parenting will be asked separately. To research the effect of VoorZorg-Verder each of the aforementioned goals are surveyed to determine whether the nurses believe these objectives have been achieved, to what extent and why or why not. To research the goal 'being able to timely identify problems, then provide support conform the methodology of VoorZorg' the nurses are asked if they are able to easily identify problems and are able to solve them with the client. To inquire about the goal 'working with existing facilities, such as neighborhood teams and school', the nurses are asked if the mothers know about the social resources relevant for them in their environment. Finally, the nurses are asked about their connection with the clients, this provides insight into the goal 'offering a trusted nurse for the mother to contact with questions'. The questions corresponding with these five goals and a general question about goals of VoorZorg-Verder can be found in Appendix E.

4.4 PROCEDURE

All interviews were conducted in Dutch, since this is the most comfortable way for the nurses to express themselves. While scheduling the interviews with the VoorZorg nurses who were willing to participate, they were asked whether they preferred the interviews online or face-to-face. All nurses opted for an online interview. The interviews would take about one hour, eventually all interviews were held within 40 to 60 minutes. Upon starting the interviews, a clear explanation of the study's purpose, procedure, and the measures in place to safeguard the privacy of the participants was provided. Then verbal consent was asked for audio recording the interviews. After the recording started, an explanation was given that the nurses could stop the interviews at any time and that they could refuse any question. Before starting with the interview, the nurses were asked again if they understood everything and if they had any other questions. Then, the interview began, an overview of all questions in the order they were asked during the interviews can be found in Appendix F.

4.5 DATA ANALYSIS

All conducted interviews were transcribed with the software Amberscript. For the data analysis ATLAS.ti software was used to code.

Thematic analysis coding was used, this is a type of qualitative analysis to identify common themes and patterns in the data. This approach works best when people's views or opinions need to be ascertained. It allows a lot of flexibility when coding the data and is an easy way of sorting a lot of data in clear themes (Alhojailan, 2012). Within

thematic analysis, both inductive and deductive approaches are possible. This study adopts a deductive approach, this means that the codes were determined in advance. The codes were based on the same factors on which the interview questions were based initially. An overview and clear explanation of the codes can be found in Appendix G. Two other themes were discovered during coding, namely reasons why participants would offer VoorZorg-Verder to a client and alternatives for VoorZorg-Verder, these did not fit in any of the other codes. After coding the interviews, all codes were revisited to see if they all were in the right place. Finally, the codes were analyzed to recognize patterns, relationships and insights and related to the theoretical framework and research questions.

4.6 ETHICS

Ethical approval for this study was granted by the BMS Ethical Committee / Domain Humanities & Social Sciences (request number: 240816) on the 2nd of May 2024. The transcripts were made without the names of the nurses and the audio recordings were deleted after finishing the transcripts.

5. RESULTS

5.1 PARTICIPANTS

Ultimately, four interviews were held with VoorZorg nurses. One of the participants stated that in total there are around 12-16 VoorZorg nurses who are executing VoorZorg-Verder. This means that one fourth of the population was interviewed. One of the participants executed VoorZorg-Verder for three years, but is only doing VoorZorg now. Another participant has been executing VoorZorg-Verder for five years. The other two participants have been executing VoorZorg-Verder since the pilot started in 2016. VoorZorg-Verder is currently being executed in the area's Zuid-Holland Zuid, Noord-Holland Noord, Den Helder and Hoorn. VoorZorg-Verder used to be executed in Amsterdam during the pilot but is not anymore, because there was too much uncertainty about money and the municipalities had a hard time fitting the program in the caseload of the nurses. The nurses who are still executing VoorZorg-Verder currently have one or two clients, they finished 2, 14 and 6 programs. Most clients finished their program, however a few withered away because of the large intervals at the end of VoorZorg-Verder. Nurses had a hard time scheduling the last home visits because mother and child had to be present, this became difficult when the child started school.

During the pilot, all clients who ended VoorZorg were offered VoorZorg-Verder. At that time, a couple of clients did not want to start VoorZorg-Verder. After the pilot, the nurses offered VoorZorg-Verder solely to clients of which they thought they needed it. Whether VoorZorg-Verder was offered depended on the extent of problems of the clients at the end of VoorZorg. Whenever there were relatively many problems, another care facility, like outpatient support, was implemented. At some times the client inquired independently if the nurse would stay a little longer, at other times it was the nurses themselves who offered to execute VoorZorg-Verder.

5.2 DEGREE OF IMPLEMENTATION

Participant demographics, attendance and fidelity were used to measure the degree of implementation, as designed by the CDC framework. The findings of participant demographics are presented above. During the interviews, the nurses mentioned many reasons for offering VoorZorg-Verder, when they did offer the program and when they did not. An extra code was created for this category and can be labeled as measuring the degree of implementation. One of the nurses mentioned that there are around 12-16 nurses executing VoorZorg-Verder, she stated that this was a small amount. Which can also already state that the degree of implementation is low.
Only one of the interviewed nurses indicated that the eight prescribed home visits per client was sufficient. The other three nurses stated that eight home visits per client was too little and that they usually executed more. This means that the individual participant attendance is low.
VoorZorg-Verder prescribes a similar structure during each home visit, so it is predictable for the clients. All participants stated that it was impossible to follow that specific structure during each home visit. One of the participants said: "Not for me, it

would be very nice if life looked like the possibility of a structured conversation"[1]. One participant thought she might have been following the structure accidentally but did not focus on it specifically. The nurses prefer to start with a conversation about how the client is doing and this can take a while. Next to that, the nurses all explained that they did not use all the leaflets, only the ones that are relevant to the current life of the client and the child. They feel it is useless to use the leaflets that are not applicable. The leaflet 'Neem de tijd, kijk en verwonder' is almost never used anymore. The nurses state that it is too childish and feels unnatural to use. Based on this, it can be stated that the fidelity to the selected program is currently very low.

During the interviews, the nurses mentioned reasons why they would offer VoorZorg-Verder to a client. The reasons that nurses would offer VoorZorg-Verder were when the problems of the client were not excessive enough for other care organizations but could cause problems for the child. One nurse said: "That you know, the child is going to get stuck soon, the parent is capable enough to get it without intense counseling, but you know there's going to be problems there, then I ask if they want to start VoorZorg-Verder"[2]. VoorZorg-Verder would also be offered if a child still needed guidance with transition to another care organization and the nurse noted that this would not go well if she did not provide guidance. When a child turns two, usually toddler puberty starts, this can be a hard transition for the mother. Many mothers who are participating in VoorZorg-Verder did not have an easy childhood with a good example. When their child starts to be rebellious, the mothers might fall back in old patterns, which causes a lot of stress. The nurses never mentioned how many VoorZorg trajectories they are currently doing, so no conclusion can be drawn about the degree of implementation in this area. However, during the research of the Verweij-Jonker institute, 60 clients started VoorZorg-Verder divided over 14 VoorZorg nurses. This means that they all had around four VoorZorg-Verder clients. Currently this is none or two, this means that the implementation is low in contrast to the pilot.

In conclusion, the nurses state that it is impossible to execute the program exactly as it was designed. Including following the manuals, the structure, and the amount of the home visits. The nurses use the design of VoorZorg-Verder as an example of how it should be executed but adapt it, so it fits the mother and their method of operation. One of the nurses said: "I think that as a nurse, as long as everything you want to tell is covered and as long as you stay well connected to the client, I think it's okay to let go of such a structure"[3]. Currently, there are not many clients receiving VoorZorg-Verder. This all means that the degree of implementation is very low right now.

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1 "Voor mij niet, het zou heel mooi zijn als het leven er zo uit zou zien dat een gesprek dezelfde structuur zou hebben."

2 "Dat je weet, het kind gaat dadelijk vastlopen, de ouder is goed genoeg om het zonder heftige hulpverlening te krijgen, maar je weet dat daar problemen gaan komen, dan vraag ik of ze begeleid willen worden".

3 "ik vind dat je als verpleegkundige, als alles maar aan bod komt wat je wil vertellen en als je maar goed blijft aansluiten op de client, vind ik dat je zo'n structuur best wel los mag laten".

5.3 FACTORS INFLUENCING IMPLEMENTATION

For a couple factors it was measured whether they influence the implementation of VoorZorg-Verder. Based on the CDC framework, these are: participant satisfaction, staff perceptions and clarity of communication. Based on the MIDI framework these are: procedural clarity, social support, self-efficacy, material and coordinator. During coding, the nurses mentioned alternatives for VoorZorg-Verder, this can also be seen as a factor influencing implementation.

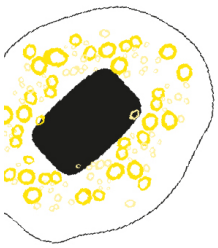
5.3.1 Factors facilitating implementation

The main tone during the interviews concerning the satisfaction of the clients was very positive. The participants all stated that the clients appreciated VoorZorg-Verder. The main reason for this is the trust relationship between the client and the nurse. The clients are usually care-avoiding and find it hard to trust care workers and listen to them. During VoorZorg, a lot of time goes into building the trust relationship. This relationship ensures that the clients fully participate in the program.
All nurses also stated that they were very positive about VoorZorg-Verder and saw an added value. One of the nurses was not executing VoorZorg-Verder anymore but wanted to participate in this study because she thought the program was beneficial and should start up again in her region. The nurses stated that it should be implemented in more places in the Netherlands. Before nurses started executing VoorZorg-Verder, they followed a short training. Even before the training all nurses felt very confident in executing VoorZorg-Verder. They had experience with VoorZorg and for them it was clear what they were expected to do during VoorZorg-Verder. This confidence made it easy for them to implement VoorZorg-Verder successfully.
The nurses really appreciate the contact with the clients in-between home visits. The nurses state that it is pleasant for them to know how the client is doing when they are not visiting. Next to that, clients text or call the nurses when there is a problem so the nurses can help them find a solution.
Social support of the environment of the nurse can influence the implementation of the program. One important part of the environment is the NCJ. During the interviews it became clear that the contact with the NCJ and municipalities was good. Occasionally the NCJ sent an invitation for a meeting with all VoorZorg nurses to discuss experiences. A meeting helped the nurses when they had problems or issues they would like to discuss. Only one participant stated that she was in contact with the municipality. She was positive about the contact with the municipality, they took her serious whenever she wanted to ask them something.

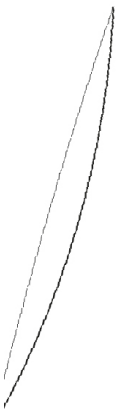
In conclusion, there are five factors that facilitate implementation of VoorZorg-Verder. These are; the satisfaction of the participants, the perceptions of the staff, the clarity of communication with NCJ, municipalities, clients and other VoorZorg nurses, the social support the nurses receive and the self-efficacy the nurses have. Currently, these factors are positive and make sure the innovation is implemented.

5.3.2 Factors impeding implementation

As stated earlier, VoorZorg-Verder would not be offered when there were other support services involved, this impedes with the implementation. The nurses state that there are

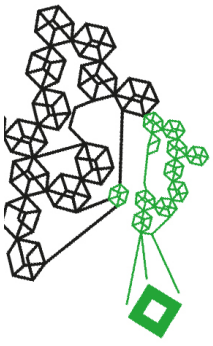


no programs that look like VoorZorg-Verder, that the program is unique. The nurses do mention other programs that mothers can receive, these are programs with more intense guidance. These usually take place whenever VoorZorg-Verder is not sufficient anymore and the problems of the child or mother are too severe. Examples of other programs are a social team, a youth team, mental health care, outpatient care or care though the Social Support Act (WMO).
Another negative influence on implementation is the material of VoorZorg-Verder. All participants said that the magazines and pamphlets were outdated and need adjustments. The part of 'Neem de tijd, kijk, speel en verwonder' was useful during VoorZorg but felt unnatural during VoorZorg-Verder. Two nurses stated that they usually were talking with the client for 1,5 hours, so there was no time left to use the material. It also depended on the preferences of the client if they would use the material. Some clients really liked reading, but others preferred hearing the tips from the nurse. All nurse mentioned these outdated materials and feel that it could be very positive after improvements but is now not helping with the implementation.
Two nurses stated that money was a reason for not offering VoorZorg-Verder. The nurses state that they only get a limited number of hours to offer VoorZorg-Verder, if they get any at all, and they have to distribute this strategically. They only get limited hours because the municipalities should have purchased VoorZorg-Verder, otherwise the nurses receive no money when they execute the program. This is a reason for nurses not to offer VoorZorg-Verder.



In conclusion, the factors that negatively influence the implementation of VoorZorg-Verder are the alternatives for the program, the materials that are currently used during the program and money.

5.3.3 Factors not influencing implementation



Procedural clarity was used to measure the determinants associated with the innovation that could influence implementation. nurses stated that they had been executing VoorZorg for a while before starting VoorZorg-Verder, this was the reason they were confident about their responsibilities. There was a short training at the beginning of VoorZorg-Verder and the nurses felt like that was enough to be able to execute the program. The nurses were very indifferent about the procedural clarity, for them it was all naturally. Therefore, the factor procedural clarity is not influencing the implementation, the nurses were neither negative, nor positive about this. This also counts for a coordinator. Participants did not really know who the coordinator was, but that they did not matter. There were enough other people they could ask questions.

5.4 ACHIEVEMENT OF GOALS OF VOORZORG-VERDER

The five goals of VoorZorg-Verder were split up into eight smaller goals. The nurses were asked whether they thought the goals were reached. Firstly, the nurses were asked what they thought the most important goals of VoorZorg-Verder were. All participants mentioned different things, this can either mean that the goals are not communicated clearly enough so it is unclear what goals are the most important, or the goals are all

equally important. One participant stated that teaching the mother to be more aware of the feelings of her child was an important goal of VoorZorg-Verder. Also, consciously discussing the father and mother role for the child. Another participant stated that VoorZorg-Verder is a great opportunity to look back with the mother and see how far she has come since starting VoorZorg. This gives the client more self-confidence and helps her with parenthood. The participant also stated explicitly that a goal is to get the most out of the trust relationship. Another participant stated that being involved for longer and helping the mother build a network around her are important goals of VoorZorg-Verder. The last participant also mentioned helping the mother with a network, but mainly stated that VoorZorg-Verder is about preparing the mother for the developments that the child will go through in the future.

The first measured goal was whether the goals achieved during VoorZorg were safeguarded and enlarged during VoorZorg-Verder. All nurses mentioned that they tried to continue the goals that were achieved during VoorZorg. One nurse said: “you hope that it's going to perpetuate that what you've been trying to bring within VoorZorg, that in VoorZorg-Verder is going to have an even firmer foundation or firmer base, that she's going to have even more self-confidence”[4]. This was mainly done by recalling what the mother had learned and discussing how she is doing now. This not only perpetuates the goal, but also gives the mother more self-confidence. The mother sees how much she has achieved since VoorZorg. Another example a nurse gave was the speech-language skills. The development is started during VoorZorg and continued and improved during VoorZorg-Verder. The last thing mentioned was how to handle money wisely and having a good network to be able to rely on for the mother. An improved self-confidence can also be categorized into another goal of VoorZorg-Verder, which is more knowledge about parenting. The nurses all state that the confidence of the mother about her ability as a mother improves during VoorZorg-Verder. Most clients already enjoy parenthood at the start, but experience difficulties when a child will not listen. During VoorZorg-Verder, the nurses help the mothers with this, since most of these mothers did not have a good example growing up.

The goal knowledge about attachment was not reached, this goal would ensure the development and the health of the child would be improved after VoorZorg-Verder. One of the nurses said that this goal was way too big for VoorZorg-Verder. VoorZorg-Verder is a preventative program and could not reach this goal. The other nurses agreed; however they did mention that the health of the child was improved because of a different lifestyle of the mother.

The mothers did learn that structure during the day is important for their child, getting out of bed on time and getting dressed on time. The mothers also learned that healthy and regular meals are important. The child does not have to have candy all day to be happy. Another part of lifestyle was smoking, many mothers that joined VoorZorg-Verder were smoking. The nurses tried hard to explain that smoking is bad and that they should stop. Some mothers listened and stopped smoking. Not all mothers stopped smoking, but the mothers that did not stop at least stopped smoking in front of their child. This was

[4] “je hoopt dat het gaat bestendigen dat wat je binnen VoorZorg hebt willen brengen, dat dat in VoorZorg-Verder nog een steviger fundament of stevigere basis krijgt, dat ze nog meer vertrouwen in zichzelf gaat krijgen”.

already a big improvement for the health of the child, so the nurses saw that as a goal reached. Another part of lifestyle that was mentioned by a nurse was the education of the mother. A few of her clients started school again, which was a big achievement. Because of the environment of the mothers, they did not feel they should or could start studying again. The nurses also provided a new environment and network for the mothers. The main existing facility the nurses helped the mothers with, was school. They helped the mothers choose a school and sometimes went with the mothers to help them decide or have conversations with the teachers. The nurses gave tips on how to handle more difficult conversations with, for example their child's teacher. The nurses also encouraged the mother to let their child go to a sport club or a social club. The nurses helped the mothers build a network around them, so they knew where to go with problems after VoorZorg-Verder ends.

The nurses all stated that they were able to identify problems in their clients and that they were able to solve these problems quickly, conform the methods of VoorZorg. On the other hand, it also happened a lot that the mothers contacted the nurses themselves whenever they had a problem. The mothers really trusted the nurses and could be completely open with their feelings. All nurses mentioned that the trust relationship between them and the mother was the most important part of VoorZorg and VoorZorg-Verder. The relationship was built during VoorZorg and continued during VoorZorg-Verder. The goal of offering a trusted nurse was definitely reached. Two quotes from the interviews that represent this relationship well are one nurse said: "And now because I understand her very well and she has confidence in me. Yes, they just say, you are my Dutch mom"[5] and one nurse mentioned that her client said: "and if I feel bad about that, for example, or sad about that, then I can always call, without feeling judged, because they know where I'm coming from and what I've been through"[6].
The mothers usually are care-avoiding, but because of this relationship the mothers are more tended to accept care when the VoorZorg nurse told them it was important.
One participant gave the example of a mother who finished VoorZorg-Verder two years ago, but sometimes still sends pictures of her child. The relationship comes from both sides, the nurses are involved in the lives of the mothers and really build a relationship. They enjoy asking the mothers about their lives, go back to previous conversations and ask about that.

6. CONCLUSION & DISCUSSION

The goal of this study was to evaluate the program VoorZorg-Verder, the main research question of this study is *Should VoorZorg-Verder be continued and improved, or cancelled?*
VoorZorg-Verder is a continuation of VoorZorg, a program designed to prevent child maltreatment. VoorZorg has been researched and proven effective (Mejdoubi et al., 2015). During VoorZorg-Verder the focus shifts to preventing severe parenting problems and to improve the developmental chances of the child. The program was developed to extend the stay of the trusted nurse and to help the mother with new developments in the

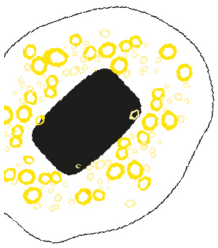
[5] "En nu omdat ik haar heel goed begrijp en zij heeft het vertrouwen in mij. Ja, ze zeggen gewoon, jij bent mijn Nederlandse mama".
[6] "and if I feel bad about that, for example, or sad about that, then I can always call, without feeling judged, because they know where I'm coming from and what I've been through."

life of her child. VoorZorg-Verder was evaluated when it started with a pilot, that lead to several points of improvement but also enthusiastic reactions of both nurses and clients (Jansma & van der Hoff, 2019). After that, no new evaluations have been executed so there is no sight of how the program is doing. The current study has done a process and effect evaluation to see how the program is doing now. These evaluations were executed by conducting interviews with VoorZorg nurses. The questions during the interviews were based on the CDC framework, the MIDI framework and the goals that were set for VoorZorg-Verder. After the interviews were held, these were transcribed and coded. The two sub-questions were answered with an analysis of the interviews.

6.1 FACTORS INFLUENCING IMPLEMENTATION

The first sub-question is: *which factors influence the implementation of VoorZorg-Verder*? This question was answered based on six areas from the CDC framework and the MIDI framework. The CDC framework explains the degree of implementation and factors influencing implementation. The MIDI framework explains factors that influence the innovation process, with specifying determinants associated with the innovation, with the adopting person and with the organization.
The degree of implementation is currently low in VoorZorg-Verder, this means that the program has not fully been put into practice. Not all planned activities have been carried out and the program is not implemented as originally designed. Based on the interviews, the individual participant attendance is low, only one of the nurses executed the prescribed eight home visits. The other three nurses executed more than eight home visits. Next to that, the fidelity of VoorZorg-Verder is low, which leads to variation in the delivery of the program. None of the nurses follow the structure of home visits, they feel it is too static and unnatural. These are all points of improvement for VoorZorg-Verder. Next, the factors that could facilitate or impede the implementation were measured. Both the nurses and the clients saw high value in the program. The participant satisfaction and staff perceptions were good, which ensured a better implementation of the program. The reason for the positive attitude was the trust relationship. The relationship ensured that clients listened to the nurses and the program had all the possible benefits.

The MIDI framework describes several determinants that influence the shift from one stage of the implementation to another stage. VoorZorg-Verder is in the implementation stage and could continue to the continuation stage depended on determinants. Three areas of the CDC framework also describe factors influencing implementation. These determinants together were used to see what factors influence the implementation of VoorZorg-Verder. Eventually the factors that were found that facilitate implementation are: participant satisfaction, staff perceptions, clarity of communication, social support and self-efficacy. Both the nurses and the clients were very positive about VoorZorg-Verder, this ensured a better implementation of the program. Communication with the NCJ and municipalities was good, this accounted for good social support. The nurses felt they could ask questions about the program and ask for help when needed, which ensured a good implementation. The self-efficacy of the nurses was high, they felt that they knew what to do and how to perform the program. The nurses are not following the program exactly as it was designed, but they do feel confident in what they are doing.

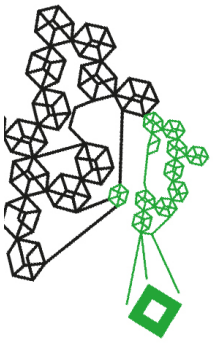


The nurse's perception on the program might be different than what was envisioned by the designers of the program. Based on the interviews, the nurses view might be that the guidance of the mothers is more important than the program. During the interviews, the nurses mention the trust relationship between them and the mothers multiple times, meaning that this is very important for them. If the program will be redesigned, it might be interesting to look further into the perceptions of the nurses concerning the guidance. The strength of the program might be in the trust relationship, so the focus can be less on the pamphlets.

Two determinants were found that impede with the implementation of VoorZorg-Verder, these are: alternatives and material and resources. At first, the nurses mentioned programs that sounded like alternatives for VoorZorg-Verder, so the code 'alternatives' was chosen. In hindsight, these programs are not similar to VoorZorg-Verder, meaning these are not alternatives. The programs the nurses mentioned were usually more intensive, when the problems are too big for VoorZorg-Verder. Whenever these other care programs were executed, VoorZorg-Verder was not offered. When other care workers were involved, the nurses felt they were in the way. Next to that, the nurses felt that those programs were more fitting for the mothers than VoorZorg-Verder.

The material developed for VoorZorg-Verder is very outdated, most of the time the nurses did not use the material. The pamphlet 'Neem de tijd, kijk en verwonder', where the nurses have to observe the mothers playing with their child feels unnatural. The subjects described in the material is based on scientific theories, which would mean that all subjects are important for the development of the child and mother. The problem with the material might then be because the nurses feel they do not need the information, because they already know it. Another explanation is that the mothers prefer that the information is told to them directly, without a paper.

The determinants procedural clarity and coordinator were found as neutral, they did not impede nor facilitate the implementation of VoorZorg-Verder. The determinant coordinator means that one or more people are responsible for coordinating VoorZorg-Verder. The nurses were unaware who exactly the coordinator was. However, this did not influence the implementation because the extensive experience of the nurses allowed them to execute the program effectively.



6.2 GOALS OF VOORZORG-VERDER

The second sub-question is: *does VoorZorg-Verder achieve its goals?* VoorZorg-Verder mentions five goals, one of those goals was very elaborate so was split into several smaller goals for clarity. Most of the goals of VoorZorg-Verder were reached based on the interviews with the nurses. Most of the progress is made with the goal improved lifestyle. The improved lifestyle of the mother could be seen by more structure in her days, getting out of bed on time and offering her child regular and healthy meals. Next to that, some mothers were able to stop smoking entirely or stopped smoking in front of their child. Lifestyle is frequently mentioned in the literature, an improved lifestyle can provide a more stable environment for the child (Jansma & van der Hoff, 2019). The outcomes of an improved lifestyle are easy to notice, and the relatively small improvements can have a big impact on the lives of the mother and child. The fact that results are easily seen ensures that the mothers are more tended to change their lifestyle.

This means for VoorZorg-Verder that emphasizing on improving lifestyle is an important part and should be continued.
Another element mentioned by the literature are the improved parenting skills. The new skills and knowledge collected improves the self-efficacy of the mother (Mejdoubi et al., 2015). With an improved self-efficacy, the mother has more trust in her own skills and in turn, her skills improve, a positive feedback loop arises. The literature suggests that this is particularly important for mothers in high-risk situations, for whom VoorZorg-Verder was developed. Next to the improved self-efficacy, the experienced pleasure of the mother is improved.
Another goal was for the nurses to be able to timely identify problems and provide support conform the methodology of VoorZorg. One of the nurses gave the example that one of the mothers called her very upset and that she was able to calm her down within ten minutes. All other nurses stated that they thought they were able to timely identify problems. This shows one of the results of the good trust relationship.
The next goal was to teach the mothers how to work with existing facilities, the main place to provide the mother with a network was school. The child had to start school and the nurses helped the mother prepare and pick a school. The nurses also helped the mother with looking for sport or social clubs for the child. This ensured the mother developed her own network, which helped the mothers continuing the behavior as learnt during VoorZorg-Verder.
The last goal was to offer the mother a trusted nurse and this might have been mentioned the most during all the interviews. Because the trust was so good between the client and the nurse, they could achieve most of the aforementioned goals. The mothers trusted the nurses, so believed what they told them and really wanted to act on the tips and new knowledge they gained. The trust relationship might therefore be the most important to focus on, if VoorZorg-Verder continues.
The only goal that was not reached is knowledge about attachment, a better attachment would ensure an improvement in the development and health of the child. The nurses stated that an improvement in the development of the child was too big a goal for VoorZorg-Verder, since it is a preventative program. Next to that, the nurses mainly saw an improvement in health because of the improved lifestyle of the mother.
According to the nurses, VoorZorg-Verder achieves most of its stated goals. However, this is observed in a small subgroup of nurses, who wanted to participate in this research. The nurses might have been biased, they might have only wanted to participate because they want to see VoorZorg-Verder continue. The nurses that are not enthusiastic about the program might not have wanted to participate. It remains unclear whether the program would be found effective for other mothers.

6.3 SUMMARY

In summary, this study has answered the two sub-questions with semi-structured interviews based on two frameworks. The first sub-question answers what factors influence the implementation of VoorZorg-Verder. Right now, the degree of implementation is low, which gives a lot of room for improvement. The factors that could facilitate the implementation are participant satisfaction, staff perceptions, clarity of communication, social support, and self-efficacy. Factors that were found as impeding the implementation are: alternatives, material and resources, and money. All goals but

one were reached, this could mean that VoorZorg-Verder still has an effect and that it still works. Despite the observed low degree of implementation, the effectiveness of the program remains notable. This raises questions about the underlying reasons for this discrepancy. It could be suggested that certain core components of the program are still delivering valuable outcomes, such as the trust relationship which is built by home visits. Even though the nurses do not follow the structure or the prescribed number of home visits, the most important subjects of VoorZorg-Verder are addressed. The effectiveness of the program, even though there is a low implementation, also suggests that the nurses possess a high level of skill, knowledge, and adaptability. This indicates that the nurses' role in this program are very important, it also establishes another time that the trust relationship is crucial.
Based on this study, the conclusion could be drawn that VoorZorg-Verder should be continued, because many of the goals are reached. This ensures that the mothers who are receiving VoorZorg-Verder experience improvements in their lives and the development of their child. However, the degree of implementation is low, which gives room for improvement. Examples for improvement are the current design of the structure of the home visits, the amount of home visits and the materials that are currently used.

This means that the answer to the research question; *should VoorZorg-Verder be continued and improved, or cancelled?* Is that VoorZorg-Verder should be continued, but there are definitely parts that should be improved.

6.4 PREVIOUS RESEARCH & IMPLICATIONS

Jansma & van der Hoff (2019) did a process evaluation of VoorZorg-Verder when it first started in 2016, this study showed very positive prospects, but also a few points of improvement. Some points are still not improved but others have been tackled now. The first point was the time the nurses got for the home visits, they thought that it was too little. During the current study, nurses admitted that it was not always enough to catch up with the client and handle the leaflets but none of the nurses stated that they wanted more time for a home visit. They chose the subjects they thought were the most important and discussed these. In the end, the nurses always discussed the subjects that needed to be discussed, so no change would be needed there. The second point from the study of Jansma & van der Hoff (2019)was that nurses did not feel sufficiently trained to start executing VoorZorg-Verder. The opposite resulted from this study, all nurses said they felt confident enough to execute VoorZorg-Verder. They deemed the training at the beginning enough to be able to execute every visit successfully. The third point of improvement was the contact with relevant parties, such as municipalities and the NCJ. The nurses stated in this study that they never really were in contact with the JGZ and that this was not needed. The contact with the NCJ and the municipality if needed, was good. The fourth point was that there were too little home visits, this point also came back in this study. Half of the nurses figured there were more home visits needed, the other half stated that it might be worth considering ending VoorZorg-Verder when the child is four years or four and a half and keeping eight home visits. When the child is four, it is time to start school, this is a new network that has a good view on the child and can help the mother. The nurses who mentioned this also stated that it became harder to

execute VoorZorg-Verder after the child started school. It became hard to plan home visits and the mother had a new network to fall back onto. When VoorZorg-Verder is redesigned, the designers should take a look at this suggestion and could consider adopting the program likewise. Another point of improvement for the program is the material, the Verweij-Jonker institute (2019) mentioned that nurses thought the language in the material was not fitting for the target audience. This was not mentioned during this study; however, the nurses did feel that the material needs adapting. A lot is changing in the world, especially around mobile phones and social media and this needs to be processed in the material of VoorZorg-Verder. Next to that, just like the previous research, the nurses mentioned 'Neem de tijd, kijk en verwonder' was not used regularly. The nurses felt forced while using it and preferred to use that time for other subjects. When adopting the program, this should be critically examined. The seventh point was that nurses felt a high mental burden while executing VoorZorg-Verder. One nurse that was also involved during the pilot stated that she had around 11 clients back then and this was all in addition to her caseload and that that was very hard. However nowadays it is only executed when there is time in the caseloads of the nurses, so this is not a problem anymore.

6.5 STRENGHTS & LIMITATIONS

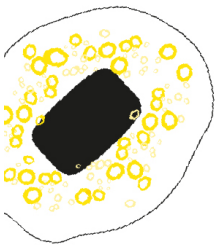
The first strength of this study is the use of the theoretical frameworks. The CDC framework and the MIDI framework combined make sure the evaluation is executed thoroughly and completely. The frameworks are scientifically designed, which strengths the conclusions in this research and makes them more reliable.
Another strength is the use of semi-structured interviews as the method of data collection. Semi-structured interviews provide a flexible and focused approach to gather information, allowing the nurses to express their opinions and experiences thoroughly. All subjects mentioned in the literature was discussed, as well as the parts nurses found important to mention. Which all together, makes for a complete image of the opinions of the nurses.
In addition this study has a practical relevance for both researchers and nurses. Improvements for VoorZorg-Verder were mentioned, as well as recommendations for future research. Given that VoorZorg-Verder has not been evaluated since it started makes this study even more valuable.

The biggest limitation of this study had to do with the methodology, specifically the number of participants. Interviews were held to find an answer to the research question. Respondents were recruited through the NCJ, who sent emails to nurses executing VoorZorg-Verder. Nurses were only contacted directly by the researcher after they had expressed that they wanted to participate. Next to that, the interviews were held during the summer, when many nurses were on vacation. This all caused the low number of participants, only four VoorZorg nurses agreed to participate in the research, so the reliability seems low. The four interviews that were held did have similar results. Next to that, one of the participants stated that there were only sixteen VoorZorg nurses who were also executing VoorZorg-Verder, so the four participants were a quarter of the total population of VoorZorg nurses executing VoorZorg-Verder. Based on this data, the

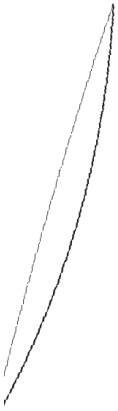
assumption can be made that results of this study are somewhat representative, and the research question can be answered.
Another limitation is that the nurses that were interviewed only executed VoorZorg-Verder in the provinces Noord-Holland and Zuid-Holland. The representativity of the population is therefore questionable. Results might be different in other parts of the Netherlands; however, it is not known whether VoorZorg-Verder is actually executed in other parts of the Netherlands. During the pilot, VoorZorg-Verder was also executed in Breda, which is in the south of the Netherlands. Unfortunately, no nurses from Breda expressed interest in joining this research.
The interviews were semi-structured, this gave participants the space to interpret questions how they felt fit and formulate their answers as they saw fit. The interview scheme made sure all subjects found in the theoretical frame were discussed during all interviews. At the same time respondents were free to answer questions their own way and not discuss what they find important. A limitation of a qualitative research is response bias. This means that respondents might give false answers to please the interviewer. To prevent this somewhat and lower the chance of response bias, interviews were used instead of questionnaires (Wetzel et al., 2016). Next to this, the interviews were held in Dutch and easy to understand words were used to decrease the chance of response bias.
Only nurses that have executed VoorZorg-Verder were interviewed, this might have caused participation bias. The nurses that did participate in the interviews were very positive about the program, which could give a one-sided view. There is no knowledge as to why nurses would not want to execute VoorZorg-Verder. The results can be influenced by this bias.

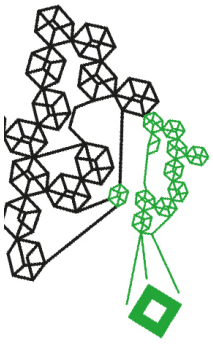
6.6 RECOMMENDATIONS

In the future, a randomized control trial (RCT) might be a good way to see if VoorZorg-Verder might be evidence-based. Nurses stated that whenever the program is evidence-based, the municipalities are more tended to purchase VoorZorg-Verder. However, currently the program is lacking the necessary standardization to implement a RCT. First, the program would need to change, and more research should be done.
Future research could start with collecting a larger and more representative sample of VoorZorg nurses. This could lead to a more comprehensive and diverse range of perspectives, which could enhance the understanding of what the effects of the program are across different contexts. Now, only the opinions of the nurses who wanted to participate are collected, more opinions could give a more complete image of how VoorZorg-Verder is doing.
Next to that, it would be interesting for future research to incorporate interviews with the clients. This might provide a different perspective on the direct impact of VoorZorg-Verder on their lives and their children's development. The clients might be able to give a more conclusive answer to the question what effects were reached because of VoorZorg-Verder and not because of other influences. They can explain what the added value is on their lives. Both recommendations might give a better understanding of what components of VoorZorg-Verder are important and ensure that the goals are reached.



“Now I see her as a very strong mother, now of two children and I think yes, if I didn't get to follow that, I just don't know how that would have gone. Possibly right too, but anyway, now I know for sure.”[7]





[7] “En nu zie ik haar echt als een hele sterke moeder, inmiddels van twee kinderen en ik denk van ja, als ik dat niet heb kunnen volgen, weet ik gewoon niet hoe dat dan gegaan zou zijn. Mogelijk ook goed, maar ieder geval, nu weet ik het zeker.”

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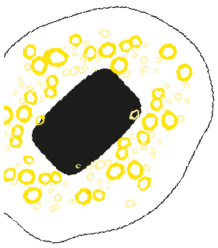
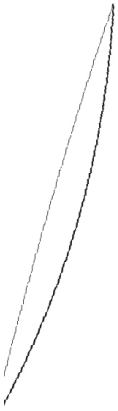
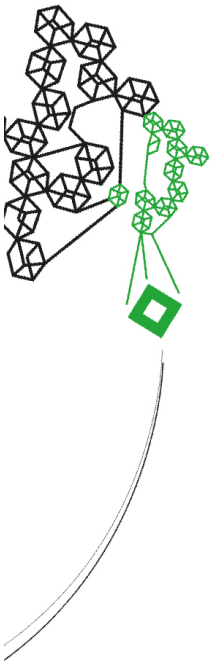


8. APPENDICES

8.1 APPENDIX A

Visit	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Age child	2 years, 9 months	3 years, 2 months	3 years, 6 months	3 years, 10 months	4 years, 3 months	4 year, 9 months	5 years, 4 months	6 years
Time since last visit	+/- 6 months	5 months	4 months	4 months	5 months	6 months	7 months	8 months





8.2 APPENDIX B

Degree of implementation	
Participant demographics	Hoeveel cliënten heeft u geholpen/ helpt u nog met VoorZorg-Verder?
	Waar kwamen/komen deze cliënten vandaan?
	Heeft u alle cliënten VoorZorg-Verder aangeboden na VoorZorg?
	Stonden cliënten open voor VoorZorg-Verder? Waarom wel/niet?
Individual participant attendance	Het doel is om acht huisbezoeken te doen, lukt dit bij alle cliënten? Waarom wel/niet?
	Hoe ervaart u het contact met de cliënten tussen de huisbezoeken door?
Fidelity tot the selected program	In de handleiding staat beschreven dat elk bezoek dezelfde structuur zou moeten hebben, lukt dit? Waarom wel/niet?
	Lukt het om alle onderwerpen die zijn voorgeschreven in de handleiding te behandelen? Waarom wel/niet?
Factors influencing implementation	
Participant satisfaction	Wat vinden uw cliënten van VoorZorg-Verder?
Staff perceptions	Hoe ervaart u VoorZorg-Verder in het algemeen?
Clarity of communication	Hoe is het contact met relevante partijen zoals NCJ en JGZ?
	Hoe ervaart u het contact met de cliënten tussen de huisbezoeken door?*

*Same questions as earlier, relates to both categories

8.3 APPENDIX C

Determinants associated with the innovation
1. Procedural clarity 2. Correctness 3. Completeness 4. Complexity 5. Compatibility 6. Observability **7.** Relevance for client
Determinants associated with the adopting person
8. Personal benefits/drawbacks 9. Outcome expectations 10. Professional obligation 11. Client satisfaction 12. Client cooperation 13. Social support 14. Descriptive norm 15. Subjective norm 16. Self-efficacy 17. Knowledge 18. Awareness of content of innovation
Determinants associated with the organization
19. Formal rectification by management 20. Replacement when staff leave 21. Staff capacity 22. Financial resources 23. Time available 24. Material resources and facilities 25. Coordinator 26. Unsettled organization 27. Information accessible about use of innovation 28. Performance feedback
Determinants associated with the socio-political context
29. Legislation and regulations

8.4 APPENDIX D

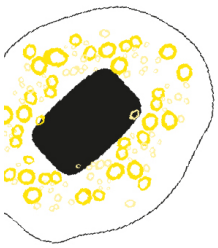
Determinants associated with the innovation	
Procedural clarity (Extent to which the procedures/guidelines of the innovation are clear)	Was het voor u duidelijk wat er van u werd verwacht toen u met VoorZorg-Verder begon?
Determinants associated with the adopting person	
Social support (support experienced by the user from important social referents relating to the use of the innovation)	Hoe is het contact met relevante partijen zoals NCJ en JGZ?*
Self-efficacy (degree to which the user believes he or she is able to implement the activities involved in the innovation)	Voelt u zich voldoende toegerust om elk bezoek succesvol uit te voeren?
Determinants associated with the organization	
Material resources and facilities	Wat vindt u van de materialen die worden gebruikt bij VoorZorg-Verder?
	Wat vindt u van de lengte van de huisbezoeken?
Coordinator	Wie is er verantwoordelijk voor de uitvoering van VoorZorg-Verder?

*Same questions as earlier, relates to both categories

8.5 APPENDIX E

Safeguard and enlarge the goals achieved during VoorZorg.	Welke doelen van VoorZorg worden voortgezet tijdens VoorZorg-Verder?
Knowledge about attachment, lifestyle (smoking, alcohol, nutrition), parenting, domestic violence, child maltreatment, debts, work, income, and use of community services.	In de handleiding staat dat de cliënten na VoorZorg-Verder kennis moeten hebben over een heleboel gebieden, lukt dit?
Knowledge about attachment	Ziet u na VoorZorg-Verder verbetering in de gezondheid en ontwikkeling van het kind?
Knowledge about lifestyle	Ziet u na VoorZorg-Verder verbetering in de levensstijl van de moeder? Lukt het om een stabiele omgeving te creëren?
Knowledge about parenting	Ziet u na VoorZorg-Verder vooruitgang in het ouderschap van de moeder? In hoe zij dat zelf ervaart? Heeft ze er plezier in?
Being able to timely identify problems, then provide support conform the methodology of VoorZorg.	Lukt het om problemen bij de cliënt te herkennen?
Working with existing facilities, such as neighborhood teams and school.	Kennen de moeders alle voor hen relevante sociale hulpmiddelen in hun omgeving?
Offering a trusted nurse for the mother to contact with questions.	Hoe is uw relatie met de cliënt?
General questions about goals	Wat ziet u als de doelen voor VoorZorg-Verder?
	Welke doelen bereikt VoorZorg-Verder, die tijdens VoorZorg niet zijn bereikt? Waarom?
	Hebben de moeders na VoorZorg-Verder geen hulp meer nodig? Durven ze het dan wel alleen aan?

8.6 APPENDIX F



Introductie

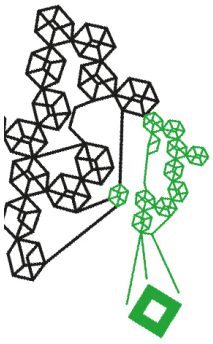
1. Hoe lang bent u al werkzaam als VoorZorg verpleegkundige?
2. Sinds wanneer voert u ook VoorZorg-Verder uit?
3. Hoeveel cliënten heeft u geholpen/helpt u met VoorZorg-Verder?
4. Waar kwamen/komen deze cliënten vandaan?

Overgang naar VoorZorg-Verder

5. Hoe ervaart u VoorZorg-Verder in het algemeen?
6. Wat vinden uw cliënten in het algemeen van VoorZorg-Verder?
7. Was het voor u duidelijk wat er van u werd verwacht toen u met VoorZorg-Verder begon?
8. Heeft u alle cliënten VoorZorg-Verder aangeboden na VoorZorg? Waarom wel/niet?
9. Stonden cliënten open voor VoorZorg-Verder? Waarom wel/niet?
10. Wie is er verantwoordelijk voor het coördineren van VoorZorg-Verder?
11. Hoe is het contact met relevante partijen zoals NCJ en JGZ?
12. Hoe ervaart u het contact met cliënten tussen de huisbezoeken door?

Tijdens VoorZorg-Verder

1. Hoe is over het algemeen uw relatie met de cliënt?
2. Er wordt voorgeschreven om acht huisbezoeken te doen, lukt dit bij alle cliënten? Waarom wel/niet?
3. Voelt u zich voldoende toegerust om elk bezoek succesvol uit te voeren? Waarom wel/niet?
4. Wat vindt u van de lengte van de huisbezoeken?
5. Wat vindt u van het materiaal dat u krijgt voor VoorZorg-Verder?



Doelen

6. Wat ziet u als de doelen van VoorZorg-Verder?
7. Welke doelen bereikt VoorZorg-Verder, die tijdens VoorZorg niet zijn bereikt? Waarom?
8. Welke doelen van VoorZorg worden voortgezet tijdens VoorZorg-Verder?
9. In de handleiding staat beschreven dat elk bezoek dezelfde structuur zou moeten hebben, lukt dit? Waarom wel/niet?
10. Lukt het om alle onderwerpen die worden benoemd in de voorlichtingsbladen en gezinsondersteunende bladen te behandelen? Waarom wel/niet?
11. In de handleiding staat dat de cliënten na afloop van VoorZorg-Verder kennis moeten hebben over een heleboel gebieden, lukt dit?
12. Kennen de moeders alle voor hen relevante sociale hulpmiddelen in hun omgeving?
13. Lukt het om snel problemen te herkennen bij de cliënten?
14. Ziet u na VoorZorg-Verder verbetering in de gezondheid en ontwikkeling van het kind?
15. Ziet u na VoorZorg-Verder verbetering in de levensstijl van de moeder? Lukt het om een stabiele omgeving te creëren?

16. Ziet u na VoorZorg-Verder vooruitgang in het ouderschap van de moeder? In hoe zij dat zelf ervaart? Heeft ze er plezier in?
17. Hebben de moeders na VoorZorg-Verder geen hulp meer nodig? Durven ze het dan wel alleen aan?

Afsluiten

18. Zijn er nog dingen die u kwijt wilt?

8.7 APPENDIX G

Code	Meaning
Participant demographics	The statistical characteristics of the individuals participating in the research and data of their VoorZorg-Verder clients.
Individual participant attendance	The amount of home visits nurses are executing per client and reasons for this amount.
Fidelity to the selected program	The degree to which VoorZorg-Verder is implemented as it was initially designed.
Participant satisfaction	The opinions of the clients regarding VoorZorg-Verder.
Staff perceptions	The opinions of the nurses regarding VoorZorg-Verder.
Clarity of communication	How the communication with relevant parties is going.
Procedural clarity	Extent to which the procedures/guidelines of VoorZorg-Verder are clear
Social support	Support experienced by the VoorZorg nurse from important social referents relation to the use of VoorZorg-Verder. (the NCJ, municipalities or other VoorZorg nurses).
Self-efficacy	Degree to which the VoorZorg nurse believes he or she is able to implement the activities involved in the innovation.
Material	The opinion of the VoorZorg nurses about the material resources and facilities available to them.
Coordinator	According to the nurses, who is their coordinator of VoorZorg-Verder
Offer VZV	Reasons for the nurses to or not offer VoorZorg-Verder to clients.
Alternatives	Options that can be offered instead of VoorZorg-Verder.
VoorZorg	Goals of VoorZorg that are continued during VoorZorg-Verder.
General knowledge	Nurses mention something about what the clients have learned.
Attachment	Improvements in the health and development of the child.
Lifestyle	Improvements in the lifestyle (smoking, nutrition, or structure during the day) of the mother and the child.
Parenting	How the mother experiences parenting.
Timely identify	The extent to which VoorZorg nurses are able to timely identify problems, then provide support conform the methodology of VoorZorg.

Existing facilities	The extent to which the mothers are working with existing facilities, such as neighborhood teams and school during and after VoorZorg-Verder.
Trusted nurse	The opinion of the VoorZorg nurse and what the trust relationship between the nurse and the client has resulted in.
General goals	What the VoorZorg nurses see as the goals of VoorZorg-Verder and whether they see these goals reached.