



ANFPP National Program Centre

National Annual Data Report

1 July 2014 to 30 June 2015

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CULTURAL ACKNOWLEDGEMENT

The Australian Nurse-Family Partnership Program National Program Centre acknowledges the traditional custodians of the lands and waters on which we live and work. We pay respect to elders past and present.



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ABBREVIATIONS

ACW	Aboriginal Community Worker
ANFPP	Australian Nurse–Family Partnership Program
ASQ	Ages and Stages Questionnaire
ASQ-SE	Ages and Stages Questionnaire: Social and Emotional
DCS	Data Collection System
DoH	Commonwealth Department of Health
df	Degrees of Freedom
FPW	Family Partnership Worker
FTE	Full Time Equivalent
GP	General Practitioner
M	Mean (average) for the data presented
N	The number of clients or infants in that specific group where results have been presented. These group number vary according to completed data and relevant analysis.
NFP	Nurse–Family Partnership
NICU	Neonatal Intensive Care Unit
NHV	Nurse Home Visitors
NPC	National Program Centre based in Brisbane (formerly referred to as the ANFPP Support Service)
NS	Nurse Supervisor
SCN	Special Care Nurseries
SD	Standard Deviation

EXPLANATORY TERMS

Active Client	An active client is a client that has accepted a referral and has been receiving visits, and has not left the program. This is used through the report to indicate the number of clients counted in the program at a point in time.
Accepted Client	The term accepted client is used within the ANFPP to represent a client who has consented to participate in the program. The client may or may not have had an initial home visit and may have subsequently left the program.
As at 30 June 2015 or 30 June 2014	Refers to cumulative data since the commencement of the program to the date specified
Attempted Visit	An attempted visit is a home visit that has been scheduled but is not completed. The reasons vary but are usually due to the client cancelling the visit or not being available at the scheduled day and time. In this case a Home Visit Encounter Form is completed with a visit outcome recorded as attempted (as opposed to completed)
Data Group	A meeting with representatives of implementing sites and Department of Health to discuss and consult with regard to the ANFPP Data Collection System
Dosage	The number of completed visits a client receives from the Nurse Home Visitor during the program, including telephone visits with program content. Within the program, clients receive 14 visits during pregnancy, 28 during infancy and 22 during toddlerhood.
Enrolled Clients	Enrolled clients is a term used within NFP communities to represent a client of the program who has consented to participating in the program and received their initial home visit. In some circumstances, enrolled clients are used in preference to accepted clients for the analysis where it will more accurately represents the measure. In this report, the calculation of dosage (visit completion rate) uses enrolled clients.
Exclusive Breastfeeding	For the Data Collection System Instructions and Manual V2.2, the question asks “Until what age was your baby fed exclusively breast milk (no water, juice, formula, cereal, or other solids)?”
Fully Immunised	Completed by the Nurse Home Visitor by mother’s self-report or documentation and according to DCS V2.1 ‘Based on the National Immunisation program Schedule (0-4 years), is [child’s name] up-to-date on all vaccinations’.
Ingestion	Referred to the child injury and ingestion section, the specific question asked is did you take your baby ‘because you were concerned your child swallowed something harmful’. Ingestion is used for brevity, but refers to a possible ingestion of a potentially harmful substance.





Intake

Throughout the report tables are presented with data recorded at intake. This means that the information in that measure was collected when the women joined the program and normally within four weeks of acceptance.

Reporting Year

Where this report refers to this reporting year, if not otherwise stated it is referring to 1 July 2014 to 30 June 2015

This Year

Standard Deviation

This is reported whenever a mean is given to provide a measure of the variability of the sample in the same units of measurement, for example if the mean age is in months, the SD will also be in months.

NFP Model Fidelity

The extent to which the program aligns with the model elements of the Nurse-Family Partnership Program

Program Elements

The eighteen elements of the program implementation that are essential to ensuring expected outcomes supported by evidence of effectiveness based on research, expert opinion, field lessons and/or theoretical rationales.

Program Domains

The six content areas or domains within the NFP Guidelines that should be apportioned based on the phase of the program. These domains are Personal Health, Environmental Health, Life Course, Maternal Role, Friends and Family and Health and Human Services.

Site

Established implementing sites have not been identified in this version of the report. Data tables presented by site represents the results derived from one implementing site. Sites do not appear in consistent order throughout the report.

1 EXECUTIVE SUMMARY

The National Annual Data Report 2014-2015 provides analysis and summary data of clients and infants from the Data Collection System for the Australian Nurse-Family Partnership Program. This program is delivered from specific Aboriginal community controlled health services across Australia.

The program commenced in 2009, however annual reporting of program implementation, client and infant outcomes commenced in 2012 and provides critical information to support the continuation of the program with fidelity to the NFP model and to assess outcomes for women, children and their families. The ANFPP has reached a level of maturity in the data collection whereby data quality and integrity, whilst always subject to improvement has allowed more robust and expansive monitoring and reporting.

In response to innovations this year, such as the Community of Practice and the Annual Data Workshop, further analysis has been undertaken to provide more information about the context in which the program is currently delivered. Additional information includes the involvement of fathers in caring for infants, access to antenatal services and education and workforce participation.

The following headings outline key finding from the analysis, which provides valuable information on the outcomes and achievements as well as aspects that require more exploration or consideration.

1.1 ANFPP CLIENT ENGAGEMENT

- Active clients reduced slightly from 197 participating women last year to 179 participating this year.
- Incoming referrals received by the program this year have reduced to 194 compared with 222 in 2013-14.
- Over 1300 women have been referred to the program, and uptake remains strong at 78% of eligible women going on to participate, exceeding the NFP target of 75%.

1.2 ANFPP IMPLEMENTATION

- Staff turnover continues to be high, with four Nurse Supervisors and three Nurse Home Visitors leaving this reporting year.
- Caseloads remaining fairly stable at around 14 clients per Nurse Home Visitor as at 30 June 2015.
- One hundred and fifty six clients have completed the program since inception, with 63 women graduating the program this year compared to 43 graduations last year.
- Enrolment early in the pregnancy remains challenging with 41% of clients participating in the program by the 16th week of pregnancy, less than the NFP target of 60%.
- Cumulative retention remains low at 41% of clients remaining in the program whereby the NFP Objective is greater than 60%. This is consistent with the results for the previous year.



- The average number of visits being received by women participating in the program are eight in pregnancy, 17 in infancy and 15 in toddlerhood.
- Clients who have graduated the program received on average 42 visits throughout the course of the program which is 66% of the expected visits under NFP Objectives.
- Maternal role and environment health domains vary against targets for all phases and personal health and life course development vary from targets only for the toddlerhood phase.

1.3 CLIENT CHARACTERISTICS

- Based on available data, 73% of clients have a weekly income of less than \$500 per week during pregnancy which constitutes a maximum of 76% of the minimum wage in Australia.
- Clients have identified 15 different languages when asked about primary language at intake.
- Nationally, 75% of clients reported daily involvement of the baby's father either caring for or playing with the baby.

1.4 HEALTH OUTCOMES FOR WOMEN ENROLLED IN ANFPP

- Antenatal care has been accessed by 92.5% of women participating in the program within four weeks of enrolment and the mean gestational age for first antenatal visit is 10.4 weeks gestation.
- A significant reduction in smoking was shown for individual clients from intake to 36 weeks of pregnancy (comparing how much they reported smoking in the two days prior to completing the form).
- Only 28% of clients reported smoking in the two days prior upon enrolment in the program compared to 39% last reporting year.
- There are very low rates of alcohol consumption during pregnancy for women in the program (when asked how many days did you drink alcohol and on how many drinks per day in the two weeks prior to completing the form).
- Only 3.6% of singleton babies born to women participating in the program had low birth weight compared with 11.8% for all Aboriginal and Torres Strait Islander women birthing in Australia in 2012.
- The average birth weight for infants of mothers participating in the program was 3,342 grams this year (N=84) exceeding national average for Indigenous women of 3,211 in 2012 and 55 grams less than the national average for all births in 2012 of 3,397 grams.

1.5 ANFPP CLIENT OUTCOMES

- Subsequent pregnancies within two years of the birth of the referral infant is 24%, which is similar to rates identified in the NFP randomised control trials (NFP 2015).



1.6 OUTCOMES FOR INFANTS IN THE ANFPP

- Average age for the cessation of exclusive breastfeeding for women participating in the program across three implementing sites is 16.6 weeks of age.
- Proportions of infants still receiving breast milk at 12 months of age is 57%, with a variation by site of between 4% and 75%.
- Percentages of infants presenting to clinics (N=4) or being admitted to hospital (N=1) for injury or ingestion are similar to last year and remain low.
- Whilst the coverage of the Ages and Stages Questionnaire across the population of infants in the program continues to be elusive, very few infants (N=6) referred to in completed questionnaires fall below the cut off score for follow-up in Ages and Stages questionnaires across all age groups.
- Similarly, there were very few infants that exceed the cut off scores for ASQ: Social and Emotional at all age groups (N=3).
- Only 26% of boys scored less than the 25th percentile for average English Language Assessment scores compared with girls where there were 62% falling under the 25th percentile for number of words identified.
- Whereas, 54% of boys and 15% of girls were above the 50th percentile in the number of words identified in the English Language Assessment.

1.7 SUMMARY

Overall the program implementation aligns with model fidelity and there are significant successes of the program to be noted such as the acceptance rate, where the majority of eligible clients that are referred go on to participate in the program. This supports the acceptance of the program in the local communities and the ongoing activities to maintain referral pathways. The delivery of the program to 98% first time mothers in the majority of implementing sites and the maintenance of an average length of visits to participants are aspects of the model that the ANFPP consistently achieves. There continues to be challenges and areas of improvement within the ANFPP in terms of model fidelity, however the focus on continuous quality means that these areas are identified and are the focus of improvement.

The turnover of staff within the program remains an issue of concern. With a small complement of program staff nationally, four Nurse Supervisors have resigned and the program has lost three long term Nurse Home Visitors. These positions have been filled, however the investment in education and subsequent disruption to caseloads and teams is evident. A study is underway to better understand the factors that influence staff retention within the program and it is an issue that continues to be the focus of attention.

Areas that require additional focus include:

- The enrolment of women before the 16th week of pregnancy,
- The retention of clients within the program,
- Content delivery within the expected domains, and
- Increasing the visit completion rate.

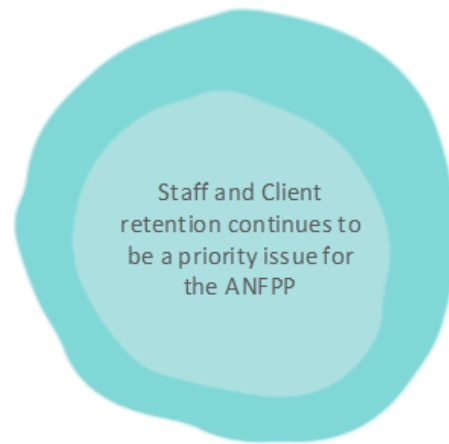
The ANFPP enrolls approximately 40% of women by the 16th week of pregnancy; the average gestational age at entry is 19 weeks. Ensuring early referrals, and certainly between the 12th and



16th week of pregnancy, is a key factor to improving this result. Early enrolment also provides a better capacity to conduct the 14 visits expected in the pregnancy phase.

Client retention has stabilised at just over 40% over the last two years, 20 percentage points lower than the model target of 60%. Women leave the program for a complex set of reasons and in the report more detail is provided about the reason given for leaving the program. It is hoped that seeking client feedback regularly will be a priority for implementing sites so that more information is available on this complex area that might influence client retention in the future.

The higher than expected attention on the environment health domain is fairly stable in the ANFPP, anecdotally thought to be a function of living in rural and remote areas and complex home environments. The average number of people living with clients for more than four nights per week varies between 4.2 and 5.7 depending on the site, with the national average of 5.1.



The attention to the maternal role varies throughout the different phases; higher than expected in pregnancy and lower than expected in both the infancy and toddlerhood phases and the causes of this deserve exploration.

Finally, the visit completion rate is lower than the expected targets. In the ANFPP, a client who stays in the program will, on average, receive 42 visits (66%) through to completion. However, it is understood that the women in the program are fairly mobile, and in many cases there will be times when the client is unavailable for visits but will resume visits on their return.

This is an area of significant discussion within program staff and the extent to which this occurs is unable to be quantified with current data management systems. It will be a priority for future recommissioning of systems to allow these instances to be tracked and reported to better inform potential ways to improve the dosage to clients.

A revised ANFPP National Quality Framework was launched in 2016 with underlying mechanisms to facilitate local continuous quality improvement activities and sharing of initiatives and successes. It is hoped that innovations such as the Community of Practice meeting being held at the same time as the National Data Workshop will increase the collective focus on program implementation and these priorities.

The positive outcomes experienced for clients of the program in relation to smoking reduction, premature births, low birth weights, child development are again demonstrated in the report. Overall the ANFPP continues to build on its strengths and as the program expands and as such, more information will be available about the challenges and successes of the program in Australia.



2 INTRODUCTION

The ANFPP National Annual Data Report provides summary data from the national monitoring of the program and provides important information with regard to the alignment of the program in Australia with NFP model fidelity. This analysis and summary information cover three main areas of interest:

- Alignment to model fidelity,
- Descriptive information about the women who have participated in the program, and
- Outcomes experienced by these women and their children according to criteria identified from the evidentiary basis of the program.

Information in this report is either cumulative, providing data since the inception of the program in Australia in 2009, or for defined periods such as financial years from 1 July to 30 June. Where possible, previous financial years' summary data have been preserved for comparison purposes.

The report has also included descriptive and demographic information about the women in the program covering the period from 1 January 2012 to 30 September 2015. Data from the 1st January 2012 is the most recent and most complete collection. These sections have been included to provide valuable information about the women in the program, such as their experience in paid work, the involvement of fathers in caregiving for infants and access and use of antenatal services. As this is the first time this information has been presented in this report, comparison with previous years is not available.

This report provides ANFPP stakeholders and the community with an opportunity to review information collected as part of the program and will assist in informing general knowledge of the program, to identify the outcomes for women participating in the program. The report also considers the ability of Aboriginal Community Controlled Health Services to successfully implement the program in Australia.

As the program expands over the next few years, it is important to consider the individual successes, overall outcomes and the impact being part of the program has on the women participating, both individually and collectively.

The breadth of information available within the program is testament to the significant investment made by the stakeholders and implementing sites to complete detailed information for each client and their infant, and to their commitment to continuous quality improvement within the program. Whilst the significant improvement in data integrity and completeness continues, there are still opportunities to identify areas for improvement and this report highlights these areas for consideration both for existing and future implementing sites.

This report will be circulated to implementing sites and ANFPP stakeholders and will inform the National Data Workshop and Community of Practice meetings proposed for May 2016. This report is a non-identifiable version of the National Annual Data Report 2014-2015.



2.1 DATA LIMITATIONS

A major focus of the 2013-2014 report was on data limitations, data completeness and the structure of the report. The National Annual Data Report has now been produced for a number of years and there is a greater understanding of some of the limitations of results provided in this report.

Specific data limitations are identified within each relevant section of the report as appropriate and more concise data analysis notes appear at the end of this report. The ANFPP Data Collection System Forms and Instructions form the basis of the national ANFPP data set and outline how the data is collected around specific data items. It should be noted that care should be taken in interpreting the results with regard to generalisability and inference as there are often small group numbers in sub-populations of the serviced communities.



3 PROGRAM SUMMARY

As outlined in Table 1 the program has maintained an active client base of around 200 women pregnant with an Aboriginal or Torres Strait Islander baby over the last few years. As at 30 June 2015 there were 179 active clients. Thirteen hundred and eighty one (1381) clients have been referred to the program since 2009. This year 63 clients graduated from the program, the highest number since its inception and exceeding last year where 44 clients graduated. Of these referrals, 1,050 were eligible for the program and of these, 817 accepted enrolment into the program which constitutes an acceptance rate of 78%. The ANFPP continues to exceed the NFP target for an acceptance rate of 75%. These figures are shown in Figure 1.

Table 1 - Summary of active clients, graduated clients and referrals for 2013-14 and 2014-15

MEASURE	AS AT 30 JUNE 2014	AS AT 30 JUNE 2015
Active clients	197	179
Graduations in year	44	63
Incoming Referrals in year	222	194
Total Graduated Clients	93	156

Table 2 outlines the number of incoming referrals across the history of the program to provide a comparison. There may be some change to these numbers since previously reported due to change in methods of calculation and subsequent data correction.

Table 2 - Program history of incoming referrals 2009-2013

YEAR	INCOMING REFERRALS
2012-13	260
2011-12	246
2010-11	228
2009-10	177

Figure 1 also outlines the processing of these referrals with 242 clients ineligible for the program and 233 who have declined participation. 'Program places full' refers to early in the initial implementation and this figure has not changed since 2012. Fifty-nine clients were unable to be located upon referral.

Sites have an active client base of up to 100 clients each and there is one Nurse Supervisor at each site supervising Nurse Home Visitors, Family Partnership Workers/Aboriginal Community Workers (FPW/ACW) and administration staff.



Table 3 outlines the staffing for the ANFPP, with current full time equivalent staffing of 12.8 Nurse Home Visitors. Twelve full-time and one part-time Nurse Home Visitor (0.8 FTE). There are eight Family Partnership Workers/Aboriginal Community Workers as part of the ANFPP teams and administrative support located at each site.



The average client caseload for Nurse Home Visitors is 14.1 clients per nurse home visitor as at 30 June this year. A number of Nurse Home Visitors were either on long service leave or left after 30 June 2015 and the caseload would vary after that date. The high attrition, despite incoming referrals, limits the growth in the active client bases and therefore Nurse Home Visitor caseloads have not been increasing over the last few years. A key priority for the ANFPP is to address staff and client retention to maintain the stability and sustainability of the program.

Table 3 - Nurse Home Visitor caseload at the end of each financial year since 2013

WORKFORCE	AS AT 30 JUNE 2013	AS AT 30 JUNE 2014	AS AT 30 JUNE 2015
ANFPP NHVs - Full Time Equivalent	16.2	12.4	12.8
Nurse Supervisors - Full Time Equivalent	3	3	3
Family Partnership Workers - Full Time Equivalent			8
NHV caseload	12.8	14.6	14.1
NS caseload (staffing)	5.4 NHVs 3.6 FPWs	5 NHV 3 FPW	5 NHV 3 FPW



4 NFP MODEL FIDELITY

4.1 REFERRAL OUTCOMES FLOWCHART

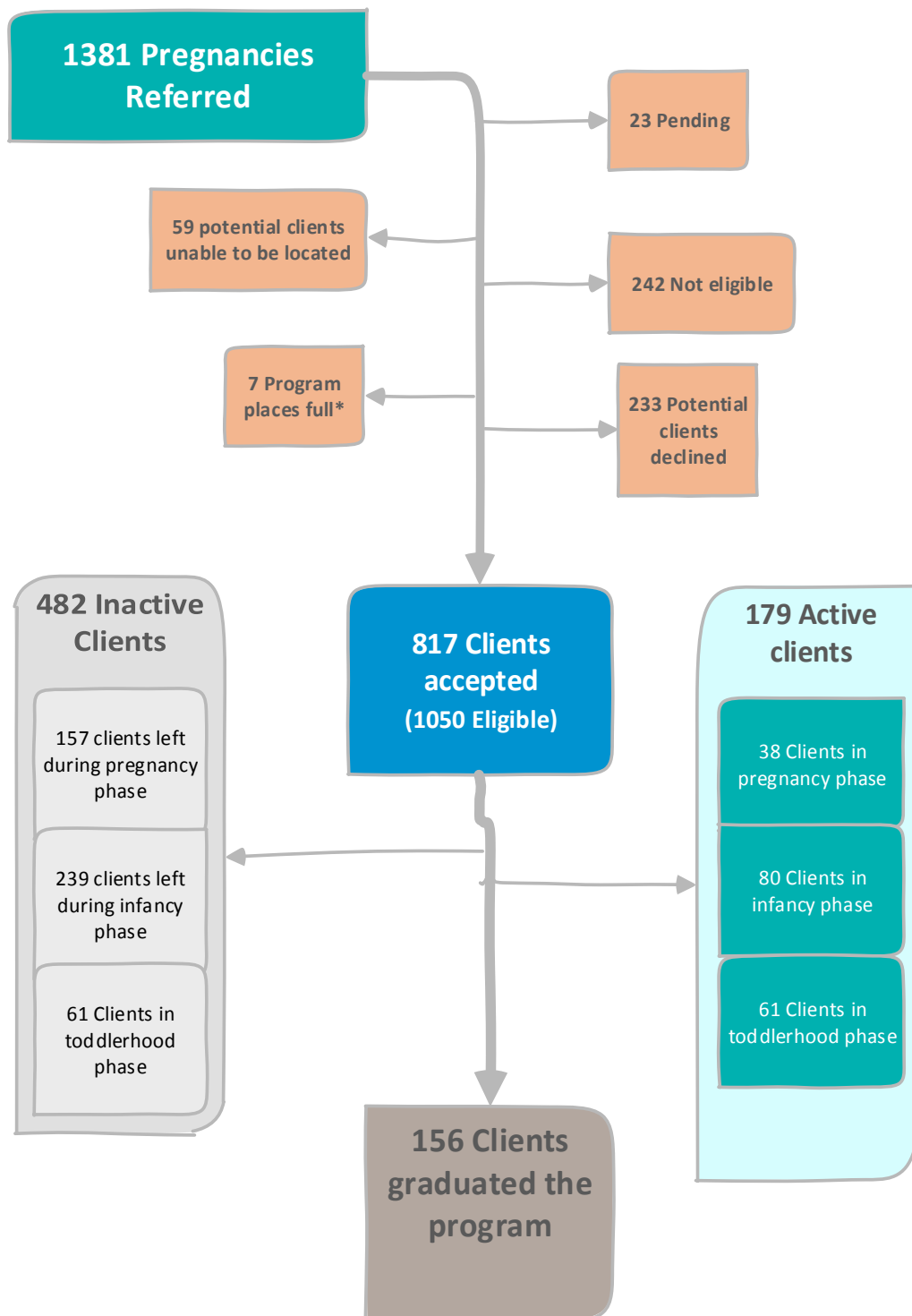


Figure 1 - Referral Outcomes Flowchart



4.2 SUMMARY OF FIDELITY MEASURES

Table 4 provides a summary of fidelity measures in a similar format to that produced in the Fidelity Report for individual sites on a quarterly basis. It outlines the measures and compares cumulative data as at 30 June 2014 and 30 June 2014 as well as individual reporting years. The reason these two figures are provided is that the cumulative results shows the program as a whole is less sensitive to recent changes than reporting year data. For example the cumulative acceptance rate (percentage of eligible clients that go on to enrol into the program) for the program is 78%. The financial year figures include only those referrals received for that year, thereby providing a more current figure of the acceptance rate, which in this case is 84%. The last column outlines the NFP objective for that measure if applicable.

This report provides the proportions of clients that are a first time mother for two of the three sites within Australia. The data is represented in this way as two of the three sites may accept multiparous women into the program on a case by case basis under certain criteria. The one site out of the three allows multiparous women into the program as part of how the program is defined therefore they are reported separately.

The referral and acceptance of women before the 16th week of pregnancy continues to be challenging within the ANFPP. Cumulatively up to June 2015, 41% of women were accepted by the 16th week of pregnancy whereas for 2014-15 data, only 32% were accepted into the program by the 16th week of pregnancy. In the past there has been a focus on the difficulty in delivering program content prior to 16 weeks gestation, and therefore a reluctance to enrol women too early in their pregnancy. Discussions with the international team have recently explored this aspect and it is clear that it is beneficial to accept clients as early in the pregnancy as possible, usually between the 12th and 16th week of pregnancy to meet NFP targets of 60% accepted before the 16th week of pregnancy and to enable dosage of visits. The additional challenge is therefore to obtain referrals as early as possible, as this can influence early engagement between the program and with eligible women.

Client retention continues to be the greatest challenge for the ANFPP, with a current cumulative retention rate of 41%. This has been the focus of discussions at the National Annual Data Workshop and continues to be a focus of quality improvement activities. A revised client feedback survey is now available electronically and implementing sites are actively seeking more information about what keeps women in the program and conditions that may contribute to the decision to leave the program. It is hoped this focus will bring an improvement in the retention rate in the future. Refer to Table 5 for a summary of the available information within the Client Change of Status form on why women choose to leave the program. The location of the visits and whether they are undertaken in the home is shown at E6 in Table 4. Generally the proportion of visits in the home has varied from 57% this year to 62-63% in previous years. Whilst the program model indicates it is preferable to conduct visits in the home, experience from England for Wave 1 of their implementation was that depending on the location, the proportion of visits in the home varied from 61% -91% (The Family-Nurse Partnership programme in England, 2011). The location of visits is explored further in 5.6 – Living Arrangements.



Table 4 - Summary of key fidelity measure of eligibility, parity, home visiting and client retention for 2014 and 2015

MEASURE	EXPLANATION	CUMULATIVE TO 30 JUNE 2014	CUMULATIVE TO 30 JUNE 2015	2013-2014	2014-2015	NFP OBJECTIVE
Client is a first-time mother (E2) *		98%	98%	99%	98%	100%
Client is a first time mother [E2] incl. *		82%	81%	86%	73%	100%
Client engagement	Acceptance	77%	78%	75%	84%	75%
	By 16 th wk	42%	41%	35%	32%	60%
	By 28 th wk	93%	92%	93%	92%	100%
	Mean gest. Age (weeks)	19	19	20	21	
Visited in her home (E6)		63%	62%	63%	57%	-
Indigenous Status (Mother)*		92%	92%	95%	94%	-
Indigenous Status (Child)*		100%	100%	99%	100%	-
Client Retention	Pregnancy	81%	81%			≥90%
	Infancy	60%	61%			≥80%
	Toddler	71%	71%			≥90%
	Cumulative Overall	41%	41%			≥60%

*First time mother and indigenous status excludes missing/unknown status

4.3 REASONS FOR LEAVING THE PROGRAM

Table 5 outlines the reason for leaving the program as collected in the Client Change of Status Form over the last two reporting years. Whilst moving away from the catchment area of the program is the reason given for 32% of clients leaving during this reporting year, there remains



58% of clients who fall into the categories of excessive missed appointments, unable to locate, feels she has what she needs from the program and other reasons. It is recognised that a certain level of attrition is expected and there may be complex reasons for leaving that are not influenced by program delivery. There is certainly an opportunity however to identify common factors and conditions that may influence their reason to stay for what constitutes a majority of clients leaving the program. Figure 2 includes all the comments received in the 'Other' category on the Client Change of Status Form over the two years reports. Only seven comments were received, two referred to the program not being what was expected.

Table 5 - Frequencies for leaving the program from the client change of status form for 2013-14 and 2014-15 reporting years

REASON FOR LEAVING	2013-14		2014-15	
	N	%	N	%
Moved Away	54	46%	27	32%
Excessive missed appointments	22	19%	19	23%
Feel she has what she needs from the program	10	9%	11	13%
Other	15	13%	8	10%
Unable to locate	5	4%	10	12%
Pressure from family	-	-	2	2%
Miscarriage	7	6%	2	2%
No longer in custody	1	<1%	2	2%
Returned to work	2	2%	1	1%
Receiving services from another program	-	-	1	1%
Refused new NHV	1	<1%	1	1%
Incarcerated or another out of home placement	1	<1%	-	-

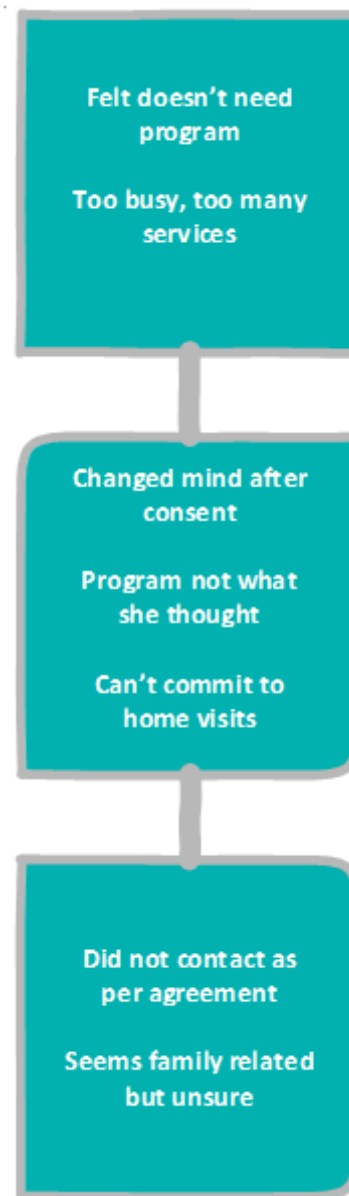


Figure 2 - Comments Received Under 'Other' on the Client Change of Status Form



4.4 DOSAGE (VISIT COMPLETION RATE)

The method of calculation of the number of visits a client receives has been revised since last year based on comments from the Annual Data Workshop held in Canberra in April 2015. Previous data reports presented the dosage percentages as shown in Table 6, Table 7 and Table 8 which complies with International reporting requirements.

Table 6 - Visit completion rate for pregnancy phase for last three years

REPORTING YEAR	MEAN % EXPECTED VISITS ACHIEVED (ALL ACTIVE / COMPLETED CLIENTS)	MEAN % EXPECTED VISITS ACHIEVED USING 14 EXPECTED VISITS (CLIENTS WHO HAVE COMPLETED PREGNANCY)	% CLIENTS GETTING 80% OR MORE OF EXPECTED VISITS, THAT IS 11 PLUS VISITS (CLIENTS WHO HAVE COMPLETED PREGNANCY)
2014-15	72.6%	54.5%	19.8%
2013-14	71.4%	54.5%	20.4%
2012-13	71.4%	54.0%	20.6%

Table 7 - Visit completion rate for infancy phase for last three years

REPORTING YEAR	MEAN % EXPECTED VISITS ACHIEVED (ALL ACTIVE CLIENTS)	MEAN % EXPECTED VISITS ACHIEVED USING 28 EXPECTED VISITS (CLIENTS WHO HAVE COMPLETED INFANCY)	% CLIENTS GETTING 65% OR MORE OF EXPECTED VISITS, THAT IS 18 PLUS VISITS (CLIENTS WHO HAVE COMPLETED INFANCY)
2014-15	57.5%	60.4%	47.2%
2013-14	56.8%	61.1%	47.7%
2012-13	57.1%	60.8%	49.0%

Table 8 - Visit completion rate for toddlerhood phase for last three reporting years

REPORTING YEAR	MEAN % EXPECTED VISITS ACHIEVED (ALL ACTIVE CLIENTS)	MEAN % EXPECTED VISITS ACHIEVED USING 22 EXPECTED VISITS (CLIENTS WHO HAVE COMPLETED TODDLERHOOD)	% CLIENTS GETTING 60% OR MORE OF EXPECTED VISITS, THAT IS 13 PLUS VISITS (CLIENTS WHO HAVE COMPLETED TODDLERHOOD)
2014-15	72.6%	54.5%	19.8%
2013-14	71.4%	54.5%	20.4%
2012-13	71.4%	54.0%	20.6%



2014-15	67.1%	66.9%	62.2%
2013-14	63.9%	65.2%	58.1%
2012-13	61.2%	65.6%	62.0%

Note: Completed visits for active clients who had their first phase visit from program commencement by 30 June of the reporting year. Telephone encounters have not been included. Calculation period to date of last visit in the phase.

Table 9 provides a more thorough analysis of the visits received by clients which shows the number of clients in each of two main groups (incorporating telephone visits with program content) and the number of visits they have received. The two groups are required to report the number of visits clients receive when they have completed a phase, and to show how many visits they have received according to their progression through a specific phase.

Table 9 - Visit length, average visits per client and visit completion rate (completed/expected) for clients based on actual time spent within the phase or who have completed the phase since the commencement of the program to 30 June 2015

PHASE	PREGNANCY PHASE		INFANCY PHASE		TODDLERHOOD PHASE		ENTIRE PROGRAM	
	Time in phase	Complete phase	Time in phase	Complete phase	Time in phase	Complete program	Time in phase	Complete program
N. clients	761	616	585	301	259	156	1605	156
N. expected visits	7,005	8,624	12,024	8,428	4,400	3,432	23,429	9,984
N. completed visits	4,932	4,559	6,575	4,870	2,774	2,168	14,281	6,315
Average. visits per client	6.7	8	11.8	17	11.4	15	9.3	42
N. completed visits incl. telephone	5,092	4,701	6,919	5,097	2,950	2,296	14,961	6,593
Dosage rate % of expected	73%	55%	58%	60%	67%	67%	N/A	66%
Number of attempted visits	1,648	1,341	2,562	1,710	1,031	749	5,241	1,930
Average length of visit	65	-	63	-	66	-	64	64

- *Time in phase is a calculation based on the time the client has been in the phase and an estimate of how many visits are expected to have occurred at that time. For clients in pregnancy phase, this takes into account when the client enrolled in the program.*
- *The dosage rate is calculated using Completed visits plus Telephone visits*



- Average visits is calculated using Completed visits plus Telephone visits
- Average Length of visit excluded telephone visits
- To compare percentage of visits completed with NFP Benchmarks, it is preferable to use clients that have completed the phase.

Clients are expected to receive 14 visits in pregnancy, 28 in infancy and 22 visits in toddlerhood and the dosage rate % of expected uses this frequency of visits. There is one exception where 11 expected visits in pregnancy has been used for the analysis, given the late enrolment of women in recent years.

Overall women completing each phase receive eight visits in pregnancy, 17 in infancy and 15 in toddlerhood. Women graduating the program, on average, have received 42 visits, or 66% of expected visits. Average length of visit has been stable across the ANFPP and averages 64 minutes per visit.

4.5 VISIT CONTENT

Table 10, Table 11 and Table 12 outline the average time spent during the visits across the six domains of personal health, environmental health, life course development, maternal role, family and friends and health and human services. The results for this reporting year, which is based on cumulative data from the commencement of the program, show a variation to expected proportions that replicate last year's results. The areas of environmental health are anecdotally high due to client needs with regard to housing and environment, however the variation in maternal role across the three phases, i.e. increased in pregnancy and reduced in both infancy and toddlerhood are difficult to explain.

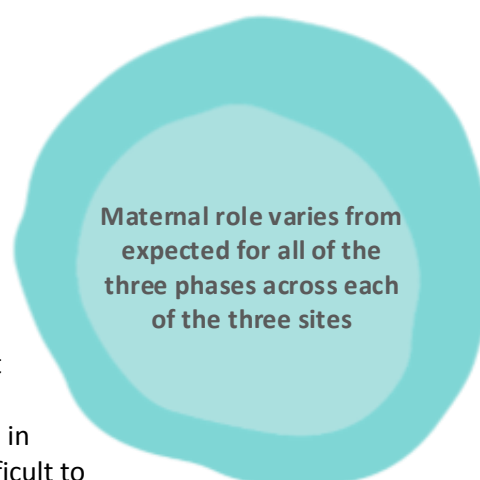


Table 10 - Average percent of time spent on the program domains in the pregnancy phase

DOMAIN	PREGNANCY			COMMENT
	2013-14	2014-15	TARGET	
Personal health	36%	34%	35-40%	✓
Environmental health	9%	9%	5-7%	↑
Life course development	10%	10%	10-15%	✓
Maternal role	26%	26%	23-25%	↑
Family and friends	14%	14%	10-15%	✓
Health and human services	6%	7%	-	



Table 11 - Average percent of time spent on the program domains in the infancy phase

DOMAIN	INFANCY			COMMENT
	2013-14	2014-15	TARGET	
Personal health	20%	20%	14-20%	✓
Environmental health	11%	11%	7-10%	↑
Life course development	11%	12%	10-15%	✓
Maternal role	39%	38%	45-50%	↓
Family and friends	14%	14%	10-15%	✓
Health and human services	5%	5%	-	

Table 12 - Average percent of time spent on the program domains in the toddlerhood phase

DOMAIN	TODDLERHOOD			COMMENT
	2013-14	2014-15	TARGET	
Personal health	17%	18%	10-15%	↑
Environmental health	12%	12%	7-10%	↑
Life course development	16%	16%	18-20%	↓
Maternal role	38%	37%	40-45%	↓
Family and friends	13%	14%	10-15%	✓
Health and human services	4%	3%	-	



5 CLIENT DEMOGRAPHICS

The following sections provide information about the women in the program, their age, relationship, work and education participation, the involvement of fathers in the care of infants and their health and antenatal care. This information is collected within the ANFPP Data Collection System and whilst available locally, this is the first time this wider information has been produced within this report. It is timely that this information be made available for a number of reasons including:

- Feedback from the Community of Practice and the Annual Data Workshop with regards to sourcing information about the community of women that participate in the program. Aspects such as maternal health, participation in the workforce and education and the reasons given by clients leaving the program are important.
- There are a number of emergent factors for consideration such as the potential for a wider evaluation of the program in Australia. The potential implementation of the STAR Framework and the inclusion of the Intimate Partner Violence Module from the NFP. Additional information available for the existing program will assist in informing discussion around these innovations.
- It is a general principle of data collection that providing information back to clients, the community, as appropriate, and program staff about the information they collect on a day to day basis not only informs practice but helps to reinforce the importance of this data. Releasing other information that is not normally reported will help to support the importance of the information they collect.
- It is important to review the types of information collected to ensure it is culturally sensitive, appropriate and relevant in maintaining alignment with international standards for data collection which is now available. The Data Collection System is the subject of a systematic review and unless the current information is analysed and checked for gaps and data collection issues, problems can continue without resolution.

Table 13 through to Table 29 outline information that has been collected within the ANFPP from 1 January 2012 until the 30 September 2015. 1 January 2012 was selected due to the concerted effort in 2013 to improve the data completeness of records. It was agreed with implementing sites that unless records were available to complete the data, a cut off of 1 January 2012 was determined as data before this date were unlikely to be obtained.

It is hoped the provision of this information will prompt future discussions around what is salient to include in program monitoring and evaluation and inform future work.

5.1 AGE OF WOMEN IN THE PROGRAM

The ages of women in the program at intake has been fairly stable at around 21 years of age. Of interest is the age range of participants, from 13 years of age to 43 years of age. This may be important as the program delivery should be flexible to accommodate the differing needs of all age groups.

Table 13 - Age at intake for women participating in the program

AGE IN YEARS	AS AT 30 JUNE 2014	AS AT 30 JUNE 2015
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Mean Age at Intake	21 yrs (N=704)	21 yrs (N=817)
Minimum age	13	13
Maximum age	41	43

Table 14 – Mean, median, minimum and maximum age of women at intake participating in the program by Site

MEAN AGE AT INTAKE AS AT 30 JUNE 2015	AGE IN YRS (N)	MEDIAN	MIN	MAX
SITE	20 (282)	19	13	37
SITE	20 (224)	19	14	36
SITE	23 (311)	22	14	43

5.2 EDUCATION AND WORKFORCE PARTICIPATION OF WOMEN IN THE PROGRAM

Around half the women who have participated in the program do not hold a level of education above secondary school. A relatively large number of records did not answer this question (8%) and a future change may be to be less specific and include broader options about the type of education or qualification. It would be beneficial to consult with sites with regard to improvements that assist in obtaining records from all clients.

Thirty four percent of clients have not been in paid work in their life so far (Table 16) and 17% were in paid work, either full or part time at intake (Table 17). The question of whether the client was in paid work at intake was not completed in 24% of cases, and consideration should be given to the best way of seeking this information.



Table 15 - Highest level of education achieved by women in the program recorded 1 Jan 2012-30 Sept 2015

LEVEL OF EDUCATION	SITE % (N)	SITE % (N)	SITE % (N)	TOTAL % (N)
Bachelor	3.4% (5)	-	1.3% (2)	1.5% (7)
Associate Diploma	0.7% (1)	-	1.9% (3)	0.8% (4)
TAFE or equivalent	7.6% (11)	15% (26)	31.4% (50)	18.2% (87)
Vocational	17.9% (26)	27.2% (47)	18.9% (30)	21.6% (103)
None	69% (100)	39.9% (69)	44.7% (71)	50.3% (240)
Unreported	1.4% (2)	17.9% (31)	1.9% (3)	7.5% (36)

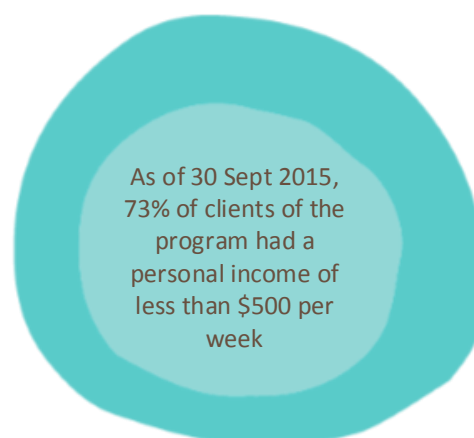


Table 16 - Proportion of women at intake who have worked in a paid job at any time by site

PAID WORK AT ANY TIME	SITE % (N)	SITE % (N)	SITE % (N)	TOTAL % (N)
Yes	63.4% (92)	45.1% (78)	67.3% (107)	58.1% (277)
No	36.6% (53)	35.8% (62)	28.9% (46)	33.8% (161)
Unreported	-	19.1% (33)	3.8% (6)	8.2% (39)

The income available to clients at intake has not been provided in table form in this section for three main reasons:

- Income is not an eligibility criteria in Australia.
- There are four questions around income, including household and individual in the DCS. There are problems with data completeness historically and the need for a more sensitive approach to whether the client has access to income.
- Prior to Version 2.2 of the DCS, information on income below \$500 per week was not collected and there was no option for no income. This has been changed in DCS Version 2.5 to accommodate lower income bands and should be available for analysis in 2015-16.



The individual income of clients was analysed and over 73% had a weekly income of less than \$500, which is 76% of the current minimum wage in Australia of \$656 (Australian Government, July 2015) with 91% data complete for this question.

Table 17 - Women participating in the program undertaking paid work at intake 1 Jan 2012-30 Sept 2015

CURRENT WORK	SITE % (N)	SITE % (N)	SITE % (N)	TOTAL % (N)
Yes, Part Time	6.9% (10)	2.9% (5)	11.9% (19)	7.1% (34)
Yes, Full Time	10.3% (15)	6.4% (11)	14.5% (23)	10.3% (49)
No	68.3% (99)	47.4% (82)	62.9% (100)	58.9% (281)
Unreported	14.5% (21)	43.4% (75)	10.7% (17)	23.7% (113)

Table 18 - Number of women that stopped paid work due to the referral pregnancy, recorded at intake 1 Jan 2012-30 Sept 2015

STOPPED WORK	SITE % (N)	SITE % (N)	SITE % (N)	TOTAL % (N)
Yes	16.6% (24)	12.1% (21)	9.4% (15)	12.6% (60)
No	60.7% (88)	36.4% (63)	67.9% (108)	54.3% (259)
Unreported	22.8% (33)	51.4% (89)	22.6% (36)	33.1% (158)



5.3 RELATIONSHIPS

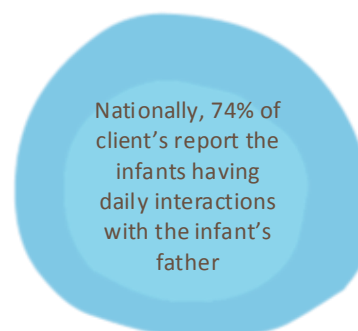
Table 19 and Table 20 provide information about the client's relationships at intake, with 44% of women either married or in a de-facto relationship. Seventy three percent of women are in a relationship at intake and Table 22 indicates that during pregnancy, the women see the baby's father daily. This raises a question on the focus on marital status in this regard and the recognition of relationships that may not be based on habitation. The Data Collection System simply asks for marital status with five categories, married or de-facto, never married, divorced, widowed and separated. Only three of these categories have been completed.

Table 19 - Marital status of participating women at intake 1 Jan 2012-30 Sept 2015

MARTIAL STATUS	SITE % (N)	SITE % (N)	SITE % (N)	TOTAL % (N)
Separated	0.7% (1)	-	0.6% (1)	0.4% (2)
Never Married	49.7% (72)	71.1% (123)	45.3% (72)	56% (267)
Married or De-facto	49.7% (72)	28.9% (50)	54.1% (86)	43.6% (208)

Table 20 - Proportion of women participating in the program currently in a relationship, recorded at intake

MEASURE	TOTAL % (N)
Yes, female	0.4% (2)
Yes, male	73% (348)
No	22.9% (109)
Unreported	3.8% (18)



5.4 INVOLVEMENT OF FATHERS

The involvement of fathers is something that has been the focus of discussions in various forums, however there has been scant information on this aspect in the program to date. The following tables outline the data collected on the involvement of fathers with women participating in the program during pregnancy and then engagement in caregiving and playing with infants over the three months prior.

Whilst the recording of aspects of contact and engagement with the baby's father have few missing values – similar to most of the other data entered on the Demographic Details Forms, the question of biological fatherhood is a question on the Demographic Details Form where in 20% of cases, this information is not recorded. There may be specific reasons why the focus of the data collection is on the biological father, however it may be worth adjusting this aspect of the collection.



Table 21 - Proportion of clients where current partner is the biological father of the child

PARTNER IS BIOLOGICAL FATHER	SITE % (N)	SITE % (N)	SITE % (N)	TOTAL % (N)
Yes	78.4% (218)	78.5% (208)	73.6% (162)	77.1% (588)
No	0.4% (1)	0.8% (2)	1.8% (4)	0.9% (7)
Unsure	2.2% (6)	1.9% (5)	4.5% (10)	2.8% (21)
Unreported	19.1% (53)	18.9% (50)	20% (44)	19.3% (147)

Table 22 - How often does the client see or talk to the baby's biological father during pregnancy

MEASURE	AS AT 30 JUNE 2015 % (N)	2014-2015 ONLY
Daily	56% (466)	63% (86)
At least once per week but not daily	11% (93)	7% (9)
Less than once per week	10% (81)	12% (16)
Not at all	20% (162)	17% (24)
Not reported	3% (27)	2% (3)

Table 23 – During the past three months, extent to which the baby's biological father spent time taking care of and/or playing with the child by Site 1 Jan 2012-30 Sept 2015

FATHER INTERACTION	SITE % (N)	SITE % (N)	SITE % (N)	TOTAL % (N)
Daily	74.5% (108)	74% (128)	73% (116)	73.8% (352)
At least once a week but not daily	9% (13)	9.8% (17)	6.3% (10)	8.4% (40)
Less than once a week	7.6% (11)	7.5% (13)	5.7% (9)	6.9% (33)
Not at all	8.3% (12)	8.1% (14)	15.1% (24)	10.5% (50)
Unreported	0.7% (1)	0.6% (1)	-	0.4% (2)

5.5 LANGUAGE

The primary language of the women is collected at intake. When the data was summarised, 14% of clients did not answer this question and instead recorded language spoken as 'other'. These languages recorded as other were recoded and are represented in Table 24 as they appeared within the Demographic Details Form. Some of these other languages were recorded as Aboriginal English. One interpretation of these results is that the question is worded in a way that promotes a 'primary language' and does not represent these languages in a way that considers



Indigenous languages spoken in Australia and groups these in one group for 'Aboriginal and Torres Strait Islander language'. In a paper by the Department of Environment and Heritage (McConvell & Thieberger, 2001, pages 5-7), the authors outline various recommendations for the collection of census data on language. These recommendations were to ask about their first language and tribal identity, what language is spoken at home, included the ability to record multiple answers and ask questions such as the ability to converse in various languages (McConvell & Thieberger, 2001, page 7). Based on these results consideration should be given to how this question is posed, the benefits of understanding more about other languages (including sign language) that may be used within the family, and improving the cultural sensitivity around the multiple languages spoken in Australia by Aboriginal and Torres Strait Islander peoples.

Table 24 - Primary language and other languages spoken by clients from commencement of the program to 30 Sept 2015

LANGUAGE IDENTIFIED	TOTAL % (N)
English	79% (603)
Aboriginal or Torres Strait Islander	1.7% (13)
Arrente (Aranda, Eastern, Western or Central Arrente)	5.2% (40)
Aboriginal English (self-stated)	1.7% (13)
Alyawarra	0.4% (3)
Anmatyeri	0.5% (4)
Auslan	0.3% (2)
Fijian	0.1% (1)
Pitjantjara	0.3% (2)
Walpiri	0.9% (7)
Kalaw Kawaw Ya	0.3% (2)
Luritja	0.8% (6)
Makaton	0.1% (1)
Torres Strait Creole	2.2% (17)
Wambaya	0.1% (1)
Warumunga	0.1% (1)
Yankunytjatjara	0.1% (1)
Yolngu Matha	0.1% (1)
Unreported	5.9% (45)

5.6 LIVING ARRANGEMENTS

One of the aspects of the ANFPP is that a reasonable proportion of visits occur outside the home. Nationally the proportion of visits in the home this reporting year is 57%. The percentages for the location of these visits has not yet been reported nationally. Anecdotally, it has been suggested that often it is preferable to conduct visits out of the home. This is perhaps due to a greater



opportunity to discuss matters freely and related to the number of people normally residing in the home. The ANFPP office environment can provide a quiet place to meet and better meeting individual needs of the client. The main locations visits occur other than in the home are the ANFPP office, friends or families homes, clinic or other. These aspects will be summarised more fully in the next annual report.

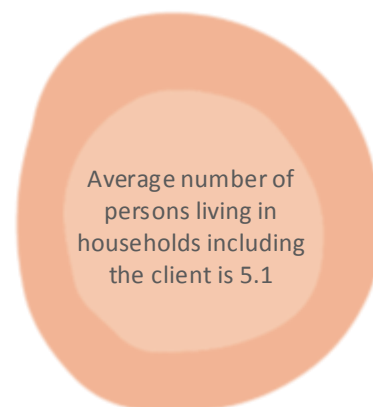


Table 25 indicates the average number of people living in the household with the client for four or more nights a week at intake. Nationally the number of persons in the household averages five.

Table 25 - Number of persons including client living in household for four or more nights a week for 2014-15 reporting year

NUMBER OF PERSONS (INCLUDING CLIENT) LIVING IN HOUSEHOLD FOR 4 NIGHTS OR MORE					
SITE	MEAN	N	SD	MIN	MAX
TOTAL	5.07	672	2.814	1	25

5.7 MATERNAL HEALTH OF WOMEN IN THE PROGRAM

Table 26 outlines the information collected at intake on self-reported existing health conditions. As shown, asthma is by far the highest condition affecting women in the program, followed by mental health and depression. Whilst this information is valuable, it really just provides an indicator and does not provide enough detail to be of value in assessing underlying health conditions of the participating women in the program, nor provide enough information for meaningful discussion around preventative management. For example it has been raised in feedback to the National Program Centre that a condition stated as diabetes does not provide enough detail to be meaningful – Type 1, Type 2 or gestational. Now that the International Guidelines for Data Collection 2015 are available to the National Program Centre, this section will be checked against what is collected internationally and best practices for health collections in Australia and Aboriginal and Torres Strait Islander communities to identify the most useful self-reported health information.

Considering mental health and depression (the second highest self-reported health condition amongst women participating in the program), the timing of collection of the Edinburgh Postnatal Depression Scale has been the subject of feedback from program staff. Currently collected as part of the maternal health assessment at intake and more recently upon infant birth, staff have indicated that this scale could be collected more often and/or as needed. Recording the scale on the client’s record as part of the health assessment form at only two milestones limits its overall usefulness. This does not limit the scale being used more often, but does limit the ability to record results. Based on this feedback consideration should be given to removing the scale from within the Maternal Health Assessment Form and collecting separately according to clinical guidelines.



Table 26 – Presence of self-reported health condition at intake for participating clients as at 30 September 2015 (Anaemia/low iron were added from ‘Other’ Category)

SELF-REPORTED HEALTH CONDITION	N	PERCENTAGE
Asthma	126	16.8%
Mental Health including depression	47	6.3%
Heart	35	4.7%
Diabetes	35	4.7%
High Blood Pressure	30	4.0%
Chronic Vaginal	22	2.9%
Obesity	18	2.4%
Chronic UTI	18	2.4%
Hearing Loss	15	2.0%
Epilepsy	8	1.1%
Kidney	4	0.5%
Genetic	3	0.4%
Anemia/low iron	3	0.4%
GI Disease	1	0.1%
Total Forms	751	-

5.8 ANTENATAL CARE

The strong relationship between regular antenatal care and positive child health outcomes has resulted in antenatal visits being a key indicator in maternal and child health (Australian Institute of Health and Welfare, 2014, page 22). This report summarises information collected at intake on whether women participating in the program have had an initial antenatal visit and how many weeks into the pregnancy the initial visit was received.

Table 27 and Table 28 outline the proportion of women in the program who indicated they had received an initial antenatal visit and when that occurred. Overall 92.5% of women in the program had access to antenatal care and had received a first visit which is a very positive result. The average gestational age when this initial antenatal visit was received is 10.4 weeks gestation with little variation between implementing sites. This compares very favourably with 62.7% of women in Australia in 2012 having their first antenatal visit before the 14th week of pregnancy (Australian Institute of Health and Welfare, 2014).

Information is now available for smaller geographical areas from the National Health Performance Agency that has identified child and maternal health indicators collected from the former Medicare Local catchments (in future these will come from Primary Health Network Regions) and produced information specifically about Aboriginal and Torres Strait Islander women for 2010-2011 (National Health Performance Authority, 2014).

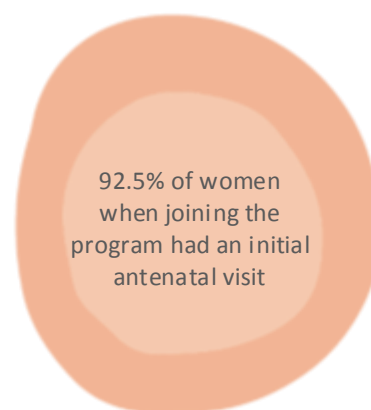


Table 27 - Proportion of women who had received at least an initial antenatal visit for the referral pregnancy upon entry to the program 1 Jan 2012-30 Sept 2015

MEASURE	SITE % (N)	SITE % (N)	SITE % (N)	TOTAL % (N)
Yes	95.6% (261)	84.7% (227)	98.6% (205)	92.5% (693)
No	4.4% (12)	15.3% (41)	1.4% (3)	7.5% (56)

Table 28 - Mean gestational age at initial antenatal visit by site 1 Jan 2012-30 Sept 2015

NATIONAL	MEAN	N	SD
TOTAL	10.395	693	5.8212

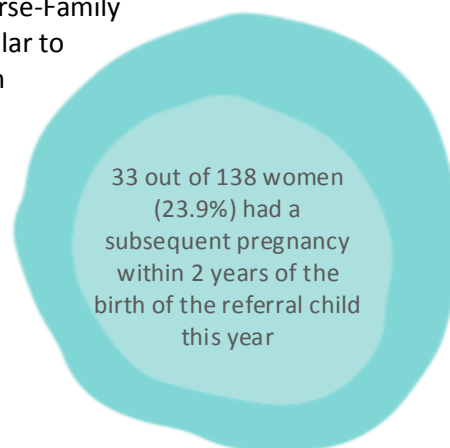


6 PROGRAM OUTCOMES

6.1 LIFE COURSE DEVELOPMENT - SUBSEQUENT PREGNANCIES

Source: Demographic Details Update Form DM24

The decline in subsequent pregnancies within two years of the birth of the referral pregnancy was one of the outcomes for the Randomised Control Trials within the Nurse-Family Partnership Program. As outlined in Table 29 this year results are similar to 2013-14 (20%) whereby the rate of subsequent pregnancies is 24%. In previous years (2011-12 and 2012-13) the proportion of incomplete data was relatively high and this may have influenced the proportions reported and indicating a steady decline. With 33% of the data missing in the first year this outcome was reported, it could be theorised that the subsequent pregnancies were reported more often, leading to a higher percentage.



Since July 2013, the attention to data quality and completeness has greatly improved and rates of 20% and 24% for 2013-14 and 2014-15 respectively is a great result for this outcome measure.

Table 29 - Percentage of clients with at least one pregnancy within 24 months after the birth of the referred pregnancy for 2014, 2013 and 2012 reporting years

REPORTING YEAR	% WITH PREGNANCY	% DATA COMPLETE
2014-15	23.9%	99.9%
2013-14	20%	99.6%
2012-13	33%	73%
2011-12	50%	67%

6.2 CIGARETTES, ALCOHOL, MARIJUANA & OTHER DRUGS USE BY WOMEN IN THE PROGRAM

6.2.1 Data Completeness

There was a large proportion of Health Habits Forms that did not have the stage completed as shown in Table 30. This potentially greatly impacted the analysis of smoking and alcohol intake rates by site and nationally. To counter this issue the incomplete stages within the form were completed based on a calculation using the client's date of acceptance, infant date of birth and date the form was completed. This allowed no missing result to be reported within the following analyses.



Table 30 - Proportion of Health Habits Forms missing the stage the form was completed as intake, 36 weeks or infancy 2014-15

HEALTH HABITS FORM	SITE % (N)	SITE % (N)	SITE % (N)
Number of Forms Missing Stage	35% (24)	7% (4)	1% (1)
Total Forms 2014-15	69	54	52

6.2.2 Smoking

Source: Health Habits Form at Intake, 36 weeks pregnancy and Infancy 12 months. Items HH01 through HH04

Nationally the number of women reporting smoking in the two days prior to completing the Health Habits Form across all phases was 33% (refer Table 31). Smoking at intake to the program was recorded as 28%, 33% at 36 week of pregnancy and 44% at infancy. It should be noted that the increase in proportion of women smoking in the prior 48 hours from 28% to 33% is cross-sectional from different cohorts. Data from individual clients were collected on a Health Habits Form at intake (within four weeks of participating in the program) and again at 36 weeks of pregnancy. They were asked how much they smoked in the two days prior to completing the form. The number smoked in these two days was compared from intake to 36 weeks of pregnancy in a matched-pairs analysis using SPSS across individual clients. The amount smoked in the previous two days reduced from intake ($M=2.61, SD=5.17$) to 36 weeks of pregnancy ($M=1.89, SD=3.722$) and showed a significant reduction in smoking in this analysis similar to results from the 2013-14 reporting year, $t(65) = 2.225, p = .03$. This is the only statistical analysis reported within this report.



Nationally, the proportions of women reporting smoking in the two days prior to completing the Health Habits Form at intake have reduced from 39% last reporting year to 28% for the 2014-15 reporting year. There are site variations in smoking in the previous 48 hours at intake, but these groups are relatively small and so they have not been individually reported.



Table 31 - Proportion of clients smoking in the two days prior at intake, 36 weeks and infancy by reporting year

REPORTING YEAR	INTAKE PERCENT (N)	36 WEEKS PERCENT (N)	INFANCY 12 MONTHS PERCENT (N)	TOTAL ACROSS ALL STAGES
2014-15 (a)	28% (23/83)	33% (16/48)	44% (19/43)	33% (58/174)
2013-14 (b)	39% (100)	23% (69)	35% (65)	
2012-13 (c)	35%	33%		
2011-12 (c)	41%	40%		

- Results include the results of the calculation of stage.
- 2013-14 reporting year includes any health habits forms completed between 1/7/13 and 30/6/14 where question was complete and stage identified.
- 2011-12 and 2012-13 reporting years includes all clients who have had an intake and a 36 week Health Habits form before 30 June of that year.

Table 32 outlines the change in smoking within individual clients from intake to 36 weeks. Data from 1 Jan 2014 until 30 September 2015 was used to identify clients that had a completed Health Habits Form for both Intake and Pregnancy 36 weeks.

Table 32 - Change in mean number of cigarettes smoked in previous 48 hours from intake to 36 weeks as matched pairs (individual clients)

REPORTING YEAR	INTAKE			36 WEEKS			CHANGE	T (DF)	SIG*	95% CONFIDENCE INTERVALS	
	M	SD	N	M	SD	N					
2014-15	2.61	5.174	66	1.89	3.722	66	0.72	2.225 (65)	0.03	.073	1.351
2013-14	2.46	4.68	104	1.89	3.889	104	0.567	3.4 (101)	.001	0.237	0.898

*Paired samples t-test (two-tailed) using SPSS

Table 33 - Mean, standard deviation, minimum and maximum cigarettes in the previous 48 hours by stage for 2014-15

STAGE	MEAN CIGARETTES OVER LAST 2 DAYS	SD	N	MIN	MAX
Intake	2.00	4.345	83	0	22
36 weeks	1.79	3.747	48	0	20
Infancy 12 mths	6.19	10.261	43	0	50
All Clients	2.98	6.460	174	0	50

The majority of women (55%) indicated they had reduced smoking during the pregnancy as shown in Table 34. Self-reported smoking at all during the pregnancy is asked at infancy when the infant is 12 months of age. Table 35 indicates that smoking at all during pregnancy was reported for 56% of women, with site variation. Across all (former) Medicare Local catchments, smoking



rates for Aboriginal and Torres Strait Islander women varied from the lowest at 29.4% to the highest at 66.4% (Healthy Communities: Child and maternal health in 2009-2012, The National Health Performance Authority, 2014 pages 30-31).

Table 34 - Self-reported reduction in smoking during pregnancy by stage for 2014-15

STAGE*	YES % (N)	NO % (N)	N
Intake	55.4% (41)	44.6% (33)	74
36 weeks	48.9% (22)	51.1% (23)	45
Infancy 12 mths	23.1% (9)	76.9% (30)	39
No stage given/total	45.6% (72)	54.4% (86)	158

Data 100% complete when calculated stage was added

Table 35 - Self reported smoking during pregnancy as asked when the infant is 12 months of age (when the first Health Habits Form is completed after the birth)

SMOKING DURING PREGNANCY BY SITE	YES % (N)	NO % (N)	N
SITE	68.2% (15)	31.8% (7)	22
SITE	62.5% (5)	37.5% (3)	8
SITE	27.3% (3)	72.7% (8)	11
TOTAL	56.1% (23)	43.9% (18)	41

- Only results from infancy 12 months stage has been reported as all other stages are during the pregnancy.
- Data 100% complete when calculated stage was added

The proportions of women smoking other peoples' cigarettes nationally was 29.9%, again with site variations. The value of collecting and reporting smoking of other people's cigarettes is queried, as it is not necessarily to identify women smoking opportunistically. In the revised version of the Health Habits Form (2.2), the question has been revised to include smoking from all sources.

Table 36 - Proportion of clients smoking from other people's cigarettes at intake, 36 weeks and infancy 12 months of age in 2014-15

STAGE	YES % (N)	NO % (N)	N
Intake	24.4% (19)	75.6% (59)	78
36 weeks	31.8% (14)	68.2% (30)	44
Infancy 12 mths	38.1% (16)	61.9% (26)	42
Total	29.9% (49)	70.1% (115)	164

- Data 100% complete when calculated stage was added



Table 37 - Proportion of clients smoking from other peoples cigarettes by Site in 2014-15

STAGE	YES % (N)	NO % (N)	N
SITE	40.6% (26)	59.4% (38)	64
SITE	28.3% (15)	71.7% (38)	53
SITE	17% (8)	83% (39)	47
Total	29.9% (49)	70.1% (115)	164

● Data 100% complete when calculated stage was added

6.2.3 Alcohol

Source: Health Habits Form at Intake, 36 weeks pregnancy and Infancy 12 months. Items HH05 and HH06

Table 39 indicates the number of different days in the previous two weeks that alcohol was consumed and the number of drinks per day over this time. As shown in the tables, the consumption of alcohol at all stages during pregnancy is very low and only increases after the infant is born.

There was no demonstrated reduction in alcohol intake from intake to 36 weeks of pregnancy in 2013-14 and this specific analysis was not repeated this reporting year. Whilst the mean number of drinks would indicate a reduction in alcohol consumption during pregnancy (refer Table 38), the limited intake of alcohol during pregnancy (5% at intake; 2% at 36 weeks of pregnancy) and the low averages of the number of drinks for the women consuming alcohol would indicate that this analysis is unlikely to demonstrate a change to alcohol consumption that didn't occur by chance.

Table 38 - Mean, standard deviation, minimum and maximum number of different days of alcohol consumption over the last two weeks at intake and 36 weeks of pregnancy

REPORTING YEAR	INTAKE					36 WEEKS					% DATA COMPLETE
	MEAN	MIN	MAX	SD	N	MEAN	MIN	MAX	SD	N	
2014-15	0.27	0	12	1.517	79	0.06	0	3	.438	47	97%
2013-14	0.04	0	1	0.20	100	0.13	0	7	.873	69	>99%*
2012-13	0.21	0	6	0.81	-	0.11	0	6	.58	-	51%
2011-12	0.30	0	6	0.99	-	0.18	0	6	.74	-	45%



Table 39 - Mean, standard deviation, minimum and maximum number of the number of drinks taken per day over the last two weeks by stage

STAGE	MEAN DRINKS PER DAY	SD	N	MIN	MAX
Intake	0.27	1.517	79	0	12
36 weeks	0.06	0.438	47	0	3
Infancy 12 months	2.09	4.029	43	0	18
Total	0.67	2.424	169	0	18

Table 40 - Comparison of mean number of drinks per day between intake and 36 weeks of pregnancy for the last four reporting years

REPORTING YEAR	INTAKE				36 WEEKS				% DATA COMPLETE
	MEAN	RANGE	SD	N	MEAN	RANGE	SD	N	
2014-15	.27	0 12	1.517	79	.06	0 3	.438	47	99.4%
2013-14*	.33	0 16	3.043	98	.06	0 3	0.385	67	>99%

*In 2013-14, data was missing for the stage of the form, not for the number of drinks per day.

- Stage was calculated in 2014-15 for missing date.
- As more than 50% of data was missing in the reporting years prior to 2013-14, they have not been included this reporting year.

6.2.4 Use of Marijuana

Source: Health Habits Form at Intake, 36 weeks pregnancy and Infancy 12 months. Items HH07 & HH08

The highest self-reported marijuana use for women participating in the program was at intake, where 8% indicated use within the previous two weeks. This reduced to 2% at 36 weeks of pregnancy, however the number of women using marijuana was too small to undertake any statistical analysis. The pattern of use this reporting year was very similar to last year where the use of marijuana is high in only a very small number of women.

Table 41 - Percentage of clients indicating any use of marijuana in the previous two weeks for 2014-15

STAGE	NONE (%)	1 OR MORE [JOINT, CONE OR BONG PER DAY] % (N)*	N
Intake	92% (77)	8.3% (7)	84
36 weeks	98% (47)	2.1% (1)	48
Infancy 12 mths	98% (42)	2.3% (1)	43
Total	95% (166)	5.1% (9)	175

*Due to the variable nature of the responses, this item was recoded to marijuana use either as yes or no. The maximum in one case was eight per day.



Table 42 - Mean number of days over the last two weeks where marijuana was used by the client

DAYS MARIJUANA WAS USED*	MEAN	SD	MIN	MAX	N
Intake	0.67	2.735	0	14	84
36 weeks pregnancy	0.13	.886	0	6	48
Infancy 12 mths	0.09	.610	0	4	43
Total	0.38	1.984	0	14	175

100% data complete with calculated stage

6.2.5 Use of Other Drugs

Source: Health Habits Form at Intake, 36 weeks pregnancy and Infancy 12 months. Items HH09 and HH10

There were no self-reported use of other drugs as defined in the Health Habits Forms for 2014-15. The questions on other drugs were not completed in 1% of forms in relation to the number of days in the last two weeks where other drugs were used and 4% of forms were not completed for the number of times per day that other drugs were used.

6.3 INFANT BIRTH COHORT

Source: Infant Birth Form IB02 IB03

There were 98 infants born to women in the program between 1 June 2014 and 30 June 2015 with one set of twins. The twins were excluded from the analysis of low birth weight and preterm birth. There were 46 girls (48%) and 50 (52%) boys born in this cohort.



Table 43 - Gender of infants born to women participating in the program by site for 2014-15 reporting year

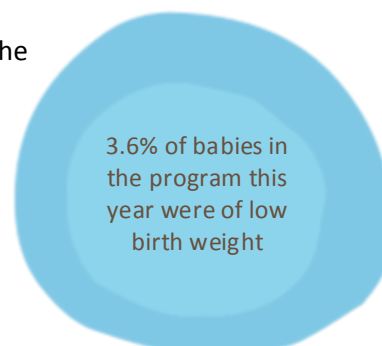
GENDER	SITE	SITE	SITE	ALL
	N (%)	N (%)	N (%)	N (%)
FEMALE	19 (49%)	14 (52%)	13 (43%)	46 (48%)
MALE	20 (51%)	13 (48%)	17 (57%)	50 (52%)
TOTAL	39	27	30	96



6.3.1 Percentage of Low Birth Weight Infants

Birth weight is considered a key indicator of health status and babies are defined as low birth weight if their weight at birth is less than 2500 grams (Australian Institute of Health and Welfare, 2014, page 74). In Australia's mothers and babies in 2012, 92.1% of babies had a birth weight of 2,500-4,449 grams.

In 2013-14, the proportion of low birth weight babies for women in the program was 3.3%, which was very low. This year, the proportion of low birth weight babies for women in the program was 3.6% as shown in Table 44 which is a very promising result. The proportion of low birth weight babies to Aboriginal and Torres Strait Islander women in 2012 was 11.8%, although this varied markedly among the states and territories with a range from 9.6% in Victoria to 14.9% in the ACT (Australian Institute of Health and Welfare, 2014, page 78).



The data constitutes a second year of a very positive result for women and children within the program when comparing these results with low birth weight babies for Aboriginal and Torres Strait Islander women from the (former) Medicare Local catchments in specific geographical areas. (Healthy Communities: Child and maternal health in 2009-2012, National Health Performance Authority, 2014, pages 24-25).

Table 44 - Percentage of singleton babies born between 1 July and 30 June at full term (>37 weeks) with a birth weight less than 2500 grams

REPORTING YEAR	SITE	SITE	SITE	ALL
	% (N)	% (N)	% (N)	% (N)
2014-15	2.8% (1/36)	4.5% (1/22)	3.8% (1/26)	3.6% (3/84)
2013-14	5.6% (2/36)	0% (0/28)	3.8 (1/28)	3.3% (3/90)
2012-13	13.1%	11.5%	9.5%	11.4%
2011-12	11.6%	11.8%	8.8%	10.5%

Missing values are less than 99% for all reported years

6.3.2 Mean Birth Weight for Full-Term Births

The average birth weight for singleton liveborn Australian babies in 2012 was 3,397 grams, and for babies of Aboriginal and Torres Strait Islander mothers the national average was 3,211 (Australian Institute of Health and Welfare, 2014, page 74).

The average birth weight for singleton, full term babies in the program, as shown in



Table 45 was 3,342 grams which was consistent to average birth weight last reporting year and again a favourable result. The average birth weight exceeds that of national figures for Aboriginal and Torres Strait Islander mothers.



Table 45 - Mean birth weight for full term (>37 weeks) babies born between 1 July and 30 June by Site

REPORTING YEAR	NATIONAL	
	MEAN G (N)	SD
2014-15	3,342 (84)	501
2013-14	3,337 (90)	514
2012-13	3,306	497
2011-12	3,292	500

Missing values are less than 99% for all reported years

*Note: Information regarding gestational diabetes or other health conditions that may impact birth weight are not currently collected and therefore weight comparison does not have health related exclusions.

6.3.3 Premature Births/Gestation Age

Sources: Infant Birth Form IB03 Gestational age at birth. Percentage of singleton infants born prematurely less than 37 weeks gestation.

Pre-term birth is associated with higher risk of neonatal outcomes (Australian Institute of Health and Welfare, 2014, page 71). The proportion of babies born prematurely in the program was 12.5% as shown in Table 46. This has increased since the exceptional result last year of only 6% of babies in the program born prematurely; however this year's result is less than the 14.3% of babies born to Aboriginal and Torres Strait Islander mothers nationally in 2012 (Australian Institute of Health and Welfare, 2014, page 73). Across Australia the proportion of pre-term births in 2012 varied from 10.4% in Tasmania to 7.6% in New South Wales.



Table 46 - Proportion of singleton babies born prematurely (<37 weeks gestation) by site

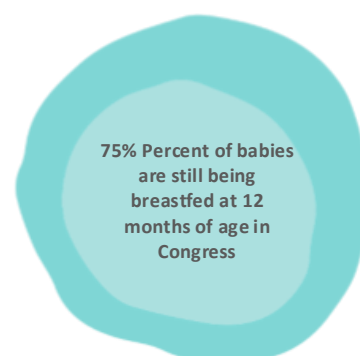
REPORTING YEAR	SITE	SITE	SITE	ALL
	% (N)	% (N)	% (N)	% (N)
2014-15	10.0% (4)	15.4% (4)	13.3% (4)	12.5% (12/96)
2013-14	3% (1)	7% (2)	10% (3)	6% (6)
2012-13	14.4%	11.6%	9.7%	12.1%
2011-12	12.4%	11.4%	9.8%	11.5%



6.3.4 Breastfeeding

Sources: *Infant Birth Form and Infant Health Care Form at Infancy six months, 12 months and Toddlerhood 12 month and 24 months. IB09, HC12, HC13, HC14 and HC15*

Breastfeeding information is collected at six monthly intervals and in DCS Version 2.2, including the age in weeks when breastfeeding ceased and when exclusive breastfeeding stopped. Current data limitations include the completion of repeated breastfeeding questions at four separate milestones, from six months to 24 months leading to potentially different answers over time, and differing opinions over the definition of exclusive breastfeeding may have impacted summary data. To improve the collection, DCS Version 2.5 reviewed these questions to better understanding of breastfeeding practices and the new forms are expected to improve breastfeeding information in future reports. For this report, Forms Version 2.1 have been presented until the new forms are completed for a reasonable period of time.



The prevalence of breastfeeding for women participating in the program continues to be impressive. Overall, 53% of infants within the program are continuing to breastfeed at six months of age, Table 47 below refers. This varies substantially by site. In the 2010 Australian national infant feeding survey, 60% of Indigenous children were being breastfed at six months of age compared with 68% for non-Indigenous infants (Australian Indigenous HealthInfoNet, 2015, page 54).

National percentages for infants ever receiving breast milk were 89% this reporting year, as shown in Table 48. In the Overview of Australian Indigenous health status (2014) breastfeeding initiation levels were 87% for Indigenous infants and 90% for non-Indigenous infants.

The most recent guidelines released by the National Health and Medical Research Council, (2012 page 1) recommends exclusive breastfeeding for the first six months of life. Table 49 outlines the age in weeks when infants stopped being breastfed exclusively. On average, the cessation of exclusive breastfeeding occurred at 11.4 weeks of age.

Table 47 - Proportion of infants continuing to get breast milk by stage and Site for 2014-15

REPORTING YEAR	STAGE	SITE	SITE	SITE	ALL
		% (N)	% (N)	% (N)	% (N)
2015	6 Months	77% (24)	13% (4)	16% (3)	53% (31)
	12 Months	75% (18)	21% (5)	4% (1)	57% (24)
	18 Months	64% (14)	nil	4% (1)	28% (15)
	24 Months	45% (9)	11% (1)	nil	21% (10)



According to the Overview of Australian Indigenous Health Status (2015, page 54) only 11% of Indigenous babies were exclusively breastfed at five months of age compared with 27% of non-Indigenous infants.

Table 48 - Number of clients who have breastfed or expressed milk for their infant at birth or shortly after for 2014-15

EVER BREASTFED OR EXPRESSED MILK FOR INFANT (recorded in Infant Birth Form)	SITE	SITE	SITE	ALL
	% (N)	% (N)	% (N)	% (N)
YES	98% (39)	96% (26)	70% (21)	89% (86)
NO	3% (1)	4% (1)	30% (9)	11% (11)
Mean Infant age (wks) when form completed	5.27	2.32	0.73	3.04

Table 49 - Mean, standard deviation and minimum and maximum age in week's exclusive breastfeeding ceased by Site

EXCLUSIVE* BREASTFEEDING CEASED	MEAN (WEEKS)	SD	MIN	MAX	N
SITE	15.3	8.130	0	24	85
SITE	9.8	6.594	1	26	33
SITE	9.0	8.525	0	24	68

*Refer to explanatory terms for definition and 90% data complete for infants no longer receiving breast milk

6.4 NEONATAL INTENSIVE CARE

Sources: *Infant Birth Form IB04*

The Maternal Health Assessment (Pregnancy Outcome) Form (formally the Infant Birth Form) collects information for each infant born to women participating in the program, the number of days the infant spent in neonatal intensive care unit (NICU) or special care nursery. The data for admission to special care nurseries (SCN) or neonatal intensive care units (NICU) from the national perinatal statistics is difficult to interpret according to the Australian Institute of Health and Welfare, (2014, page 84) as it is dependent on the different states and territories health sectors.

Table 50 and Table 51 summarise information collected in the Infant Birth Form about the number of days infants were admitted to NICU/SCN by the mother's self-report. This data is presented in this report for the first time. Overall the percentage of babies in the program spending any days in the NICU was 22% without a lot of site variation. The reasons for admission are not currently collected.



Table 50 - Number of infants being admitted to neonatal intensive care unit (mother's self-report) by site 2014-15

INFANTS IN NICU	SITE	SITE	SITE	ALL
	% (N)	% (N)	% (N)	% (N)
YES	23% (9)	25% (7)	20% (6)	22% (22)
NO	77% (31)	75% (21)	80% (24)	78% (76)

Table 51 - Mean, standard deviation, minimum and maximum days in NICU for infants by Site in 2014-15

MEAN DAYS IN NICU BY SITE	MEAN	SD	MIN	MAX	NO. INFANTS
SITE	7.08	19.789	0	100	38
SITE	7.18	19.123	0	82	22
SITE	2.48	6.626	0	27	29
ALL	5.61	16.451	0	100	89

6.5 CHILDHOOD INJURIES AND INGESTION

Source: Infant Health Care Form HC08 HC09.

There is very little current information available from national and state injury surveillance units for childhood injury and poisoning within the age groups comparable to infants within the program of 0-2 years. The following tables outline data related to presentations at a General Practice (GP), Medical Centre or clinic, or admission for injury or possible ingestion of something harmful.

The proportion of children presenting at GP surgeries and accident and emergency clinics for concern of swallowing something harmful or injuries has been steadily reducing in the 6-12 months age group since 2012, and proportions of children this reporting years has reduced in the 0-6 months of age to 3.8%. The 6-12 month age group has slightly increased to 4.7%. It should be noted across all age groups that this constitutes only four children over 2014-15. There was one admission to hospital for injury or ingestion in the 6-12 month age group this reporting year.



Table 52 - Proportions of infants presenting to clinics (mother's self-report) for injury or ingestion for 2013-14 and 2014-15 reporting years

REPORTING YEAR	BIRTH TO 6 MONTHS	6 TO 12 MONTHS	% DATA COMPLETE
	% (N)	% (N)	
2014-15	3.3% (2/60)	4.7% (2/43)	99%
2013-14	3.8%	4.3%	97%

Missing data for previous years was greater than 25% and are not presented
Clinics represent general practitioner, medical centre or hospital emergency department.

Table 53 - Mean number of infant presentations to clinics for injury or ingestion for birth to six months and six to 12 months for 2013-14 and 2014-15 reporting years

REPORTING YEAR	6 MONTH STAGE (BIRTH TO 6 MONTHS)				12 MONTH STAGE (6 TO 12 MONTHS)				% DATA COMPLETE
	MEAN	SD	N	MAX	MEAN	SD	N	MAX	
2014-15	0.05	.287	60	2	0.05	.213	43	1	>99%
2013-14	0.08	.417	79	3	0.04	.205	69	1	97%

Clinics represent general practitioner, medical centre or hospital emergency department.
Missing data for previous years was greater than 25% and are not presented

Table 54 - Mean number of infant presentations to clinics for injury or ingestion for 12-18 months and 18-24 months for 2013-14 and 2014-15 reporting years

REPORTING YEAR	18 MONTH STAGE (12-18 MONTHS)				24 MONTH STAGE (18-24 MONTHS)				% DATA COMPLETE
	MEAN	SD	N	MAX	MEAN	SD	N	MAX	
2014-15	0	-	53	0	0.04	.202	48	1	
2013-14	0.14	.462	44	2	0.13	.335	40	1	100%

Clinics represent general practitioner, medical centre or hospital emergency department.
Missing data for previous years was greater than 25% and are not presented

Table 55 - Proportions of infants admitted to hospital (mother's self-report) for injury or ingestion for 2013-14 and 2014-15 reporting years

REPORTING YEAR	BIRTH TO 6 MONTHS	6 TO 12 MONTHS	% DATA COMPLETE
	% (N)	% (N)	
2014-15	0 (0/61)	2.3% (1/43)	100%

There were no infant admissions for injury or ingestion in 2013-14 reporting year
Missing data for previous years was greater than 25% and are not presented



Table 56 - Mean number of infant admissions for injury or ingestion for birth to six months and six to 12 months for the 2014-15 reporting year

REPORTING YEAR	6 MONTH STAGE (BIRTH TO 6 MONTHS)				12 MONTH STAGE (6 TO 12 MONTHS)				% DATA COMPLETE
	MEAN	SD	N	MAX	MEAN	SD	N	MAX	
2014-15	0	-	61	0	0.05	.305	43	2	>99%

Clinics represent general practitioner, medical centre or hospital emergency department.

Note: There were no infant admissions for injury or ingestion in 2013-14 reporting year

Table 57 - Mean number of infant admissions for injury or ingestion for 6-12 months and 18-24 months for the 2014-15 reporting year

REPORTING YEAR	18 MONTH STAGE (12-18 MONTHS)				24 MONTH STAGE (18-24 MONTHS)				% DATA COMPLETE
	MEAN	SD	N	MAX	MEAN	SD	N	MAX	
2014-15	0	-	53	0	0	-	49	0	>99%

Clinics represent general practitioner, medical centre or hospital emergency department.

Missing data for previous years was greater than 25% and are not presented

6.6 IMMUNISATION

Source: Infant Health Care Form HC03 and HC04

The percentage of infants within the program stated as being fully immunized were 97.6% at 12 months of age and 100% at 24 months of age. This exceeds the percentages from last reporting year which were 91.5% at 12 months and 92.5% at 24 months which is a promising result. Responses on whether the infant is fully up to date with immunisation are based on 60% mother's self-report and 40% written records. Immunisation percentages have been reported in Table 58 below, however at 12 months and 24 months are the key milestones reported for immunisation.

In 2012-2013, immunisation rates for Aboriginal and Torres Strait Islander children varied between (former) Medicare Local catchments from 68.7% in metropolitan areas to 96.9% in regional areas for children at 12 months of age and between 81.6% in metropolitan areas and 97% in rural areas at 24 months of age (My Healthy Communities, 2015). The percentages shown for infants within the program exceed these rates in both age groups.

In 2013, according to the Australian Childhood Immunisation Register in 2013, immunisation rates for Indigenous children were 87% at 12 months and 88% at 24 months (Australian Indigenous HealthInfoNet, 2015, pages 53-54). The percentages of infants within the program for 2014-15 exceed these figures.

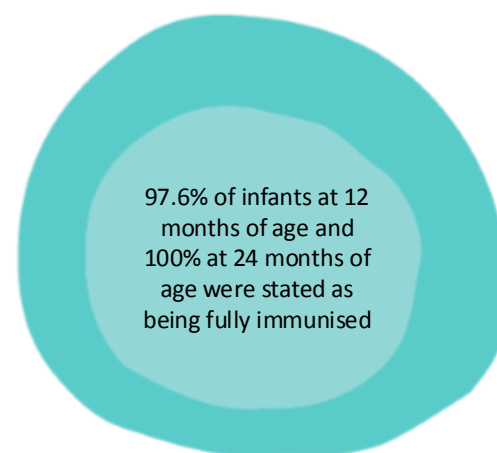


Table 58 - Proportion of infants up to date on all vaccinations for the stage for 2014-15 reporting year

STAGE	YES % (N)	NO % (N)	TOTAL
at 6 Months	94.9% (56)	5.1% (3)	59
at 12 Months	97.6% (41)	2.4% (1)	42
at 18 Months	88.7% (47)	11.3% (6)	53
at 24 Months	100%(49)	0% (0)	49
All	95.1% (193)	4.9% (10)	203

Data completeness >98%. Immunisation responses are based on 60% mother's self-report and 40% written records

6.7 AGES AND STAGES QUESTIONNAIRES

Source: Infant Health Care Form HC21, HC22, HC23, HC16

The Ages and Stages Questionnaires (ASQ) are completed at various developmental milestones for infants within the program. The ASQ is collected at 4, 10, 14 and 20 months. The Ages and Stages Questionnaires: Social Emotional (ASQ:SE) is collected at 6, 12, 18 and 24 months. Recording the scores for the ASQ in the Infant Health Care Form at 6, 12, 18 and 24 months has been recognised as a limitation and DCSS Version 2.5 has separate ASQ and ASQ:SE data entry forms. It is expected that this will resolve issues of data completeness associated with the Ages and Stages Questionnaires, however as shown in Table 59, there are between 17% and 19% of results incomplete for the ASQ and ASQ:SE this reporting year. A secondary issue within the ANFPP is that the systems are not currently in place to track cohort numbers in each age group at any point in time. This limits the ability to determine what proportion of infants within the program had ASQ and ASQ:SE questionnaires administered, and therefore reduces the validity of the results. From available information, these results roughly cover 82% of infants under 12 months and between 85% and 95% of infants 12 to 24 months.

Table 59 - Summary of data completeness for ASQ Questionnaire Forms for 2-14-15 reporting year

DATA COMPLETE	% INCOMPLETE	N TOTAL FORMS
Stage the questionnaire was delivered	8% (17)	207
ASQ Questionnaires	17% (35)	207
ASQ: Social and Emotional	19% (40)	207

Table 60 through to Table 63 outline the mean scores for the questionnaires at each age group. There were very low number of children within the program that fell below the cut off score for follow-up and potential referral. Overall there were three in the four month age group and one infant in each of the 10, 14 and 20 months age groups (*note these may be the same infants appearing in more than one cohort over the 12 month period). In 2013-14 reporting year there were 20 infants below the cut off. This is a very good result for the women and children in the program.



The statistical comparison with standardised norms for each age group will again be conducted when there is at least 12 months' worth of data from the program collected on the new ASQ Data Entry Forms. The results suggest however infants are doing better in these areas over last reporting year.

Table 60 - Ages and stages questionnaire results for four month age group for the 2014-15 reporting year

TOPIC	MEAN	N	SD	MIN	MAX	MEDIAN	N (%) BELOW CUT-OFF SCORE
COMMUNICATION	56.61	31	3.739	50	60	55.00	0
GROSS MOTOR	52.74	31	8.046	30	60	55.00	2 (6%)
FINE MOTOR	53.39	31	7.570	30	60	55.00	1 (3%)
PROBLEM SOLVING	54.52	31	5.221	45	60	55.00	0
PERSONAL/SOCIAL	55.48	31	5.378	45	60	55.00	0

Table 61 - Ages and stages questionnaire results for 10 month age group for the 2014-15 reporting year

TOPIC	MEAN	N	SD	MIN	MAX	MEDIAN	N (%) BELOW CUT-OFF SCORE
COMMUNICATION	53.75	24	7.837	30	60	55.00	0
GROSS MOTOR	52.08	24	12.151	10	60	60.00	1 (4%)
FINE MOTOR	54.79	24	4.773	45	60	55.00	0
PROBLEM SOLVING	52.08	24	5.882	40	60	50.00	0
PERSONAL/SOCIAL	53.12	24	6.886	40	60	55.00	0



Table 62 - Ages and stages questionnaire results for 14 month age group for the 2014-15 reporting year

TOPIC	MEAN	N	SD	MIN	MAX	MEDIAN	N (%) BELOW CUT-OFF SCORE
COMMUNICATION	53.52	27	7.181	35	60	55.00	0
GROSS MOTOR	59.26	27	2.280	50	60	60.00	0
FINE MOTOR	52.04	27	7.106	40	60	50.00	0
PROBLEM SOLVING	49.81	27	11.559	10	60	50.00	1 (4%)
PERSONAL/SOCIAL	55.00	27	7.338	35	60	60.00	0

Table 63 - Ages and stages questionnaire results for 20 month age group for the 2014-15 reporting year

TOPIC	MEAN	N	SD	MIN	MAX	MEDIAN	N (%) BELOW CUT-OFF SCORE
COMMUNICATION	52.69	26	9.190	30	60	55.00	0
GROSS MOTOR	56.73	26	4.678	45	60	60.00	0
FINE MOTOR	54.04	26	7.214	35	60	55.00	1 (4%)
PROBLEM SOLVING	50.19	26	7.808	35	60	50.00	0
PERSONAL/SOCIAL	56.15	26	6.051	35	60	60.00	0

Seventy five ASQ:SE scores were entered in the DCS for the infants within the program in 2014-15 reporting year and again this figure suggests that not all infants are being assessed using these questionnaire at the expected age groups. These results are shown in Table 64. Further consideration of data completeness and if all infants within the program are receiving these questionnaires will need to be addressed once the new forms are in place at all sites and data is collected for at least 12 months. The results shown for the small cohort in each age group that very few infants have a result over the cut off score for follow-up and potential referral (N=3).



Table 64 - Ages and Stages: Social and Emotional questionnaire scores for infants by age group for the 2014-15 reporting year

TOPIC	MEAN	N	SD	MIN	MAX	MEDIAN	DATA MISSING	N (%) OVER CUT-OFF SCORE
6 MTHS	11.40	25	10.360	0	40	10.00	2 (7%)	0
12 MTHS	19.64	14	16.108	0	60	12.50	1 (7%)	1 (7%)
18 MTHS	17.22	18	12.032	0	40	15.00	2 (10%)	0
24 MTHS	24.72	18	18.188	5	60	20.00	1 (5%)	2 (11%)

6.8 ENGLISH LANGUAGE ASSESSMENT

Source: English Language Assessment EL01

The challenge of not having systems in place to identify how many infants of women remaining in the program are at 21 months within the reporting year, and therefore how many language assessments represent the whole of the population of infants is most acute for the English Language Assessment. Without this information, determining what proportion of the population these results pertain to limits the ability for interpretation. If only a proportion of infants are receiving this assessment, the interpretation demands consideration of whether a sub group of infants are being assessed based on concern. This would then produce results that may be worse than actual for the population of infants. Similarly as shown in Table 65, other influences may be operating whereby more boys have received the assessment in two sites without information about the gender ratio of infants for women remaining in the program.

The establishment of systems to resolve denominator issues are critical for these analyses in the future for analysis and to inform quality improvement activities. This would also include ensuring this assessment is conducted at the appropriate age for the majority of infants.

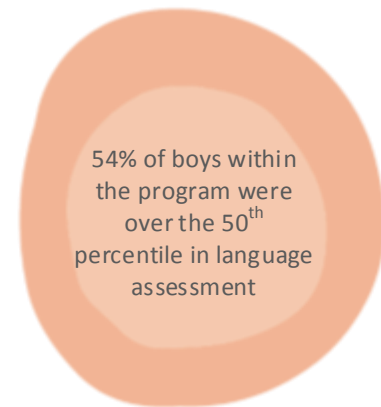
Table 65 - Gender of infants having a completed English Language Assessment by site for 2014-15 reporting year

GENDER	SITE	SITE	SITE	ALL
	N (%)	N (%)	N (%)	N (%)
FEMALE	10 (59%)	3 (27%)	8 (33%)	21(40%)
MALE	7 (41%)	8 (73%)	16 (67%)	31 (60%)
TOTAL	17	11	24	52

The Macarthur CDI Form B English Language Assessment scores were analysed for 52 children this reporting year. In the last Annual Data Report, it was identified that the boys were doing better in terms of language than the girls, which is opposite to what you would normally expect given the standardised norm tables. There were equivalent numbers of boys and girls having the assessment in 2013-14. Table 65 outlines the number of these assessments undertaken by gender by site.



As shown, a much larger group of boys are having a language assessment conducted at two sites despite very little differences in the gender of births cohorts (see Table 43). The English language scores for the last two reporting years were adjusted to accommodate the assessment being conducted outside of the 21 month age group to allow the analysis to be conducted in comparison to percentiles. The variation in age group the assessment was conducted in 2013-14 was 19 to 24 months. This year the range of age groups for the assessment was 15 to 25 months, well outside the recommendations for assessment. This year, the language assessment conducted at 15 months has been excluded from the analysis and only assessments conducted between 19 and 25 months were adjusted for the analysis. Table 65 shows the proportions of infants who are assessed outside the recommended age of 21 months by site. There are many reasons for taking this assessment outside the recommended age group, however it would be ideal if the majority of infants were assessed at 21 months to ensure the quality of the results.



It is difficult to hypothesize on the reason more boys have had a language assessment at two sites this reporting year. It may be by chance that women remaining in the program happen to have boy infants, or that there is more concern over boy's language skills and they are more often assessed. Issues related to coding of source data and categorization cannot be excluded.

Table 67 and Table 68 outline the results of the language assessments conducted within this financial year on 52 infants. There is some variation to last year's results with a slight decrease in the mean number of words identified overall. The mean number of words for girls is lower than boys for adjusted results, and this is supported by the percentiles shown in Table 68 where 63% of girls were under the 25th percentile (N=13) compared with only 26% (N=8). It is reassuring to note that 54% of boys and 15% of girls were above the 50th percentile in the number of words identified.

Table 66 - Frequencies and percent of infants undertaking an English Language Assessment at the appropriate age group for 2014-15 reporting year

AGE AT ASSESSMENT	SITE	SITE	SITE	ALL
	N (%)	N (%)	N (%)	N (%)
21 MONTHS	5 (28%)	1 (9%)	9 (38%)	15(28%)
TAKEN AT <=20 MTHS OR >=22 MTHS	13 (72%)	10 (91%)	15 (63%)	38 (72%)
TOTAL	18	11	24	53



Table 67 – Mean, median, standard deviation, minimum, maximum and median words identified in the language assessment at 21 months*

WORDS IDENTIFIED	MEAN	N	SD	MIN	MAX	MED	% DATA COMPLETE
2014-15 Adjusted	35.9	52	22.011	0	96	32.5	100%
2013-14 Adjusted	36.7	38	23.705	0	100		91%
2014 Raw	39.9		23.266	1	100		91%
2013	49.4		25.6	1	99		67%
2012	49.4		20.1	16	95		81%

*Individual scores for number of words have been adjusted according to the age at assessment based on the percentile tables for each sex

Table 68 - Mean, median, standard deviation, minimum, maximum and median words identified in the language assessment at 21 months* by gender for 2014-15 reporting year

GENDER	MEAN	N	SD	MIN	MAX	MEDIAN
Girls	34.05	21	18.726	10	95	28
Boys	37.16	31	24.203	0	96	38

*Individual scores for number of words have been adjusted according to the age at assessment based on the percentile tables for each sex

Table 69 - Number and percent of infants according to percentiles from CDI Toddler Form B

GROUP	UNDER 25TH PERCENTILE	BETWEEN 25TH AND 50TH PERCENTILE	BETWEEN 50TH AND 75TH PERCENTILE	OVER 75TH PERCENTILE
Girls	13 (62%)	5 (24%)	1 (5%)	2 (10%)
Boys	8 (26%)	6 (19%)	11 (35%)	6 (19%)
Total	21 (40%)	11 (21%)	12 (23%)	8 (15%)



7 DATA ANALYSIS NOTES

This report is intended to provide relevant and current information about the ANFPP as sourced from the Data Collection System. Therefore it focusses on the summary data as it aligns with model fidelity and outline outcomes and achievements from available information for 2014-15. It is not intended as an evaluation of the program.

The key data analysis notes include:

- Where a form is in error or duplicated, these have been excluded from the analysis.
- Due to the recent nature of the upgrade to Forms Version 2.2 at only two sites, the new fields collected have not been analysed. A positive outcome of this was that the changes implemented in July this year have not impacted the ability to produce this report and therefore adequate consideration was given to the continuity of data. The only impact the new forms had was on income questions which can be accommodated in future.
- The dosage calculations are based on enrolled clients and not accepted clients. That is, to be included in the dosage calculations a client must be accepted and received their first home visit.
- There may be a variation in numbers of previous reporting years. This can be the result of targeted data quality activities that change previous data, changes in methodology of calculation or correction of errors identified. It is recommended that where possible, use the most recent Annual Data Report for historical reporting specifically around incoming referrals and active clients.



8 CONCLUSION

This report has been able to capture very positive outcomes for clients and children within the ANFPP in Australia. Women continue to be referred to the program at all three sites and 1,381 have been referred to the program since inception. Uptake of the program by the women referred remains strong, with 78% of eligible women going on to participate in the program exceeding the NFP target of 75%. Active clients have reduced slightly from 197 participating women last year to 179 this year and incoming referrals have reduced slightly compared with incoming referrals in the 200s for the last few years.

Retaining staff in the program continues to be of concern with the most significant turnover being experienced in Nurse Supervisors. Nurse Home Visitor caseloads have remained stable with approximately 14 clients per nurse home visitor. Despite these challenges the program experienced the highest number of graduations this year with 63 women completing the program. Obtaining referrals and therefore enrolling clients early in the pregnancy is an area that anecdotally requires constant attention by local program staff. Only 41% of clients are accepted into the program by the 16th week of pregnancy, less than the NFP target of 60%. Similarly the number of women continuing in the program until their child turns two years of age is 41% overall compared with the NFP target of 60% or greater.

Visit completion rates for each phase are at 55%, 60% and 67% for pregnancy, infancy and toddlerhood phases respectively. The average number of visits for women completing the program is 42, inclusive of telephone visits with program content. These visits are calculated for clients from the commencement of the program in 2009 until 30 June 2015. The visit completion rate for clients in the pregnancy phase, based on time in phase, is 78%. This larger visit completion rate may indicate an improvement in visit dosage as this group includes women that were in the pregnancy phase as at 30 June 2015, thus entering the program more recently.

The positive health outcomes for women in the program continue to be promising. Nearly 93% of women have received at least an initial antenatal visit within four weeks of entering the program and the average age of the initial antenatal visit was within the first trimester (under 14 weeks). A significant reduction in smoking was shown for individual clients from intake to 36 weeks of pregnancy and self-reported alcohol consumption was very low again this year. Self-reported marijuana use is limited to a very small number of clients. No self-reported use of other drugs was identified. Twenty four percent of women experience subsequent pregnancies within two years of the referred infant birth which is a great result and similar to NFP outcomes for the randomised control trials.

Only 3.6% of singleton babies born to women participating in the program had low birth weight compared with 11.8% for all Aboriginal and Torres Strait Islander women birthing in Australia in 2012. This pattern of small proportions of infants being born with a low birth weight has been demonstrated over the last two years. The average age for the cessation of exclusive breastfeeding for women participating in the program across three implementing sites is 16.6 weeks of age. The percentages of infants still receiving breast milk at 12 months of age was 57%, with sites varying between 4% and 75% at that age group.

The percentages of infants presenting to a clinic or general practitioner, or being admitted to hospital for an injury or suspected ingestion of a harmful substance reported by mothers' were very low, affecting five infants under two years of age. Similarly the number of children under the cut-off for follow-up or referral for the Ages and Stages questionnaire was also very low at five children in total across all age groups.



The percentages of children who were reported as fully immunised were extremely positive with 100% of two year olds and 97.6% of 12 month old infants. Finally the percentage of infants exceeding the 50th percentile for the English Language Assessment were 54% for boys and 15% for girls. These outcomes for children within the program provide a very sound basis for their future.

The report also provides expanded information regarding the women in the program, the involvement of fathers and their participation in education and work and this information collectively will inform future directions and improvements not only in data collection and monitoring, but also in service delivery and meeting the needs of women on their journey in the program. There are recognised opportunities for reviewing the Data Collection System, including more social and emotional wellbeing determinants and incorporating international data collection guidelines in the future.

The ability to capture these outcomes for a second year is testament to the hard work and investment by program staff at sites to collecting the information as part of delivering the program to women and their children. Ongoing maintenance and quality improvement of the Data Collection System and the national data set, particularly in light of the planned program expansion to other services, will ensure the information about the outcomes for all clients and infants within the program is accurate, unbiased and adequately reflect the achievements of the program.



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10 FEEDBACK

Comments and feedback on this report can be submitted by email to info@anfpp.com.au via the ANFPP website at www.anfpp.com.au or addressed to the ANFPP National Program Centre, PO Box 1874 Milton Q 4064.

