ANFPP National Program Centre

National Annual Data Report

1 July 2015 – 30 June 2016

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Growing Stronger Families
Funded by the Australian Government

CULTURAL ACKNOWLEDGEMENT

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

ABBREVIATIONS AND ACRONYMS

ACCHO	Aboriginal Controlled Community Health Organisation
ACW	Aboriginal Community Worker
ANKA	ANFPP National Knowledge Access Project
ANFPP	Australian Nurse-Family Partnership Program
ASQ	Ages and Stages Questionnaires
ASQ:SE	Ages and Stages Questionnaires: Social-Emotional
DCS	Data Collection System
EPDS	Edinburgh Postnatal Depression Scale
FPW	Family Partnership Worker[1]
FTE	Full-Time Equivalent
GP	General Practitioner
IPV	Intimate Partner Violence
N	Number of clients or infants in a group that have contributed to calculated results
NFP	Nurse-Family Partnership (USA)
NHV	Nurse Home Visitor
NICU	Neonatal Intensive Care Unit
NPC	National Program Centre
NS	Nurse Supervisor
RCT	Randomised Controlled Trial
SCN	Special Care Nurseries
SD	Standard Deviation
STAR	Strengths and Risks Framework
SITE	Established implementing sites have not been identified in this version of the report. Data presented in tables by site represent the results from each individual implementing site. Sites do not appear in consistent order throughout the report.

[1] A unique adaptation of the Nurse-Family Partnership program for Australia has been the inclusion of the Family Partnership Worker (FPW). FPWs promote trust and respect between the clients and their family, the Indigenous community and health providers. In many implementing organisations, the FPW position can be referred to by a title that is relevant to the local administration including Aboriginal FPW, Aboriginal Community Worker (ACW) and Family Community Worker (FCW). Where FPW is referred to in ANFPP documents, the term is inclusive of this role irrespective of the local title for the position.

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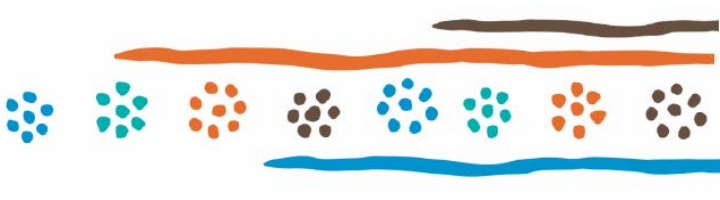


FIGURES

SUMMARY

Overall, Australian Nurse-Family Partnership Program (ANFPP) implementation aligns with Nurse-Family Partnership (NFP) model fidelity. There are significant successes of ANFPP, such as the acceptance rate where the majority of eligible clients who are referred go on to participate in the program. This achievement supports the recognition of the program's goals by the local communities and the ongoing activities to maintain referral pathways. As the program expands, there continues to be new and existing challenges and areas for improvement in terms of model fidelity, however the program's focus on continuous quality improvement, including the use of a site self-assessment tool to inform the development of quality improvement plans, provides the program with a means for identifying and addressing these areas.

The positive outcomes of the program in relation to premature births and low birth weights are again demonstrated in this report. While previous reports have found evidence of smoking reduction, this year there is no statistical evidence of changes in smoking during pregnancy. Overall however, ANFPP continues to build on its strengths and as the program expands, more information will be available about the challenges and successes of the program in Australia.

Visit completion rates for each phase in the program (pregnancy, infancy and toddlerhood), as well as overall client retention rates continue to be below expected targets. In addition, staff attrition within the program remains an area to be better understood. With a small complement of program staff nationally, disruption to caseloads and teams is evident as a result of staff attrition. The ANFPP National Workforce Development Study is underway to better understand factors that influence program staff attrition and retention which are issues that continue to be the focus of attention.

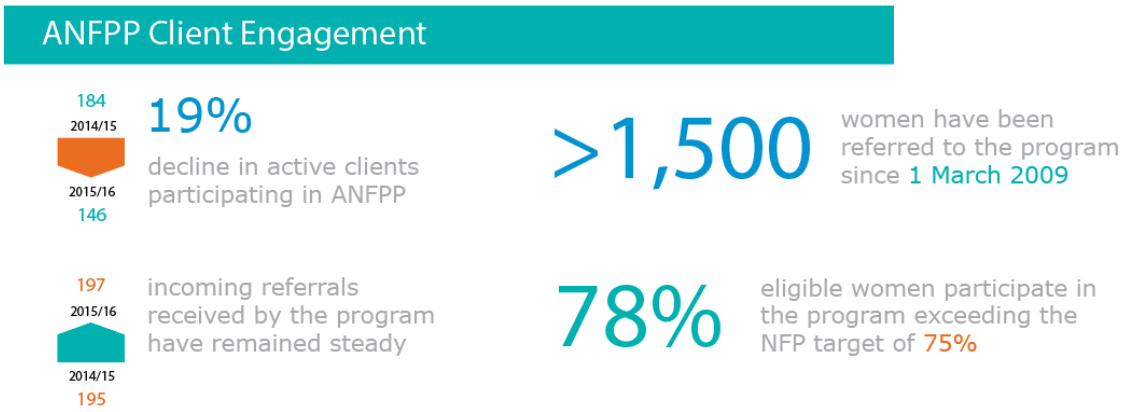
Despite these challenges, the program experienced the second highest number of graduations within a one-year reporting period. Program referrals and clients accepted into the program for 2015-16 also remained steady when compared to 2014-15.

This report also provides further information regarding the women in the program, the involvement of fathers, and the women's participation in education and work. This information collectively will inform improvements not only in data collection and monitoring, but also in service delivery and meeting the needs of women in their journey through the program.

Based on results, including comparison with targets and trends, key areas that require focus going forward include:

- Increasing the enrolment of women before the 16th week of pregnancy.
- Increasing the retention of clients within the program.
- Increasing expected domain content delivery within relevant phases.
- Increasing the visit completion rate.
- Increasing collaboration with local and national Indigenous smoking reduction programs.

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



ANFPP Implementation

2014/15
2015/16

2.8
fewer Nurse Home Visitors (FTE)

3
Nurse Supervisors (turnover has occurred within positions)

14.9
2015/16
2014/15
14.1

Nurse Home Visitor caseloads remain stable with approx. 14 clients per Nurse Home Visitor

41.6%
2014/15
2015/16
37.8%

3.8%
decline in cumulative retention of clients in ANFPP, less than the NFP target of 60%

50.5%
of client visits occurred in the home compared to 57% in 2014/15

42.6
average number of visits received throughout the program by clients who have graduated, this is 67% of the planned visits outlined by the NFP

49
women completed the program compared to 65 in 2014/15

enrolment early in pregnancy remains challenging with 40.8% of clients participating by week 16, less than the NFP target of 60%

207 clients have completed the program since March 2009

7.4
average number of visits received by women in the program in the pregnancy phase (14 visits recommended)

37.5%
of visit time was spent on the maternal role domain during the infancy phase

35.6%
of visit time was spent on the maternal role domain during the toddlerhood phase

16.2 average number of visits received by women in the program in the infancy phase (28 visits recommended)

14 average number of visits received by women in the program in the toddlerhood phase (22 visits recommended)

67% of expected visits are received by ANFPP clients on average

64 minutes is the average length of ANFPP visits

Client Characteristics

>25%
of clients in the program reported having a household income of less than $500 per week

>15 languages other than English were identified by clients when asked about their primary language at program intake

13.8%
of home visits were attended by the client with their partner present

21 years is the average age of women at program intake

Health Outcomes for Women Enrolled in ANFPP

94% of women in the program participated in antenatal care prior to program intake

10.1 weeks is the average gestational age for the initial antenatal visit

there are very low rates of alcohol consumption during pregnancy for women in the program

9.9%
of full term babies born in 2015-16 to women in ANFPP had a low birth weight. The national average is 10.9% for full term babies born to Indigenous mothers

Health Outcomes for Women Enrolled in ANFPP

16.8% of women had a subsequent pregnancy within 24 months after the birth of the program referred pregnancy

Outcomes for Infants in ANFPP

50% of infants within the program are continuing to breastfeed at 6 months of age

the average number of words identified in the English Language Assessment for 2015/16 was 41.1 compared to 35.9 for 2014/15

5.5% of infants 0-12 months presented at clinics for injury or ingestion compared to 9.1% for infants and toddlers 13-24 months

6.8% of infants 0-12 months were admitted to hospital for injury or ingestion compared to 4.5% for infants and toddlers 13-24 months

1 INTRODUCTION

The ANFPP National Annual Data Report 2015-16 provides summary data and analysis of clients and infants participating in the program and also provides important information with regard to the alignment of the program in Australia with NFP model fidelity. The analysis and summary data cover three main areas of interest:

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

As at 30 June 2016, there were five sites implementing ANFPP across Australia, including three Aboriginal Community Controlled Health Organisations (ACCHO) which are well established in delivering the program; another ACCHO in the early stages of implementation; and a State government health organisation planning for implementation.

For the purpose of this report the three established sites will be reported upon, excluding the ACCHO site in the early stages of implementation and the State government health organisation.

ANFPP commenced in Australia in 2009, however annual reporting of program implementation, as well as client and infant outcomes, commenced in 2011-12. The annual report provides critical information to support the continuation of the program with fidelity to the NFP model and assesses outcomes for participating women, children and their families. ANFPP has continued to revise its data collection system and processes to improve how the information collected by program staff can inform their delivery of care and to target data quality improvements. However while some gains have been achieved, data quality is an ongoing process and is always subject to improvement to allow more robust and expansive monitoring and reporting.

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 presented for comparison purposes.

The report also includes descriptive and demographic information about the women in the program covering the period from 1 January 2012 to 30 June 2016. Data from 1 January 2012 is the most reliable period available for reporting following a data quality improvement project which targeted improvements in data recorded from 1 January 2012. The descriptive and demographic 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 program visits, and uptake of antenatal services.

It is important to review information collected to ensure the methods of collection and the presentation of program information are culturally sensitive and appropriate. The Data Collection System (DCS) 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. Ongoing maintenance and quality improvement of the DCS and the national data set, aligned to the planned program expansion, will ensure the information about the outcomes for all clients and infants within the program is accurate, unbiased, and adequately reflects the achievements of the program.

This report provides ANFPP stakeholders and the community with an opportunity to review information collected as part of the program. It will also assist in informing general knowledge of the program and to identify the outcomes for women participating in the program. As the program expands over the 2015 to 2018 period of contract with the Commonwealth Government, it is important to consider the individual successes, overall outcomes, and the individual and collective impact on women participating in the program.

Information currently available for the program can assist in reviewing current progress and informing discussion for future innovations. There are currently a number of emergent factors for consideration within the program such as the potential for a wider evaluation of the program in Australia via an anticipated Randomised Controlled Trial (RCT), the potential implementation of the Strengths and Risks (STAR) Framework, the inclusion of the Intimate Partner Violence (IPV) intervention from the NFP, and the development of the ANFPP National Knowledge Access (ANKA) project.

1.1 Data Limitations

The National Annual Data Report has been produced since 2011-12 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, for example, where calculations have been made to derive a client's phase when this data was originally incomplete, and more concise data analysis notes appear at the end of this report. Additionally, it is important to remember that data from 1 January 2012 is the most recent period available for reliable reporting, and is in most cases the earliest date data is provided throughout the report.

The ANFPP DCS forms and instructions are derived from the national ANFPP dataset and outline how the data is collected around specific data items. It should be noted that care is required in interpreting the results with regard to generalisability and inference due to small group numbers in sub-populations of the serviced communities.

2 National ANFPP Expansion and Site Implementation

ANFPP continues to expand its program delivery to sites across the country. During 2015-16, two new sites joined ANFPP, however due to the early stages of implementation at new sites, no initial data has been included with the aggregated program figures provided throughout this report.

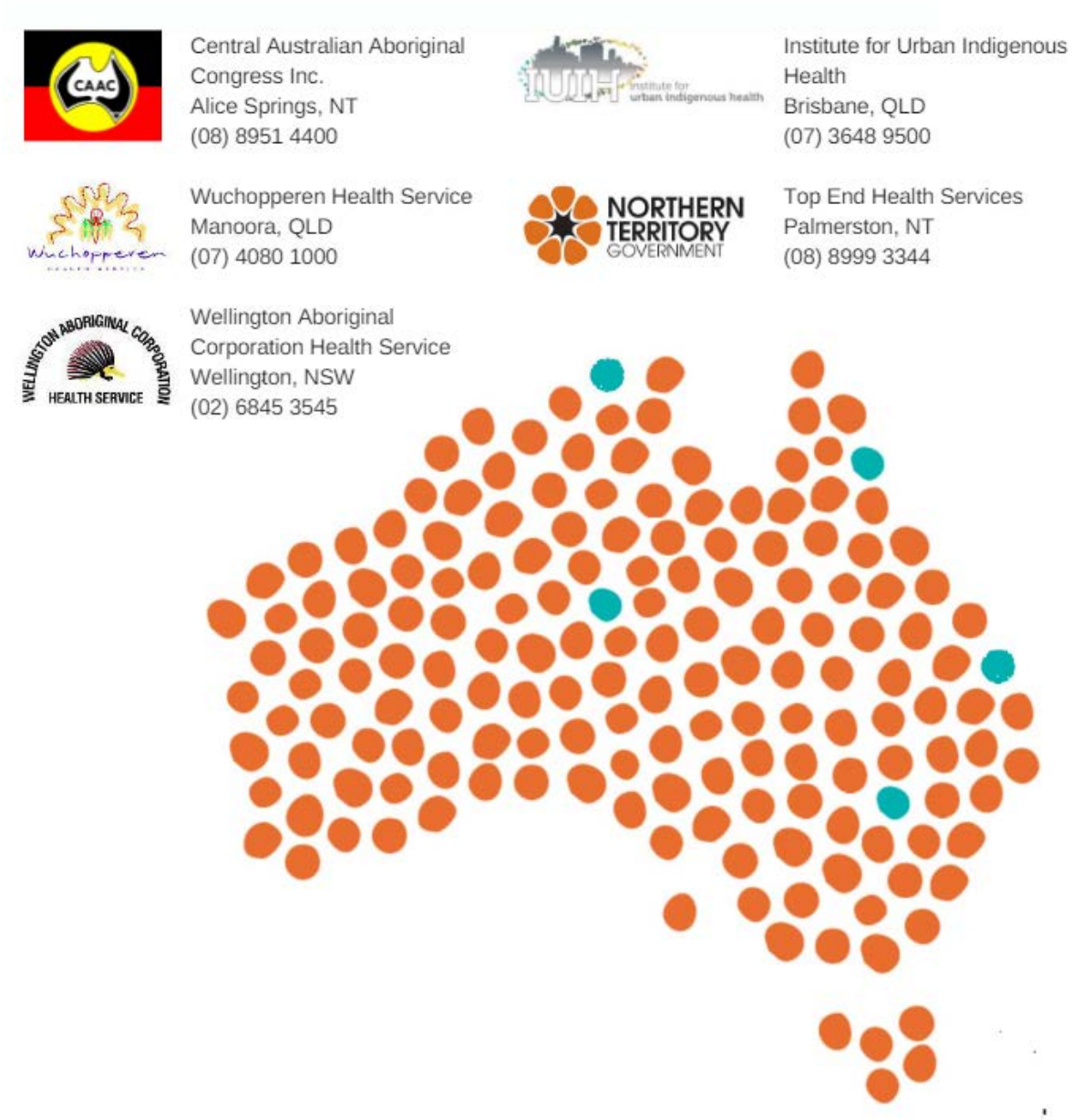


Figure 1. ANFPP site locations as at 30 June 2016

3 PROGRAM SUMMARY

The program has maintained an active client base of around 150 to 200 women pregnant with an Aboriginal or Torres Strait Islander baby since 2012-13. Table 1 summarises incoming client referrals, clients accepted, active clients, and graduations from the program since 1 July 2012.

The acceptance rate by clients indicates that clients are willing to consent and participate in the program at intake.

Since March 2009, there has been a cumulative total of 1,580 clients referred to the program. Of these referrals, 1,210 were eligible for the program and of these eligible clients, 941 accepted enrolment into the program which constitutes an acceptance rate of 78%. ANFPP continues to exceed the NFP target for an overall acceptance rate of 75%. These figures are shown in the Referral Outcome Flowchart in Figure 3.

78% eligible women participate in the program exceeding the NFP target of 75%

Table 1. Summary of active clients, graduated clients, and referrals between 2012-13 and 2015-16

MEASURE	2012-13	2013-14	2014-15	2015-16
Incoming referrals	260	221	195	197
Eligible referrals	195	177	141	145
Clients accepted (% of eligible referrals)	166 (85.1%)	127 (71.8%)	119 (84.4%)	118 (81.4%)
Active clients	200	198	184	149
Graduations in year	32	44	65	49
Total graduated clients (cumulative)	49	93	158	207

As at 30 June 2016 there were 149 active clients.

In 2015-16, 49 clients graduated from the program, which is less than the number of graduations in 2014-15, but exceeds the result for 2013-14 when 44 clients graduated. The three established ANFPP sites have an active client base ranging between approximately 25 to 70 clients per site.

49 women completed the program compared to 65 in 2014/15

The reduction in women completing the program during 2015-16 can be attributed to a range of reasons including continual missed appointments, moving out of the service area and instances where the woman is no longer able to be located further. Additionally, any reduction in workforce capacity at a site will impact the number of clients accepted into the program, which has been the case at one ANFPP site.

Strategies developed for clients who have excessive missed appointments include:
1. Earlier intervention via an FPW following up with a client after the first missed appointment.
2. FPW to increase the number of family visits (now including the use of goal setting activities).
3. NHV to review client engagement at more frequent intervals and during times of disengagement.

Exploring the reasons for client disengagement in more detail will also enable the program to understand and address the range of experiences that lead to disengagement and women leaving the program before completion.

The Referral Outcomes Flowchart (Figure 3) also outlines the outcomes of client referrals since March 2009 with 272 clients ineligible for the program and 269 clients who declined participation. The outcome 'program places full' refers to an outcome early in the initial implementation of the program and this figure has not changed since 2012. Eighty-one clients were unable to be located following their referral to the program since March 2009.

Figure 2 shows the number of incoming referrals since 2009-10 to provide a comparison to 2015-16. These numbers may differ slightly to numbers previously reported due to ongoing data quality revision and subsequent updates to the data. The data in this report represents the latest revision based on the most recent data.

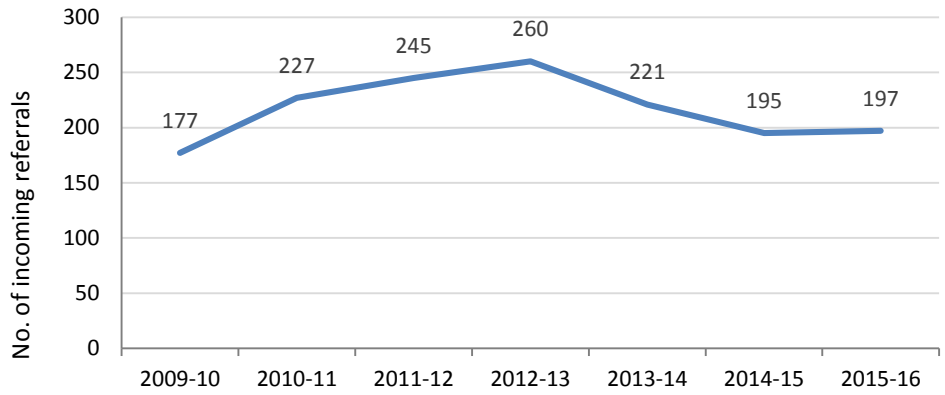


Figure 2. Program history of incoming referrals from 2009-10 to 2015-16

Each site has a home visiting team made up of three roles specific to the program: Nurse Supervisor (NS), Nurse Home Visitor (NHV) and Family Partnership Worker (FPW)[2]. Some sites also have dedicated administrative staff.

Table 2 outlines the staffing for the three established ANFPP sites, with FTE staffing of 10 NHV as at 30 June 2016. There were nine FPW as part of the ANFPP teams across the three established sites as at 30 June 2016.

Table 2. Nurse Home Visitor caseload at the end of each financial year since 2012-13

WORKFORCE	2012-13	2013-14	2014-15	2015-16
NHV - FTE	16.2	12.4	12.8	10.0
NS - FTE	3	3	3	3
FPW - FTE	10.8	9	8	9
Average NHV caseload in program	12.8	14.6	14.1	14.9
Average NS caseload (staffing) in program	5.4 NHVs	4.1 NHV	4.3 NHV	3.3 NHV
	3.6 FPWs	3 FPW	2.7 FPW	3 FPW

The average client caseload for NHV is 14.9 as at 30 June 2016. The decreased number of NHV FTE in the program during 2015-16 limits the growth in the active client base although NHV caseloads have increased since 2012-13. A key priority for the program is to address both staff retention and client retention to maintain the stability and sustainability of the program.

Nurse Home Visitor caseloads remain stable with approx. 14 clients per Nurse Home Visitor

[2] A unique adaptation of the Nurse-Family Partnership program for Australia has been the inclusion of the Family Partnership Worker (FPW). FPWs promote trust and respect between the clients and their family, the Indigenous community and health providers. In many implementing organisations, the FPW position can be referred to by a title that is relevant to the local administration including Aboriginal FPW, Aboriginal Community Worker (ACW) and Family Community Worker (FCW). Where FPW is referred to in ANFPP documents, the term is inclusive of this role irrespective of the local title for the position.

4 NFP Model Fidelity

4.1 Referral Outcomes Flowchart: 1 March 2009 to 30 June 2016

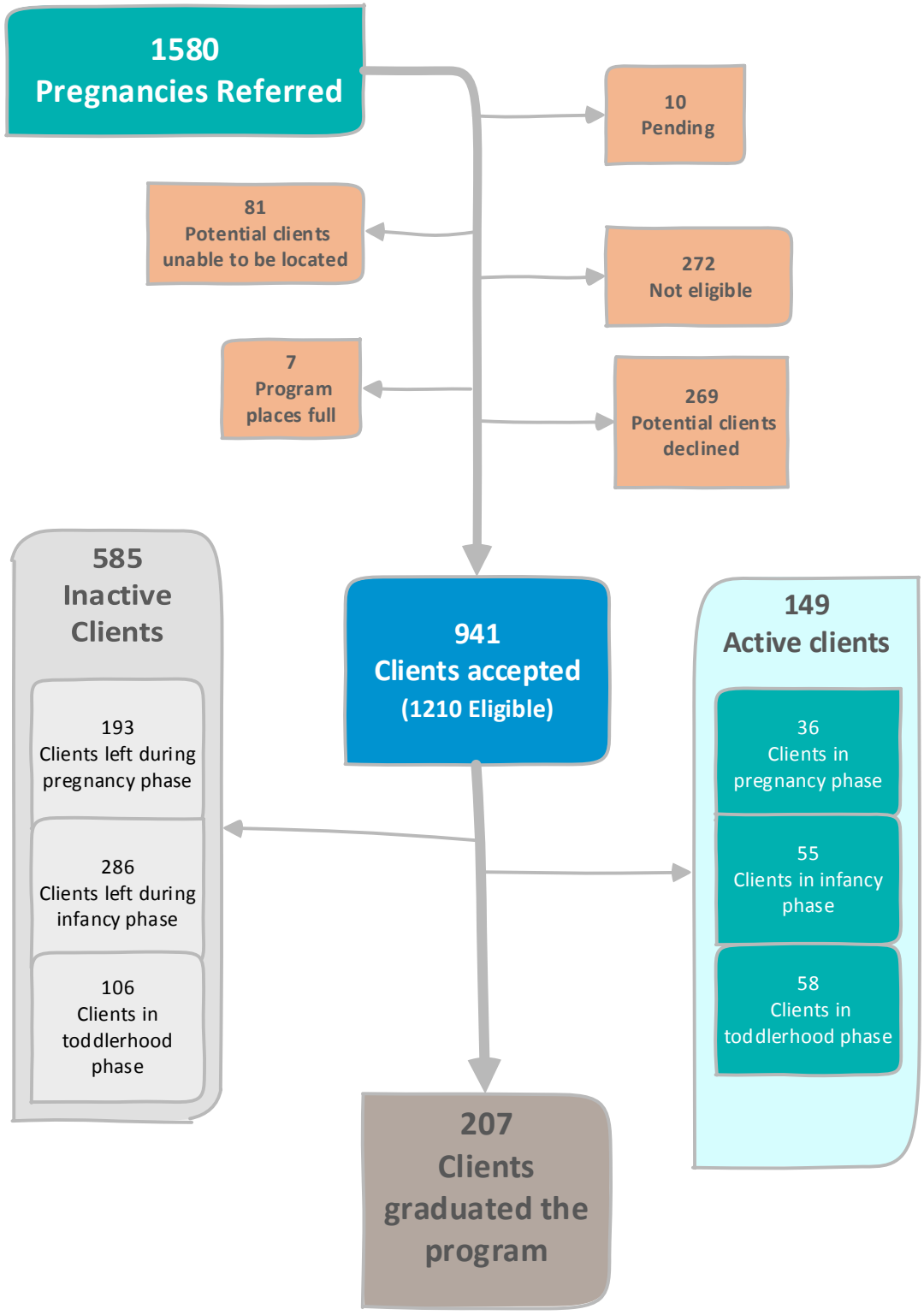


Figure 3. Referral outcomes flowchart from 1 March 2009 until 30 June 2016

4.2 Summary of Fidelity Measures

Table 3 provides a summary of key fidelity measures in a format similar to that provided in each site's quarterly fidelity report. Cumulative data in addition to data for individual reporting years is shown since the cumulative data for the program as a whole is less sensitive to changes than data for a single reporting year. For example, the cumulative client acceptance rate (percentage of eligible clients that go on to enrol into 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 81%.

Table 3. Summary of key fidelity measures regarding eligibility, parity, home visiting and client retention for 2014-15 and 2015-16

MEASURE	DETAIL	CUMULATIVE TO 30 JUNE 2015	CUMULATIVE TO 30 JUNE 2016	2014-2015	2015-2016	NFP OBJECTIVE
Client is a first-time mother (E2) excl. multiparous site/s*		97.4%	97.2%	92.8%	95.6%	100%
Client is a first time mother [E2] incl. multiparous site/s*		81.1%	81.2%	73.2%	82.1%	100%
Indigenous Status (Mother)*		92.2%	91.9%	93.9%	88.9%	-
Indigenous Status (Child)*		100%	100%	100%	100%	-
Client engagement [E4]	Acceptance	78%	78%	84%	81%	75%
	By 16th wk	41.1%	40.8%	34.5%	39.0%	60%
	By 28th wk	92.1%	91.7%	89.7%	89.0%	100%
	Mean gest. Age (weeks)	18.9	19.0	20.1	19.5	-
Visited in her home (E6)		61.5%	60.0%	57.1%	50.5%	-
Client Retention [E7]	Pregnancy	81.4%	79.6%	-	-	≥90%
	Infancy	61.2%	59.6%	-	-	≥80%
	Toddler	69.5%	69.5%	-	-	≥90%
	Overall	41.6%	37.8%	-	-	≥60%

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

Note: This report provides two results for the proportion of clients that are a first time mother since sites have differing policies regarding the acceptance of multiparous women.

As the client engagement figures demonstrate in Table 3, the referral and acceptance of women before the 16th week of pregnancy continues to be challenging for the program. Cumulatively up to June 2016, 40.8% of women were accepted by the 16th week of pregnancy compared to 2014-15 where 41.1% of clients were accepted into the program by the 16th week of pregnancy.

enrolment early in pregnancy remains challenging with **40.8%** of clients participating by week 16, less than the NFP target of **60%**

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. Previous discussions with the NFP international team have 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. This early acceptance enables the program to meet NFP targets of 60% accepted before the 16th week of pregnancy and also facilitates sufficient time in the program to enable a higher number of client visits. Additionally, the client is introduced to the program early enough in her pregnancy to enable a therapeutic relationship and behaviour change. An ongoing challenge is therefore to obtain client referrals to the program as early as possible since this can influence early engagement between the program and with eligible women.

Enrolment in the program for clients at a later stage of pregnancy is likely to be related to the time a client first presents to a hospital or midwife. If a client first presents later in pregnancy for their antenatal care, a referral agency can then only refer commensurate with that later stage of pregnancy.

To increase early referrals, sites cannot rely solely on referral agencies to refer sufficient eligible clients, but will also need an effective, consistent marketing campaign supported by the Community Reference Group to help ANFPP become a well-known program within the community. Also, many clients are teenagers or in their early twenties and rely heavily on social media for their advice and information. ANFPP may need to explore less traditional methods of referring (utilizing social media such as Facebook, YouTube and Twitter) rather than more traditional methods (brochures, phoning and faxing).

Additionally, engagement by staff (particularly the FPWs) at community and cultural events will help make connections with service providers and referral agencies. Staff may require additional community engagement training to market and promote the program.

Another possible strategy to increase early referrals to the program is to include current clients as a referral source and encourage clients to refer family members and friends who meet eligibility criteria.

Client retention continues to be a challenge for the program, with a cumulative retention rate of 37.8% for 2015-16 compared to a rate of 41.6% for 2014-15. The retention rate continues to be a focus of quality improvement activities, including the use of a client feedback survey form to actively seek more information about what keeps women in the program and whether previously unidentified conditions may contribute to the decision to leave the program. It is hoped that better information will reveal ways to improve the retention rate in the future. Refer to Table 4 for a summary of the available information on why women choose to leave the program.

3.8%

decline in cumulative retention of clients in ANFPP, less than the NFP target of **60%**

A decline in client retention rate is related to a decline in clients completing the program. This decline may be related to client disengagement and/or any reduction in workforce capacity. The time required to recruit and train new staff further impacts capacity to accept new referrals.

Exploring the reasons for client disengagement in detail will enable the program to understand and address the range of experiences that lead to disengagement and a client leaving the program before completion.

Additionally, strategies to increase staff retention will enable clients to establish an ongoing therapeutic relationship with a single NHV and subsequently increase client engagement and retention throughout the program.

The proportion of visits undertaken in the home is shown at E6 in Table 3. During 2015-16, 50.5% of visits occurred in the home. This result continues a decreasing trend of visits occurring in the home since 2013-14, with 57.1% of visits occurring in the home in 2014-15 and 63% for 2013-14. Cumulatively, the national rate of visits in the home for the program is 60.0% as at 30 June 2016. The location of visits is explored further in Section 5.6 Living Arrangements.

50.5%
of client visits occurred in the home compared to 57% in 2014/15

The location of client visits is generally not based on a NHV or FPW decision, but is client-driven based a range of issues and experiences. A common issue is housing, which influences the client to prefer visits outside of the home. For example, clients may live in an overcrowded house with other family members, be transient, or live in a shelter.

Strategies that have assisted to increase visits in the home with some clients have included:
1. Building rapport with family members.
2. Helping clients understand why visits are recommended at home, for example reassuring clients that staff will not judge their home or other family members.
3. Supporting clients to source secure housing options through referrals to housing support services and advocacy for supported accommodation.

An opportunity to collect the reason why a visit has not occurred in the home will be considered in a review of the DCS forms. This information would help in understanding the issues leading to visits occurring outside the home so that further strategies could be developed to meet the needs of clients.

4.3 Reasons for Leaving the Program

Table 4 below outlines the reason clients have left the program over the last two reporting years. Moving out of the service catchment area is the main reason given for clients leaving the program for 2014-15 and 2015-16. During 2015-16, 22% of clients were unable to have a service provided by the program, which reflects the situation at one site where there were insufficient NHVs throughout periods of the year. The other main reasons recorded for clients leaving the program during 2015-16 include excessive missed appointments (19.2%) and client unable to be located (14.4%). It is recognised that a certain level of client and staff attrition is expected and there may be complex reasons for clients leaving that are not influenced by program delivery. Collectively, 42.3% of women left the program during 2015-16 for unknown underlying reasons, for example, excessive missed appointments, unable to be located or reasons categorised as 'other'. This large proportion of clients leaving the program for unknown reasons highlights an opportunity to identify common factors and conditions that may influence a client's decision to leave the program and explore strategies to manage excessive missed appointments beyond 'discharging' the client.

Table 4. Reasons for leaving the program for 2014-15 and 2015-16

REASON FOR LEAVING	2014-15		2015-16	
	NO.	%	NO.	%
Moved out of service area	20	29.4%	25	24.0%
Program unable to service client	0	0.0%	23	22.1%
Excessive missed appointments / attempted visits	17	25.0%	20	19.2%
Unable to locate	6	8.8%	15	14.4%
Other reason for declining	8	11.8%	9	8.7%
Client feels she has received all she needs from the program	11	16.2%	5	4.8%
Miscarriage - end of program	2	2.9%	3	2.9%
Returned to work	1	1.5%	3	2.9%
Child no longer in family's custody	0	0.0%	1	1.0%
Receiving services from another program	1	1.5%	0	0.0%
Pressure from family members	1	1.5%	0	0.0%
Refused new NHV	1	1.5%	0	0.0%

4.4 Dosage (Visit Completion Rate)

Table 5 shows a summary of visits received by clients according to the clients' progression through each phase of the program. The count of visits includes home visits and telephone visits with program content. Ideally, clients complete 14 visits in pregnancy, 28 in infancy, and 22 visits in toddlerhood and the calculation for dosage rate as a percentage of expected visits uses these expected visit numbers.

Table 5. 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 from 1 March 2009 to 30 June 2016

Phase	Pregnancy Phase		Infancy Phase		Toddlerhood Phase		Entire program	
Indicator	In phase	Completed phase	In phase	Completed phase	In phase	Completed phase	In program	Completed program
Number of clients	878	703	669	369	315	207	941	207
Number of expected visits	8,030	9,842	13,951	10,332	5,606	4,554	27,823	13,248
Number of completed visits	5,620	5,225	7,490	5,992	3,501	2,895	16,611	8,400
Number of completed visits incl. telephone	5,843	5,426	7,952	6,300	3,754	3,098	17,549	8,810
Average. visits per client	6.7	7.7	11.9	17.1	11.9	15.0	9.4	42.6
Dosage rate % of expected	73%	55%	57%	61%	67%	68%	N/A	67%
Number of attempted visits	1,878	1,496	2,855	2,006	1,295	975	6,028	2,452
Average length of visit (mins)	65	-	63	-	66	-	-	64

Notes:

- *'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 and average visits are calculated using completed visits plus telephone visits.*
- *Average length of visit excludes telephone visits.*

Overall, women completing each phase receive 7.7 visits during pregnancy, 17.1 visits during infancy and 15 visits during toddlerhood (all including telephone visits with program content). Women graduating the program, on average, have received 42.6 visits (including telephone contact with the client where program content was delivered), or 67% of expected visits. Average length of visit is very stable across the program and remains at an average of 64 minutes per visit. The average visit length within each phase of the program has not changed since 2014-15.

67% of expected visits are received by ANFPP clients on average

64 minutes is the average length of ANFPP visits

There is a range of client issues which impact on the number of visits received by clients throughout the phases of the program. These include:
1. Late referral and acceptance into the program – clients will be unable to receive recommended number of visits during pregnancy phase.
2. Housing – clients may be homeless or unable to provide consistency with their location throughout the program.
3. Family responsibility – clients may not be able to attend appointments as family issues arise.
4. Cultural issues – clients may be unavailable for visits for extended periods.
5. Complex circumstances – clients may not be able to receive scheduled program visits due to circumstances such as IPV, addiction, or incarceration.
6. Clients' perception of the program – clients may view the program as an extension of clinical services, as a service that they only engage with when they have a crisis, or the program may be viewed more as friends who drop in and talk about the client's child and family.
7. Availability of other services – clients may feel they receive sufficient information from other services, for example hospitals and community midwives, or they may feel 'over-serviced' and unable to commit to attending all appointments for all services.

Strategies to address these issues include:
1. Educating the clients about the program in more detail and explaining the differences between the program and other services available.
2. Respect for periods of cultural leave (e.g. Sorry Business) followed up sensitively to re-engage clients.
3. Reminding clients there is an expectation that they attend booked appointments just as they would attend any medical appointment.
4. Early intervention where a FPW will follow up with a client after the first missed appointment.
5. Sites to consider options for flexible delivery of the program to address client needs and maintain engagement

At least one site is looking into developing a bi-monthly newsletter. The newsletter will include testimonials from clients regarding the benefits they have received from the program, with the aim to encourage client engagement after hearing the benefits of the program from their peers.

Table 6, Table 7 and Table 8 present the dosage percentages which comply with international reporting requirements. This method of calculation differs to the method used for data shown in Table 5 (which is based on comments obtained during the ANFPP National Annual Data Workshop held in 2015).

Table 6. Visit completion rate for pregnancy phase from 2012-13 to 2015-16

REPORTING YEAR	MEAN % EXPECTED VISITS ACHIEVED (ALL ACTIVE 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)
2015-16	72.8%	55.1%	20.5%
2014-15	72.7%	54.7%	20.1%
2013-14	71.5%	54.5%	20.3%
2012-13	71.4%	54.0%	20.6%

Table 7. Visit completion rate for infancy phase from 2012-13 to 2015-16

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)
2015-16	57.0%	61.0%	45.3%
2014-15	57.6%	60.9%	47.5%
2013-14	57.1%	61.4%	47.7%
2012-13	57.1%	60.8%	49.0%

Table 8. Visit completion rate for toddlerhood phase from 2012-13 to 2015-16

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)
2015-16	67.0%	68.0%	61.8%
2014-15	66.5%	67.5%	62.7%
2013-14	64.1%	65.5%	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.

4.5 Visit Content

Table 9, Table 10 and Table 11 outline the average time spent during the visits across the six program domains of:

- Personal health
- Environmental health
- Life course development
- Maternal role
- Family and friends
- Health and human services.

Visit time spent in the area of environmental health is high. Anecdotally, program staff report that this is due to client needs with regard to housing and environment. The NFP target for the maternal role domain is met for the pregnancy phase, however it is not met for the infancy and toddlerhood phases. This could be in part because, although the average time spent on maternal role increases after the pregnancy phase, the corresponding target also increases.

37.5%
of visit time was spent on the maternal role domain during the infancy phase

35.6%
of visit time was spent on the maternal role domain during the toddlerhood phase

The delivery of program content is planned for visits according to the phase of the program. However, flexible program delivery also considers changes in the personal circumstances of the client. A NHV may adjust program content for a visit to meet the needs of the client during the visit rather than deliver the planned content. For example, the environmental health or personal health domains may be covered in preference to maternal role where a client faces issues related to their housing such as overcrowding.

NHVs review the content delivered during visits and plan future visits to catch up on previous content that was unable to be delivered. However, maintaining a consistent and close alignment with planned visit content may be difficult to manage if a NHV has a caseload which includes a high proportion of clients with complex needs.

The potential implementation of the Strengths and Risks (STAR) Framework may assist to better understand how NHVs manage program content delivery around client specific circumstances.

Table 9. Average percent of time spent on the program domains in the pregnancy phase

DOMAIN	PREGNANCY			STATUS
	2014-15	2015-16	TARGET	
Personal health	34.4%	33.7%	35-40%	✓
Environmental health	9.4%	9.4%	5-7%	↑
Life course development	9.8%	10.1%	10-15%	✓
Maternal role	25.9%	25.5%	23-25%	↑
Family and friends	14.3%	14.6%	10-15%	✓
Health and human services	6.2%	6.7%	-	

Table 10. Average percent of time spent on the program domains in the infancy phase

DOMAIN	INFANCY			STATUS
	2014-15	2015-16	TARGET	
Personal health	20.1%	20.0%	14-20%	✓
Environmental health	10.9%	11.1%	7-10%	↑
Life course development	11.6%	11.8%	10-15%	✓
Maternal role	38.2%	37.5%	45-50%	↓
Family and friends	13.7%	13.8%	10-15%	✓
Health and human services	5.5%	5.8%	-	

Table 11. Average percent of time spent on the program domains in the toddlerhood phase

DOMAIN	TODDLERHOOD			STATUS
	2014-15	2015-16	TARGET	
Personal health	17.6%	17.2%	10-15%	↑
Environmental health	11.7%	11.8%	7-10%	↑
Life course development	15.6%	15.3%	18-20%	↓
Maternal role	37.1%	35.6%	40-45%	↓
Family and friends	14.1%	14.6%	10-15%	✓
Health and human services	3.9%	5.4%	-	

5 CLIENT DEMOGRAPHICS

The following sections provide information about the women in the program, their age, relationship, health, work and education participation, the involvement of fathers in the care of infants, and antenatal care. This information has been reported annually since 2014-15 following feedback from the 2015 Community of Practice and the National Annual Data Workshop.

Table 12 through Table 29 outline information that has been collected within ANFPP from 1 January 2012 until 30 June 2016. January 1 2012 was selected in agreement with implementing sites in 2013 as a starting date to target effort to improve the data completeness of records for reporting.

5.1 AGE OF WOMEN IN THE PROGRAM

21 years is the average age of women at program intake

The average age of women at intake into the program has been fairly stable at around 21 years of age. The age range of participants, from 13 years of age to 43 years of age, is useful information for informing program delivery since program delivery needs to be flexible to accommodate the differing needs of all age groups. The age of clients may also influence the likely disruptors to the mother-child dyadic relationships and expectations of program content and style of delivery.

Table 12. Age at intake for women participating in the program

AGE IN YEARS	2013-14	2014-15	2015-16
Cumulative no. of clients (N)	704	823	941
Mean age at intake	21	21	21
Median age at intake	20	20	20
Minimum age	13	13	13
Maximum age	41	43	43

Table 13. Mean, median, minimum and maximum age of women participating in the program by site

AGE IN YEARS 2015-16	Site	Site	Site	TOTAL
Cumulative no. of clients (N)	360	315	266	941
Mean	23	20	20	21
Median	22	19	19	20
Min	14	13	14	13
Max	43	37	36	43

5.2 Education and Workforce Participation of Women in the Program

Table 14 shows the highest level of education achieved by women after school at program intake. Half of all women who have participated in the program did not hold a level of education above secondary school when they commenced the program.

Table 14. Highest level of education achieved by women at program intake from 1 January 2012 to 30 June 2016

LEVEL OF EDUCATION	SITE		SITE		SITE		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Bachelor	5	2.8%	0	0.0%	4	2.1%	9	1.6%
Associate Diploma	2	1.1%	0	0.0%	3	1.6%	5	0.9%
TAFE or equivalent	13	7.2%	30	14.7%	55	29.4%	98	17.1%
Vocational	31	17.1%	61	29.9%	41	21.9%	133	23.3%
None	124	68.5%	82	40.2%	80	42.8%	286	50.0%
Unreported	6	3.3%	31	15.2%	4	2.1%	41	7.2%

Table 15. Highest level of education achieved by women when infant is aged 12 months from 1 January 2012 to 30 June 2016

LEVEL OF EDUCATION	SITE		SITE		SITE		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Bachelor	4	4.2%	0	0.0%	1	1.3%	5	2.3%
Associate Diploma	0	0.0%	0	0.0%	1	1.3%	1	0.5%
TAFE or equivalent	9	9.4%	7	15.2%	26	34.7%	42	19.4%
Vocational	18	18.8%	22	47.8%	13	17.3%	53	24.4%
None	57	59.4%	16	34.8%	33	44.0%	106	48.8%
Unreported	8	8.3%	1	2.2%	1	1.3%	10	4.6%

Table 16. Highest level of education achieved by women when toddler is aged 24 months from 1 January 2012 to 30 June 2016

LEVEL OF EDUCATION	SITE		SITE		SITE		Total	
	No.	%	No.	%	No.	%	No.	%
Bachelor	5	6.3%	0	0.0%	0	0.0%	5	3.0%
Associate Diploma	0	0.0%	1	2.6%	0	0.0%	1	0.6%
TAFE or equivalent	9	11.4%	15	38.5%	18	38.3%	42	25.5%
Vocational	21	26.6%	14	35.9%	8	17.0%	43	26.1%
None	40	50.6%	9	23.1%	21	44.7%	70	42.4%
Unreported	4	5.1%	0	0.0%	0	0.0%	4	2.4%

Table 17 shows that 17.1% of clients were in paid work, either full or part time, at intake. This figure reduces to 15.2% of clients when the infant is aged 12 months and increase again to 17% when the toddler is aged 24 months.

Table 17. Women participating in the program undertaking paid work at intake from 1 January 2012 to 30 June 2016

CURRENT WORK	SITE		SITE		SITE		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Full-time	17	9.4%	12	5.9%	25	13.4%	54	9.4%
Part-time	10	5.5%	10	4.9%	24	12.8%	44	7.7%
Not working	128	70.7%	106	52.0%	121	64.7%	355	62.1%
Unreported	26	14.4%	76	37.3%	17	9.1%	119	20.8%

Table 18. Women participating in the program undertaking paid work when infant is aged 12 months from 1 January 2012 to 30 June 2016

CURRENT WORK	SITE		SITE		SITE		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Full-time	3	3.1%	1	2.2%	4	5.3%	8	3.7%
Part-time	4	4.2%	4	8.7%	17	22.7%	25	11.5%
Not working	85	88.5%	27	58.7%	48	64.0%	160	73.7%
Unreported	4	4.2%	14	30.4%	6	8.0%	24	11.1%

Table 19. Women participating in the program undertaking paid work when toddler is aged 24 months from 1 January 2012 to 30 June 2016

CURRENT WORK	SITE		SITE		SITE		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Full-time	4	5.1%	5	12.8%	2	4.3%	11	6.7%
Part-time	5	6.3%	4	10.3%	8	17.0%	17	10.3%
Not working	64	81.0%	24	61.5%	35	74.5%	123	74.5%
Unreported	6	7.6%	6	15.4%	2	4.3%	14	8.5%

Income is a major determinant of economic wellbeing for most people and households (ABS, 2015). Within the ANFPP DCS, there are five questions at program intake regarding income and financial support, including household and individual income. Historically, there are data completeness issues with these questions which indicates that there may be more sensitive approaches to collecting information on whether the client has access to income and their knowledge of household income. It should also be noted that income is not an eligibility criteria for acceptance into the program in Australia.

Table 20 shows the household income at program intake during 2015-16. Over 25% of clients in the program report having a household income of less than $500 per week, which is substantially less than the average national household income in 2013–14 of $998 per week (ABS, 2015). Analysis of the income for individual clients shows that 60.8% of clients during 2015-16 reported a personal income of less than $500 per week.

>25%

of clients in the program reported having a household income of less than $500 per week

Table 20. Household income at program intake during 2015-16

HOUSEHOLD INCOME	TOTAL	
	NO.	%
< $500	25	25.8%
$500-999	21	21.6%
> $1000	15	15.5%
Don't know	31	32.0%
No income	1	1.0%
Unreported	4	4.1%

5.3 Involvement of Partners

Involved biological fathers are a protective factor against child maltreatment (Rosenberg & Wilcox, 2006), have a substantial influence on children's ability to read (Lloyd, 1999), and their caring can also result in better language and cognitive abilities as well as educational readiness and outcomes (Pruett, 2000).

13.8%

of home visits were attended by the client with their partner present

Table 21 outlines the involvement of partners during home visits with women participating in the program. Across the program, 13.8% of partners are present during home visits with the client. This rate ranges from 8.5% to 21% across the implementing sites.

Table 22, Table 23 and Table 24 show data related to the biological father of the child. Table 23 shows that across the program, approximately three quarters (73.5%) of clients talk to the biological father of the child daily. Given the frequency of daily contact between father and child also reported, there could be further opportunities to increase fathers' participation in home visits.

Table 21. Proportion of home visits where partner is also present during 2015-16

	SITE		SITE		SITE		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%
Partner present during home visit	1,028	11.9%	303	8.5%	1,012	21.0%	2,343	13.8%

Table 22. Proportion of clients where current partner is the biological father of the child at intake from 1 January 2012 to 30 June 2016

Partner is biological father of child	SITE		SITE		SITE		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%
Yes	140	81.9%	152	77.2%	132	72.1%	424	77.0%
No	1	0.6%	2	1.0%	12	6.6%	15	2.7%
Unsure	0	0.0%	0	0.0%	1	0.5%	1	0.2%
Unreported	30	17.5%	43	21.8%	38	20.8%	111	20.1%

Table 23. How often does the client talk to the biological father of the child at intake from 1 January 2012 to 30 June 2016

FREQUENCY	SITE		SITE		SITE		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%
Daily	127	74.3%	141	71.6%	137	74.9%	405	73.5%
At least once per week but not daily	14	8.2%	22	11.2%	10	5.5%	46	8.3%
Less than once per week	14	8.2%	15	7.6%	10	5.5%	39	7.1%
Not at all	14	8.2%	18	9.1%	26	14.2%	58	10.5%
Unreported	2	1.2%	1	0.5%	0	0.0%	3	0.5%

Table 24. How often did the baby's biological father spend time taking care of and/or playing with the baby (during the past 3 months) from 1 January 2012 to 30 June 2016

FREQUENCY	SITE		SITE		SITE		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%
Daily	193	59.6%	98	51.9%	156	60.5%	447	58.0%
At least once per week but not daily	37	11.4%	23	12.2%	28	10.9%	88	11.4%
Less than once per week	28	8.6%	23	12.2%	23	8.9%	74	9.6%
Not at all	62	19.1%	42	22.2%	48	18.6%	152	19.7%
Unreported	4	1.2%	3	1.6%	3	1.2%	10	1.3%

5.4 Indigenous Status of Accepted Clients

Table 25 shows the Indigenous status of all clients who have been accepted into the program. More than two thirds of clients in the program self-identify as Aboriginal.

Data quality: There is no indication of Indigenous status for over 10% of accepted clients. This proportion of accepted clients have no Demographic Details form available to identify the client's Indigenous status.

Table 25. Indigenous status of all accepted clients

INDIGENOUS STATUS	TOTAL	
	NO.	%
Aboriginal	646	68.7%
Torres Strait Islander	61	6.5%
Aboriginal and Torres Strait Islander	63	6.7%
Non-Indigenous woman with Indigenous partner	65	6.9%
Other	3	0.3%
Unreported	103	10.9%

5.5 Language

>15 languages other than English were identified by clients when asked about their primary language at program intake

The primary language of women in the program is collected at intake in three categories: English, Aboriginal or Torres Strait Islander language and other language. Primary language spoken was recorded as 'other' for 13% of clients, excluding where data is not available. Table 26 shows the primary language spoken, including where the 'other' language response was specified. 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 include:

- Asking about first language and tribal identity.
- Asking what language is spoken at home.
- Providing the ability to record multiple answers.
- Asking 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 26. Primary language spoken for clients accepted into the program from 1 January 2012 to 30 June 2016

PRIMARY LANGUAGE	TOTAL	
	NO.	%
English	469	82.0%
Aboriginal or Torres Strait Islander	19	3.3%
Aboriginal English, so described	11	1.9%
Torres Strait Creole	11	1.9%
Alyawarr (Alyawarra)	1	0.2%
Anmatyerr	4	0.7%
Arrernte (Aranda, Western and Eastern Arrente)	28	4.9%
Auslan	1	0.2%
Fijian	1	0.2%
Kalaw Kawaw Ya/Kalaw Lagaw Ya	1	0.2%
Luritja	3	0.5%
Makaton	1	0.2%
Pitjantjatjara	1	0.2%
Wambaya	1	0.2%
Warlpiri	7	1.2%
Yankunytjatjara	1	0.2%
Yolngu Matha	1	0.2%
Unreported	11	1.9%

5.6 Living Arrangements

During 2015-16, 50.5% of client visits occurred in the home. Overall, the rate of visits in the home from 1 January 2012 to 30 June 2016 is 60.0%. These figures support what has been reported anecdotally within the program – that it is often preferable based on a client's needs to conduct visits out of the home. This is perhaps due to a greater opportunity to discuss matters more freely, particularly matters related to other people normally residing in the home. Alternative visit locations that can provide a quiet place to meet and better suit the individual needs of the client include the ANFPP office environment, friends or families homes, or clinics.

Table 27 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 4.9. The maximum number of people living in the household ranges from 10 to 17 people across the sites. These figures would support the anecdotal information about the requirement to find a quiet place for visits, although model fidelity recommends that the majority of visits should occur in the home.

Table 27. Number of persons including client living in household for 4 or more nights a week at client intake from 1 Jan 2012 to 30 Jun 2016

NO. PERSONS LIVING IN HOUSEHOLD FOR 4 OR MORE NIGHTS	SITE	SITE	SITE	TOTAL
N	171	197	183	551
Mean	5.7	5.4	3.8	4.9
SD	2.7	2.6	1.9	2.6
Min	2	1	1	1
Max	17	13	10	17

5.7 Maternal Health of Women in the Program

Figure 4 shows the results of 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 (excluding the broad 'other' category). While this information is valuable, it provides only an indicator without enough detail to be of value in assessing underlying health conditions and meaningful discussion around preventative or early management for women participating in the program.

Considering mental health and depression (the second highest self-reported health condition amongst women participating in the program – excluding the broad 'other' category), the timing of collection of the Edinburgh Postnatal Depression Scale (EPDS) has been the subject of feedback from program staff. Previously 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, the EPDS has been removed from the Maternal Health Assessment Form and will be collected as a separate form as recommended by clinical guidelines.

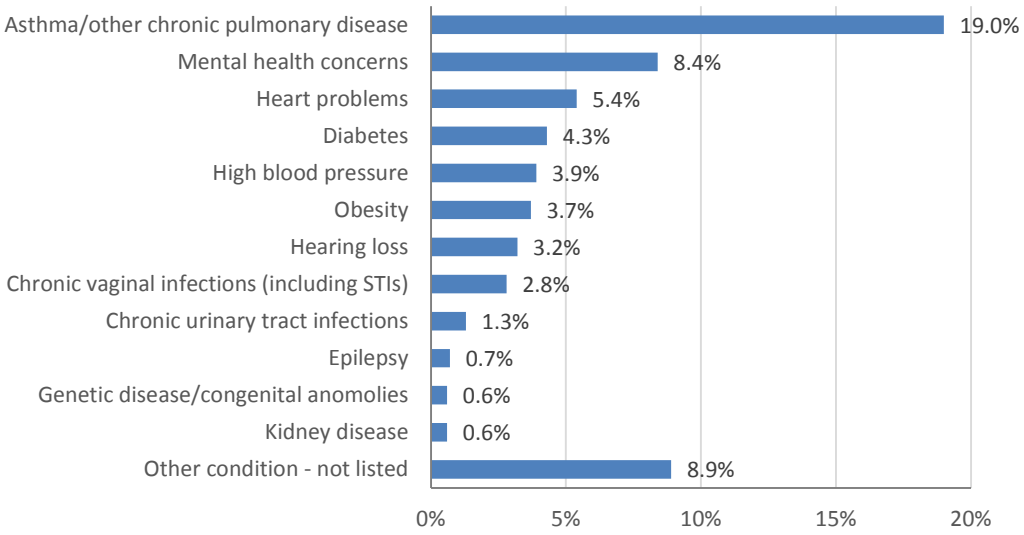


Figure 4. Presence of self-reported health condition at intake from 1 January 2012 to 30 June 2016

5.8 Antenatal Care

This section 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. Regular antenatal care in the first trimester (before 14 weeks gestational age) is associated with better maternal health in pregnancy, fewer interventions in late pregnancy and positive child health outcomes (Australian Institute of Health and Welfare, 2015).

94% of women in the program participated in antenatal care prior to program intake

Table 28 and Table 29 outline the proportion of women in the program who indicated they had received an initial antenatal visit and which stage of pregnancy that visit occurred. From 1 January 2012 to 30 June 2016, 94% of women in the program had participated in antenatal care prior to joining the program. The average gestational age for this initial antenatal visit is 10.1 weeks with a small variation in the average among sites, ranging from 9.4 weeks to 11.2 weeks across the program. Figure 5 shows that during 2015-16, 79.2% of clients in the program had their first antenatal visit before the 14th week of pregnancy. This compares very favourably with 62% of women in Australia in 2013 having their first antenatal visit before the 14th week of pregnancy (Australian Institute of Health and Welfare, 2015). It should be noted that these figures do not exclude any minimum or maximum gestational age for the first antenatal visit.

Table 28. Proportion of women who had received at least one antenatal for the referral pregnancy prior to entering the program from 1 January 2012 to 30 June 2016

CLIENTS WHO RECEIVED AN ANTENATAL VISIT PRIOR TO THE PROGRAM	SITE		SITE		SITE		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%
Number of clients	178	92.1%	179	91.1%	180	98.9%	537	94.0%

Table 29. Mean gestational age at first antenatal visit from 1 January 2012 to 30 June 2016

MEAN GESTATIONAL AGE AT FIRST ANTENATAL VISIT (WEEKS)	SITE	SITE	SITE	TOTAL
N	164	163	178	505
Mean	11.2	9.9	9.4	10.1
SD	6.5	5.1	5.3	5.7
Min	2	2	3	2
Max	34	26	28	34

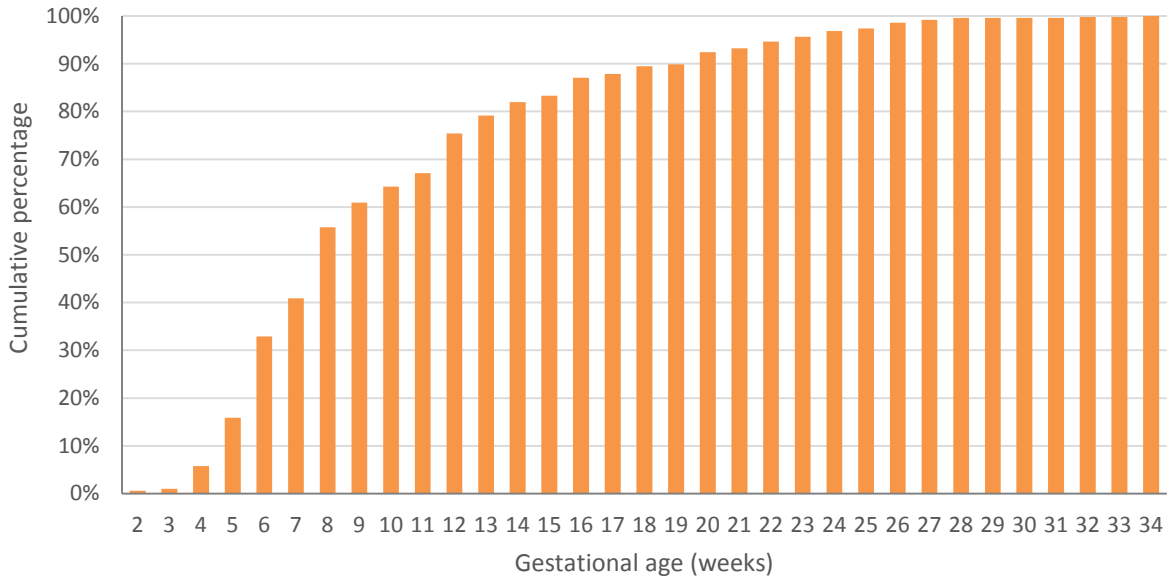


Figure 5. Percentage of ANFPP clients having first antenatal visit by gestational age for 2015-16

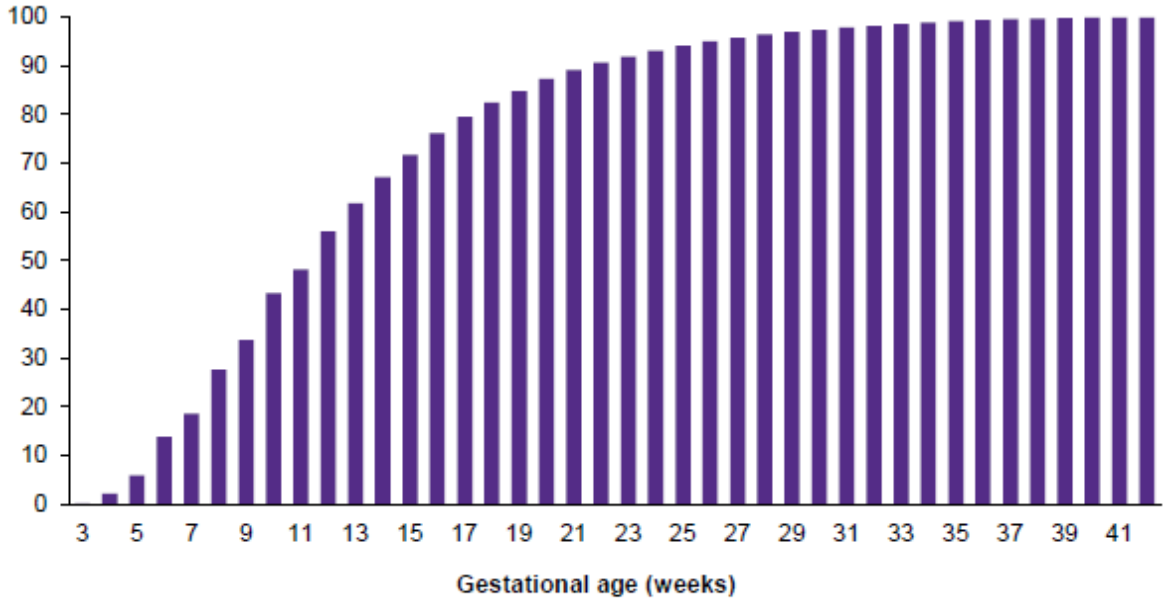


Figure 6. Percentage of Australian women having first antenatal visit by gestational age for 2013 (AIHW, 2015)

6 Program Outcomes

6.1 Life Course Development – Subsequent Pregnancies

Source: Demographic Details Update Form DM24

Table 30 shows the proportion of clients who have at least one pregnancy within 24 months after the birth from the program referred pregnancy. For 2015-16, 16.8% of women had a subsequent pregnancy within 24 months after the birth from the program referred pregnancy. The overall proportion of women having a subsequent pregnancy within 24 months has been below 20% since 2012-13, except for 2014-15 where the result was 23.6%.

Table 30. Percentage of clients with at least one pregnancy within 24 months after the birth of the referred pregnancy from 2012-13 to 2015-16

AT LEAST ONE PREGNANCY BY TODDLER AGE 24 MONTHS	TOTAL	
	NO.	%
2015-16	17	16.8%
2014-15	35	23.6%
2013-14	31	18.8%
2012-13	23	17.8%
2012-13 to 2015-16	106	19.5%

6.2 Cigarettes, Alcohol, Marijuana and Other Drug Use by Women in the Program

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

6.2.1 Data Completeness

Health Habits forms have been completed for approximately 74% of women joining the program during 2015-16. Additionally, there was a large proportion of completed Health Habits forms that did not have the phase provided. This potentially impacted the analysis of smoking and alcohol rates by phase. To counter this issue, the incomplete phase within a form was derived based on a calculation using the client's date of acceptance, infant date of birth and date the form was completed.

It should be noted that there is not a consistent number of Health Habits forms available across the three program phases. The largest number of forms available is for program intake (N=90). The number of forms available for clients at 36 weeks pregnant and at infant aged 12 months is less than half this figure (N=41 and N=39, respectively).

6.2.2 Smoking

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

The proportion of clients who smoke varies with the phase of the program. The lowest proportion of clients who smoke occurs at 36 weeks pregnant with much higher proportions occurring at infant age 12 months.

Table 31 shows that during 2015-16, the proportion of women reporting smoking in the two days prior to completing the Health Habits form at program intake is 38.9%.

Table 32 shows that during 2015-16, the proportion of women reporting smoking in the two days prior to completing the Health Habits form at 36 weeks pregnant is 29.3%. While this proportion is less than the proportion of clients smoking at intake, it does not indicate a reduction in smoking in individual clients across the program (see Table 37 for further details). However, the ANFPP results for clients smoking during pregnancy compare favourably with the 2013 national rates (the most recent published data available) where 47% of Indigenous mothers smoked during pregnancy (AIHW, 2015).

Table 33 shows that during 2015-16, the proportion of women reporting smoking in the two days prior to completing the Health Habits form at infant age 12 months is 71.8%.

Client's often cite stress as the main reason they return to smoking after the baby is born. Clients often live in households where other household members smoke which can increase the likelihood of the mother returning to smoking. A common perception mothers may have is that smoking outside will not harm their baby.

Strategies developed to support smoking cessation:
1. Improved education regarding the impacts of smoking beyond pregnancy.
2. For staff to be less accepting and more assertive when clients smoke during a visit.
3. Providing additional support to the client such as setting up activities with a smoking cessation team.

Table 31. Proportion of clients smoking in the two days prior at program intake

CLIENTS SMOKING IN THE TWO DAYS PRIOR AT PROGRAM INTAKE	TOTAL	
	NO.	%
2015-16	35	38.9%
2014-15	23	27.1%
2013-14	41	37.3%
2012-13	54	34.0%
2012-13 to 2015-16	153	34.5%

Table 32. Proportion of clients smoking in the two days prior at 36 weeks pregnant

CLIENTS SMOKING IN THE TWO DAYS PRIOR AT 36 WEEKS PREGNANT	TOTAL	
	NO.	%
2015-16	12	29.3%
2014-15	17	34.0%
2013-14	19	25.0%
2012-13	37	26.8%
2012-13 to 2015-16	85	27.9%

Table 33. Proportion of clients smoking in the two days prior at infant age 12 months

CLIENTS SMOKING IN THE TWO DAYS PRIOR AT INFANT AGE 12 MONTHS	TOTAL	
	NO.	%
2015-16	28	71.8%
2014-15	19	44.2%
2013-14	28	36.8%
2012-13	22	50.0%
2012-13 to 2015-16	97	48.0%

Table 34 to Table 36 shows that the average number of cigarettes smoked per day follows the same variation by program phase of clients who smoke. The lowest average number of cigarettes smoked per day occurs at 36 weeks pregnant (2.6) with a higher average occurring at infant age 12 months (4.5). While the average number of cigarettes smoked at 36 weeks pregnant is less than the average at program intake (3.4), this does not indicate a reduction in smoking in individual clients across the program (see Table 37 for further details).

Table 34. Average number of cigarettes smoked at program intake

AVERAGE NUMBER OF CIGARETTES SMOKED AT PROGRAM INTAKE	TOTAL	
	N	MEAN
2015-16	35	3.4
2014-15	23	1.9
2013-14	41	2.8
2012-13	54	3.8
2012-13 to 2015-16	153	3.1

Table 35. Average number of cigarettes smoked at 36 weeks pregnant

AVERAGE NUMBER OF CIGARETTES SMOKED AT 36 WEEKS PREGNANT	TOTAL	
	N	MEAN
2015-16	12	2.6
2014-15	17	1.8
2013-14	19	1.3
2012-13	37	2.6
2012-13 to 2015-16	85	2.1

Table 36. Average number of cigarettes smoked at infant age 12 months

AVERAGE NUMBER OF CIGARETTES SMOKED AT INFANT AGE 12 MONTHS	TOTAL	
	N	MEAN
2015-16	28	4.5
2014-15	19	6.2
2013-14	28	3.9
2012-13	22	6.4
2012-13 to 2015-16	97	5.1

Table 37 shows further analysis (paired samples t-test using SPSS) conducted on individual clients having an intake Health Habits form recorded during 2015-16 and a 36 week Health Habits form completed prior to 31 Dec 2016. This analysis shows no significant change in the average number of cigarettes smoked during pregnancy within the same cohort of clients. This is a departure from previous years' results that have shown a reduction in smoking during pregnancy.

It is recommended that monitoring continue in this important health aspect of pregnancy and the ANFPP supports collaboration with local and national Indigenous smoking reduction programs.

Table 37. Change in the average number of cigarettes smoked per client from intake to 36 weeks

YEAR	INTAKE			36 WEEKS			CHANGE IN MEAN	T (DF)	SIG*	95% CONFIDENCE INTERVALS	
	MEAN	SD	N	MEAN	SD	N					
2015-16	2.73	6.086	37	2.84	7.581	37	+0.11	T=-0.14 (37)	0.89	-1.67	1.453
2014-15	2.61	5.174	66	1.89	3.722	66	-0.72	T=2.2 (65)	0.03	0.073	1.351
2013-14	2.46	4.68	104	1.89	3.889	104	-0.57	T=3.4 (101)	0.001	0.237	0.898

6.2.3 Alcohol

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

The number of women consuming alcohol is very small so caution should be used when interpreting the results. Table 38 to Table 43 show that during 2015-16, the highest proportion of clients consuming alcohol in the program was at infant age 12 months, where 30.8% of women indicated alcohol consumption within the previous two weeks.

Table 38. Proportion of clients drinking alcohol in the two weeks prior at program intake

CLIENTS DRINKING ALCOHOL IN THE TWO WEEKS PRIOR AT PROGRAM INTAKE	TOTAL	
	NO.	%
2015-16	4	4.4%
2014-15	5	5.9%
2013-14	5	4.5%
2012-13	11	6.9%
2012-13 to 2015-16	25	5.6%

Table 39. Proportion of clients drinking alcohol in the two weeks prior at 36 weeks pregnant

CLIENTS DRINKING ALCOHOL IN THE TWO WEEKS PRIOR AT 36 WEEKS PREGNANT	TOTAL	
	NO.	%
2015-16	1	2.4%
2014-15	1	2.0%
2013-14	2	2.6%
2012-13	3	2.2%
2012-13 to 2015-16	7	2.3%

Table 40. Proportion of clients drinking alcohol in the two weeks prior at infant age 12 months

CLIENTS DRINKING ALCOHOL IN THE TWO WEEKS PRIOR AT INFANT AGE 12 MONTHS	TOTAL	
	NO.	%
2015-16	12	30.8%
2014-15	13	30.2%
2013-14	26	34.2%
2012-13	15	34.1%
2012-13 to 2015-16	66	32.7%

Table 41. Average number of drinks per day in the two weeks prior at program intake

AVERAGE NO. OF DRINKS PER DAY IN THE TWO WEEKS PRIOR AT PROGRAM INTAKE	TOTAL	
	N	MEAN
2015-16	4	0.1
2014-15	5	0.3
2013-14	5	0.3
2012-13	11	0.3
2012-13 to 2015-16	25	0.2

Table 42. Average number of drinks per day in the two weeks prior at 36 weeks pregnant

AVERAGE NO. OF DRINKS PER DAY IN THE TWO WEEKS PRIOR AT 36 WEEKS PREGNANT	TOTAL	
	N	MEAN
2015-16	1	0.0
2014-15	1	0.1
2013-14	2	0.1
2012-13	3	0.1
2012-13 to 2015-16	7	0.1

Table 43. Average number of drinks per day in the two weeks prior at infant age 12 months

AVERAGE NO. OF DRINKS PER DAY IN THE TWO WEEKS PRIOR AT INFANT AGE 12 MONTHS	TOTAL	
	N	MEAN
2015-16	12	2.6
2014-15	13	2.1
2013-14	26	1.9
2012-13	15	3.2
2012-13 to 2015-16	66	2.4

6.2.4 Use of Marijuana

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

The number of women reporting the use of marijuana is very small so caution should be used when interpreting the results. Table 44 to Table 46 show that during 2015-16, the highest self-reported marijuana use for women participating in the program was at 36 weeks pregnant, where 9.8% of women indicated use within the previous two weeks. The lowest self-reported marijuana use was 2.6% at infant age 12 months.

Table 44. Proportion of clients indicating the use of marijuana in the two weeks prior at program intake

CLIENTS USING MARIJUANA IN THE TWO WEEKS PRIOR AT PROGRAM INTAKE	TOTAL	
	NO.	%
2015-16	6	6.7%
2014-15	7	8.2%
2013-14	6	5.5%
2012-13	14	8.8%
2012-13 to 2015-16	33	7.4%

Table 45. Proportion of clients indicating the use of marijuana in the two weeks prior at 36 weeks pregnant

CLIENTS USING MARIJUANA IN THE TWO WEEKS PRIOR AT 36 WEEKS PREGNANT	TOTAL	
	NO.	%
2015-16	4	9.8%
2014-15	1	2.0%
2013-14	5	6.6%
2012-13	5	3.6%
2012-13 to 2015-16	15	4.9%

Table 46. Proportion of clients indicating the use of marijuana in the two weeks prior at infant age 12 months

CLIENTS USING MARIJUANA IN THE TWO WEEKS PRIOR AT INFANT AGE 12 MONTHS	TOTAL	
	NO.	%
2015-16	1	2.6%
2014-15	1	2.3%
2013-14	6	7.9%
2012-13	4	9.1%
2012-13 to 2015-16	12	5.9%

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 was no self-reported use of other drugs as defined in the Health Habits Forms for 2015-16 or 2014-15. As there are only three responses in earlier years indicating the use of other drugs, no further analysis is provided.

6.3 Infant Birth Cohort

Source: Infant Birth Form IB02 IB03

There were 87 infants born to women in the program between 1 July 2015 and 30 June 2016, including one set of twins. There were 54 girls (62.1%) and 33 boys (37.9%) born in this cohort.

Table 47. Gender of infants born to women participating in the program during 2015-16

GENDER	TOTAL	
	NO.	%
Female	54	62.1%
Male	33	37.9%
Total	87	100.0%

There have been 725 infants born to women in the program since the commencement of the program in March 2009 to 30 June 2016. Table 48 shows the number of births each year within the program.

Table 48. Number of infants born between 1 March 2009 and 30 June 2016

YEAR	NUMBER OF BIRTHS DURING YEAR	CUMULATIVE NUMBER OF BIRTHS
2008-09	2	2
2009-10	64	66
2010-11	116	182
2011-12	122	304
2012-13	136	440
2013-14	100	540
2014-15	98	638
2015-16	87	725

6.3.1 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 (before 37 completed weeks' gestation) is associated with a higher risk of adverse neonatal outcomes (AIHW, 2015). Table 49 shows that during 2015-16, 12.9% of babies born in the program were born pre-term (< 37 weeks gestation). In Australia, 14% of babies of Indigenous mothers were born pre-term in 2013, compared with 8% of babies of non-Indigenous mothers (AIHW, 2015).

Table 49. Percentage of singleton babies born at full-term (>=37 weeks gestation)

PROPORTION OF BABIES BORN AT FULL-TERM	SITE		SITE		SITE		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%
2015-16	29	85.3%	17	85.0%	28	90.3%	74	87.1%
2014-15	36	90.0%	22	84.6%	27	87.1%	85	87.6%
2013-14	38	95.0%	28	90.3%	27	93.1%	93	93.0%
2012-13	25	67.6%	29	87.9%	56	90.3%	110	83.3%

6.3.2 Birth Weight of Infants

A baby's birthweight is a key indicator of infant health and a determinant of a baby's chances of survival and health later in life (AIHW, 2015). According to the AIHW, babies are defined as low birth weight if their weight at birth is less than 2500 grams either as a result of prematurity or restricted foetal growth.

As shown in Table 50, during 2015-16, there were two full-term singleton babies born in the program with low birth weight. Table 51 shows that 9.9% of all singleton babies born during 2015-16 (which includes pre-term babies) had a low birth weight. This is a favourable result when compared to the proportion of low birthweight babies born to Aboriginal and Torres Strait Islander mothers nationally, which is 10.9% for 2013 (SCRGSP 2016). Table 52 shows that the birth weight of this cohort ranges from 2,100 to 5,098 grams.

9.9%

of full term babies born in 2015-16 to women in ANFPP had a low birth weight. The national average is 10.9% for full term babies born to Indigenous mothers

Table 50. Percentage of singleton babies born at full term (>=37 weeks) with a birth weight less than 2500 grams

BIRTH WEIGHT LESS THAN 2500 GRAMS (FULL-TERM BABIES)	TOTAL	
	NO.	%
2015-16	2	2.9%
2014-15	3	3.6%
2013-14	3	3.3%

Table 51. Percentage of singleton babies born with a birth weight less than 2500 grams

BIRTH WEIGHT LESS THAN 2500 GRAMS (ALL SINGLETON BABIES)	TOTAL	
	NO.	%
2015-16	8	9.9%
2014-15	10	11.2%
2013-14	5	5.2%
2012-13	20	15.2%

Table 52. Mean birth weight for full term (>=37 weeks) singleton babies born during 2015-16

MEAN BIRTH WEIGHT FOR FULL-TERM BABIES	SITE	SITE	SITE	TOTAL
N	27	16	27	70
Mean	3,325.1	3,334.4	3,436.9	3,370.4
SD	566.0	525.1	480.9	527.8
Min	2,100	2,700	2,100	2,100
Max	5,098	4,280	4,260	5,098

6.3.3 Breastfeeding

Sources: Infant Birth Form and Infant Health Care Form at Infancy 6 months, 12 months and Toddlerhood 12 month and 24 months. IB09, HC12, HC14 and HC27

Breastfeeding information within ANFPP is collected at 6 monthly intervals. Table 53 shows that overall, during 2015-16, 50% of infants within the program are continuing to breastfeed at six months of age. This compares to the Australian average where only 15% of infants are exclusively breastfed to around six months of age (NHMRC 2012). It should be noted that the program results vary substantially by site, and with small numbers of complete data available, these results should be interpreted with caution. The most recent guidelines for Australia recommend that infants are exclusively breastfed until around 6 months of age when solid foods are introduced (NHMRC 2012).

Table 53. Proportion of infants being breastfed by stage for 2015-16

PROPORTION OF INFANTS BEING BREASTFED	TOTAL	
	NO.	%
After birth	81	94.2%
6 months	14	50.0%
12 months	18	46.2%
18 months	10	30.3%
24 months	9	31.0%

Table 54 shows the average age across the program when exclusive breastfeeding ceased was 12.3 weeks during 2015-16.

Table 54. Mean age of infant in weeks when exclusive breastfeeding ceased during 2015-16.

MEAN AGE (WEEKS) WHEN EXCLUSIVE BREASTFEEDING CEASED	TOTAL
N	110
Mean	12.3
SD	8.7
Min	0
Max	24

Data quality: It should be noted that there is not a consistent number of forms available across the five stage cohorts for a reliable comparison. The largest number of forms with data available is the Infant Birth form after birth (N=86). The number of forms available for clients at subsequent stages is generally less than half this figure (N=28, N=39, N= 33, N=29 for the 6-month, 12-month, 18-month and 24-month stages respectively). Data regarding the age when exclusive breastfeeding ceased is approximately 80% complete.

6.4 Neonatal Intensive Care

Sources: Infant Birth Form IB04

Table 55 and Table 56 summarise information collected in the Infant Birth Form about the proportion of infants admitted to neonatal intensive care units (NICU) and the number of days infants were admitted to NICU by the mother's self-report. During 2015-16, the overall percentage of babies in the program spending any days in the NICU was 24.4%. This is similar to the national

rate for Indigenous babies which is 24% for 2013 (AIHW, 2015). The reasons for admission are not currently collected by ANFPP.

Data quality: There may be differences in the classification of referral to NICU across the jurisdictions. This means that the total figure across sites may be unreliable based on the different methods of interpretation and collection across sites.

Table 55. Proportion of infants being admitted to neonatal intensive care unit (mother's self-report) from 2012-13 to 2015-16

PROPORTION OF INFANTS ADMITTED TO NICU	TOTAL	
	NO.	%
2015-16	22	24.4%
2014-15	22	22.2%
2013-14	21	21.0%
2012-13	35	25.9%
2012-13 to 2015-16	100	23.6%

Table 56. Mean, standard deviation, minimum and maximum days in NICU for infants in 2015-16

AVERAGE DAYS IN NICU	TOTAL
N	22
Mean	7.1
SD	7.6
Min	1
Max	30

6.5 Childhood Injuries and Ingestion

Source: Infant Health Care Form HC08 HC09.

Table 57 and Table 58 present results for children presenting at clinics for injury and/or ingestion. During 2015-16, the proportion of children presenting at GP surgeries and accident and emergency clinics for concern of swallowing something harmful or injuries is 5.5% for infants aged 0-12 months and 9.1% for infants and toddlers aged 13-24 months. Both of these figures are a small increase compared to figures in 2014-15 (3.8% for both cohorts), however, the small numbers involved mean that any results require cautious interpretation.

Table 59 and Table 60 present results for children admitted to hospital for injury and/or ingestion. During 2015-16, the proportion of children admitted to hospital for injury or ingestion is 6.8% for infants aged 0-12 months and 4.5% for infants and toddlers aged 13-24 months. Both of these figures are a small increase compared to figures in 2014-15 (1% for both cohorts), however, the small numbers involved mean that any results require cautious interpretation.

5.5% of infants 0-12 months presented at clinics for injury or ingestion compared to 9.1% for infants and toddlers 13-24 months

6.8% of infants 0-12 months were admitted to hospital for injury or ingestion compared to 4.5% for infants and toddlers 13-24 months

For comparison with the Australian average, for the period 2011–13, 1.2% of Indigenous infants aged less than 12 months were hospitalised due to injury (AIHW 2016). It should be noted that the results for the program combine injury and ingestion and are based on very small numbers and should be interpreted with caution.

Table 57. Proportions of infants aged 0-12 months presenting to clinics (mother's self-report) for injury or ingestion from 2012-13 to 2015-16

PROPORTION OF INFANTS AGED 0-12 MONTHS PRESENTING TO CLINICS FOR INJURY/INGESTION	TOTAL	
	NO.	%
2015-16	4	5.5%
2014-15	4	3.8%
2013-14	13	8.3%
2012-13	6	5.4%
2012-13 to 2015-16	27	6.1%

Table 58. Proportions of toddlers aged 13-24 months presenting to clinics (mother's self-report) for injury or ingestion from 2012-13 to 2015-16

PROPORTION OF TODDLERS AGED 13-24 MONTHS PRESENTING TO CLINICS FOR INJURY/INGESTION	TOTAL	
	NO.	%
2015-16	6	9.1%
2014-15	4	3.8%
2013-14	9	10.3%
2012-13	7	13.0%
2012-13 to 2015-16	26	8.4%

Table 59. Proportions of infants aged 0-12 months admitted to hospital (mother's self-report) for injury or ingestion from 2012-13 to 2015-16

PROPORTION OF INFANTS AGED 0-12 MONTHS ADMITTED TO HOSPITAL FOR INJURY/INGESTION	TOTAL	
	NO.	%
2015-16	5	6.8%
2014-15	1	1.0%
2013-14	10	6.4%
2012-13	5	4.5%
2012-13 to 2015-16	21	4.7%

Table 60. Proportions of toddlers aged 13-24 months admitted to hospital (mother's self-report) for injury or ingestion from 2012-13 to 2015-16

PROPORTION OF TODDLERS AGED 13-24 MONTHS ADMITTED TO HOSPITAL FOR INJURY/INGESTION	TOTAL	
	NO.	%
2015-16	3	4.5%
2014-15	1	1.0%
2013-14	7	8.0%
2012-13	1	1.9%
2012-13 to 2015-16	12	3.9%

6.6 Immunisation

Source: Infant Health Care Form HC03 and HC04

The percentage of infants with up-to-date immunisations are shown in Table 61. The underlying data is small due to a technical issue which has resulted in limited availability of this data (see Data quality section below). No further analysis is provided due to the unreliability of the small numbers and the lack of representation of two sites in the data.

Data quality: A change in the Infant Health Care form used for collection of immunisation data during 2015-16 has resulted in some data being unavailable within the data extract files from sites. Data is currently only available for one site from 1 July 2015 to 28 February 2016. It is expected that all immunisation data will be available for reporting when the technical issue is resolved.

Table 61. Proportions of infants aged 0-12 months with up-to-date immunisations during 2015-16

STAGE	YES		NO		TOTAL	UNAVAILABLE
	NO.	%	NO.	%		
6 Months	6	100%	0	0%	6	24
12 Months	9	81.8%	2	19.2%	11	32
18 Months	6	66.7%	3	33.3%	9	26
24 Months	13	100%	0	0%	13	18

6.7 Ages and Stages Questionnaires

Source: Infant Health Care Form HC21, HC22, HC23, HC16, Ages and Stages Questionnaire Result Form AS03 and Ages and Stages Questionnaire: Social and Emotional Development Result Form AS04

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 DCS Version 2.5, which was implemented across sites during 2015-16, has separate ASQ and ASQ:SE data entry forms.

Table 62 through Table 65 outline the mean scores for the questionnaires at each age group during 2015-16. There was a very low proportion of children within the program that fell below the cut off score for follow-up and potential referral. Overall during 2015-16, there were no children in the four month age group below the cut-off score. The highest number of children below the cut-off score is for the 20 month age group in the communication area, where four children (10.8%) were below the cut-off score.

Table 62. Ages and stages questionnaire results for 4-month age group during 2015-16*

ASQ 4-MONTH AGE GROUP*	COMMUNIC-ATION	GROSS MOTOR	FINE MOTOR	PROBLEM SOLVING	PERSONAL / SOCIAL
N	28	28	28	28	28
Mean	55.5	57.5	55.4	57.7	55.7
SD	5.7	4.5	6.1	4.3	6.5
Min	45	45	40	45	40
Max	60	60	60	60	60
Below cut-off score N (%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Table 63. Ages and stages questionnaire results for 10-month age group during 2015-16*

ASQ 10-MONTH AGE GROUP*	COMMUNIC-ATION	GROSS MOTOR	FINE MOTOR	PROBLEM SOLVING	PERSONAL / SOCIAL
N	35	35	35	35	35
Mean	55.0	50.7	55.4	51.1	52.0
SD	6.3	10.8	7.4	10.4	9.7
Min	35	10	25	20	20
Max	60	60	60	60	60
Below cut-off score N (%)	0 (0%)	1 (2.9%)	1 (2.9%)	2 (5.8%)	1 (2.9%)

Table 64. Ages and stages questionnaire results for 14-month age group during 2015-16*

ASQ 14-MONTH AGE GROUP*	COMMUNIC-ATION	GROSS MOTOR	FINE MOTOR	PROBLEM SOLVING	PERSONAL / SOCIAL
N	22	22	22	22	22
Mean	52.3	58.4	51.4	50.2	49.8
SD	8.5	3.5	7.7	6.3	11.7
Min	30	50	40	40	10
Max	60	60	60	60	60
Below cut-off score N (%)	1 (4.5%)	0 (0%)	0 (0%)	0 (0%)	1 (4.5%)

Table 65. Ages and stages questionnaire results for 20-month age group during 2015-16*

ASQ 20-MONTH AGE GROUP*	COMMUNIC-ATION	GROSS MOTOR	FINE MOTOR	PROBLEM SOLVING	PERSONAL / SOCIAL
N	37	37	37	37	37
Mean	49.9	56.1	53.2	46.1	53.9
SD	11.5	9.3	6.7	8.6	8.3
Min	20	10	35	30	25
Max	60	60	60	60	60
Below cut-off score N (%)	4 (10.8%)	1 (2.7%)	1 (2.7%)	0 (0%)	1 (2.7%)

Seventy-eight ASQ:SE scores were entered in the DCS for infants within the program during 2015-16. These results are shown in Table 66. The results for the small cohort in each age group show that only one infant across all cohorts had a result over the cut off score for follow-up and potential referral.

Table 66. Ages and stages: Social and emotional questionnaire results during 2015-16

ASQ:SE	6-MONTH*	12-MONTH*	18-MONTH*	24-MONTH*
N	15	31	18	14
Mean	13.0	12.4	12.5	13.6
SD	15.8	7.5	8.2	6.1
Min	0	0	5	5
Max	60	40	35	25
Over cut-off score N (%)	1 (6.7%)	0 (0%)	0 (0%)	0 (0%)

6.8 English Language Assessment

Source: English Language Assessment EL01

The current ANFPP DCS is not able to track how many infants are aged 21 months in the program within the reporting year. This situation affects the analysis and interpretation of results for the English Language Assessment since 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 skewed relative to the actual results for the population of infants.

The NPC is in the process of establishing a new system to resolve these issues so that descriptions of the number of infants and the gender ratio can be available for these analyses in the future, which will also inform quality improvement activities in practice. This would also include ensuring this assessment is conducted at the appropriate age for the majority of infants.

Table 67 outlines the proportion of English Language Assessments completed by gender. During 2015-16, more than two thirds of the assessments were completed by girls. Overall, the numbers comprising the cohort are small.

Table 67. Gender of infants having a completed English Language Assessment for 2015-16

GENDER ALL AGES	TOTAL	
	NO.	%
Female	19	68%
Male	9	32%
Total	28	100%

Table 68 shows the results of the language assessments conducted during 2015-16. Overall, there is an increase in the average number of words identified for 2015-16 (41.1) when compared to the result for 2014-15 (35.9). The mean number of words is generally higher for females than males. The individual number of words identified ranges from 6 to 67 words.

*Table 68. Mean, standard deviation, minimum and maximum words identified in the language assessment at 21 months**

2015-16 21 MONTHS*	TOTAL		
	FEMALE	MALE	TOTAL
N	13	8	21
% (of all ages)	68%	89%	75%
Mean	46.5	32.4	41.1
SD	9.8	13.7	13.3
Min	36	6	6
Max	67	60	67

7 DATA QUALITY IMPROVEMENT

Opportunities for improvement in the collection and monitoring of ANFPP data have been identified throughout this report. Table 69 summarises these opportunities as a quick reference for future consideration at appropriate forums for discussion, including the ANFPP Data Group and the ANFPP National Annual Conference.

Table 69. Data Quality Improvement Recommendations from the National Annual Data Report

TOPIC	SUGGESTION	FORM	PAGE REF.
Primary Language	Consider broadening information collected about language within the program and improving cultural sensitivity and information available	Demographic Details Forms	25-26
Health Conditions	Consider more accurate collection of underlying health conditions such as gestational diabetes and details of heart conditions and review condition list for relevancy.	Maternal Health Assessment Forms	27-28
Demographic Information	Review the information provided in this report and determine enhancements. Consider data collection items that enable comparability of results to Australian averages, for example, regarding smoking, alcohol and other drug use. Also explore more appropriate mechanisms to identify income and whether this item is a critical factor for the purposes of the ANFPP.	Demographic Details Forms	20-27 31-38
Collection of ASQ and ASQ:SE Information	Implement mechanisms for identifying infant cohorts to support interpretation of results and quality improvement activities.	ASQ Data Entry Forms & National Data Set	46-48
Immunisations	Implement mechanisms for identifying infant cohorts and further detail regarding timing of immunisations to support interpretation of results.	Infant Healthcare Form & National Data Set	46
Client Attrition	Research suggestion to explore the reasons clients leave the program, for example, is it in certain phases; are commonalities evident from the data?	Client feedback survey/form	5-13

8 DATA ANALYSIS NOTES

This report is intended to provide relevant and current information about ANFPP as sourced from the DCS. Therefore it focusses on the summary data as it aligns with model fidelity and outlines outcomes and achievements from available information for 2015-16 with some comparisons to other years' results. It is not intended as an evaluation of the program.

The key data analysis notes include:

- Where a form is in error or duplicated, it has been excluded from the analysis.
- Where data regarding the client's stage in the program is missing from the form, this has been calculated using the infant's date of birth and the date of the relevant form, so that no stage data is missing for the analysis.
- Missing data for immunisation from the revised Infant Health Care Form will be followed up for inclusion in future data extract files, so that it is available for future reporting.
- 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 figures presented in previous reporting years. This can be the result of changes in methodology of calculation or targeted data quality activities that adjust previous data through improved completion (where more data is available) or validation (where data errors are corrected). It is recommended that where possible, the most recent Annual Data Report is used for historical reporting, specifically around incoming referrals and active clients.

9 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 program to represent a client who has consented to participate in ANFPP. The client may or may not have had an initial home visit and may have subsequently left the program.
As at 30 June 2016 or 30 June 2015	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 (rather than recorded as completed).
Data Group	A meeting with representatives of implementing sites and the Commonwealth Department of Health to discuss and consult with regard to the ANFPP DCS.
Dosage	The number of completed visits a client receives from the NHV 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.
Fully Immunised	Completed by the NHV 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 in 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 2015 to 30 June 2016.
Standard Deviation	This is reported when 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 Standard Deviation will also be in months.
NFP Model Fidelity	The extent to which the program aligns with the model elements of the NFP 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.

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11 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 QLD 4064.