



**Australian Nurse-Family Partnership Program (ANFPP)**

**National Support Service**

# **National Annual Data Report**

*1 July 2020–30 June 2021*

## ANFPP NATIONAL SUPPORT SERVICE

Molly Wardaguga Research Centre | Charles Darwin University

Level 11 East Tower, 410 Ann Street | Brisbane QLD 4000 Australia

## ANFPP GENERAL ENQUIRIES

[info@anfpp.com.au](mailto:info@anfpp.com.au)

07 3169 4283 or 0448 570 503 (during business hours)

## ANFPP TRAINING AND EDUCATION SUPPORT

[education@anfpp.com.au](mailto:education@anfpp.com.au)

## ANFPP IT SUPPORT

[helpdesk@anfpp.com.au](mailto:helpdesk@anfpp.com.au)

## ANFPP MEDIA ENQUIRIES & MARKETING MATERIALS

[communication@anfpp.com.au](mailto:communication@anfpp.com.au)

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## Cultural Acknowledgement

The Australian Nurse-Family Partnership Program (ANFPP) National Support Service (NSS) acknowledges the Traditional Custodians of the lands and waters on which we live and work. We pay respect to Elders past and present.

We further acknowledge that Aboriginal and Torres Strait Islander people and communities are diverse and dynamic and continue to evolve and develop in response to historical and present social, economic, cultural and political circumstances. Diversity includes gender, age, languages, backgrounds, sexual orientations, religious beliefs, family responsibilities, marriage status, life and work experiences, personality and educational levels<sup>1</sup>.

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1 Commonwealth of Australia. (2013). National Aboriginal and Torres Strait Islander Health Plan 2013- 2023. Canberra, Australia: Commonwealth of Australia.

## Abbreviations

<b>ACCHO</b>	Aboriginal Community Controlled Health Organisation
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>ANFPP</b>	Australian Nurse-Family Partnership Program
<b>CME</b>	Core Model Element
<b>EPDS</b>	Edinburgh Postnatal Depression Scale
<b>FPW</b>	Family Partnership Worker
<b>NFP</b>	Nurse-Family Partnership
<b>NHV</b>	Nurse Home Visitor
<b>NSS</b>	National Support Service
<b>US</b>	United States
<b>WHO</b>	World Health Organization

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## Executive Summary

The Australian Nurse-Family Partnership Program (ANFPP) National Annual Data Report 2020-21 is focused on the reporting period from July 1 2020 to June 30 2021. In addition, we include data representing previous annual reporting periods from 2017-2018 for the purpose of tracking progress, as well as aggregated data for the ANFPP duration from 2009 when the program commenced in Wave 1 Australian sites. There has been significant cleaning and updating of the ANFPP 2009-21 data collection during 2020-21.

The current version of the National Support Service (NSS) has been operational since July 1 2020. This Annual Report represents the first year of NSS operation, and reports on data generated from sites that have been running between four and 12 years, depending on their year of establishment.

The NSS has implemented a number of strategies from a strategic, education and site support perspective to improve the quality, analysis and presentation of data. In our first 12 months of operation we have achieved a number of successes underpinned by the following:

- The generation of Client Completeness and Data Quality Reports. Reports are sent to each site prior to every quarterly reporting period to identify quality issues that will negatively impact on data reporting. This has led to decreased missing data and increased accuracy of data, however, improvements are still required. Challenges around working across two data systems (Communicare and ANKA) has resulted in being unable to combine variables in some circumstances, as explained in the body of this report where relevant.
- The ANFPP curriculum is provided across three core units. The NSS has embedded additional education regarding data across all three units. Our focus has been on how data benefits clients, families and communities (in addition to the Australian government or University of Colorado). Our messaging includes 'data belongs to women and sites, not the NSS'; 'data tells a woman's and her child's story' and 'what are we doing that is or is not captured in the data', etc. We believe this messaging has led to significant improvements in ownership and investment of data at the site level.
- Using data through Continuous Quality Improvement activities called 'Quality Site Self-Assessment' (QSSA) in the ANFPP. The QSSA process has been reviewed and redeveloped over the past year to now include presentation of site level data reviewed by the site teams in a process that is facilitated by the NSS. Teams are then supported to identify their own

priority areas for quality improvement cycles over the next 12 months. These action plans are reviewed three monthly, using additional data to improve progress.

- Having a Systems Manager (Associate Professor Sandy Campbell) who has a clinical midwifery background, combined with epidemiology qualifications has resulted in improved interrogation and analysis of the data, that has not been reported in Australia to date. We are confident that our analysis and reporting will continue to improve over the months and years ahead as we refine and improve our data systems and data entry.
- Embedding the NSS within the Molly Wardaguga Research Centre at the Charles Darwin University has also provided a strong research and evaluation platform to inform the NSS activities. Access to expertise in research (specifically First Nations maternal and child health research), health economics, statistics, evaluation and monitoring across the Molly team has benefited the activities and quality of our data and services.
- Leadership by our First Nations Team members ensures our work privileges First Nations Knowledge and Ways of Working. The NSS proudly reports a 36% composition of team members who identify as Aboriginal and/or Torres Strait Islander. This enhances our ability to ensure our work meets the needs of the sites and families engaged in the ANFPP program.

### **How to read this report**

The report is organised into sections. The introduction at Section 1 provides a brief overview of the ANFP Program including the data collection system. Readers wanting more detailed information on the ANFPP are referred to the Australian and international Nurse-Family Partnership program websites<sup>2</sup>. There is also information on the initial response by program sites to the COVID-19 pandemic.

Section 2 provides a data summary from 2009-2021 and includes ANFPP data on approximately 1880 women who have enrolled in the program. A comparison of multiparous and first-time mothers shows that the majority of multiparous mothers were enrolled in remote areas. Their characteristics

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<sup>2</sup> [www.anfpp.com.au](http://www.anfpp.com.au) or [www.nursefamilypartnership.org/](http://www.nursefamilypartnership.org/)

differ from first-time mothers, however, it's likely we would find many of the same differences in a comparison between women from remote areas and the other Australian remoteness areas.

Sections 3 and 4 of the report are about operational aspects of the ANFPP including program implementation and workforce. Sections 5 and 6 are focused on the ANFPP clients in 2020-21. Section 5 includes a descriptive analysis of client characteristics and Section 6 describes selected program outcomes. Australian Institute of Health and Welfare data are used throughout Section 6 to compare ANFPP outcomes with those of Aboriginal and Torres Strait Islander mothers and babies nationally.

The final section of the report includes conclusions and future directions. A table at Appendix 1 summarises the ANFPP Core Model Elements and related benchmarks for 2020-21. Multiparous and first-time mothers were reviewed in relation to program attrition and is presented in Appendix 2.

As far as possible, to enhance clarity for readers, information about denominators and missing data is included in the tables and graphs in the report. There are three frequently used denominators: first, the number of active clients at June 30 2020-21 n= 561; second, the number of clients enrolled/accepted in 2020 n=449; and third, the number of singleton babies born in the program in 2020-21 n = 281. The denominator selected for use in each table or graph is dependent on the information being presented. Where practicable, the amount of missing data is noted either within tables and graphs, or as part of a footnote.

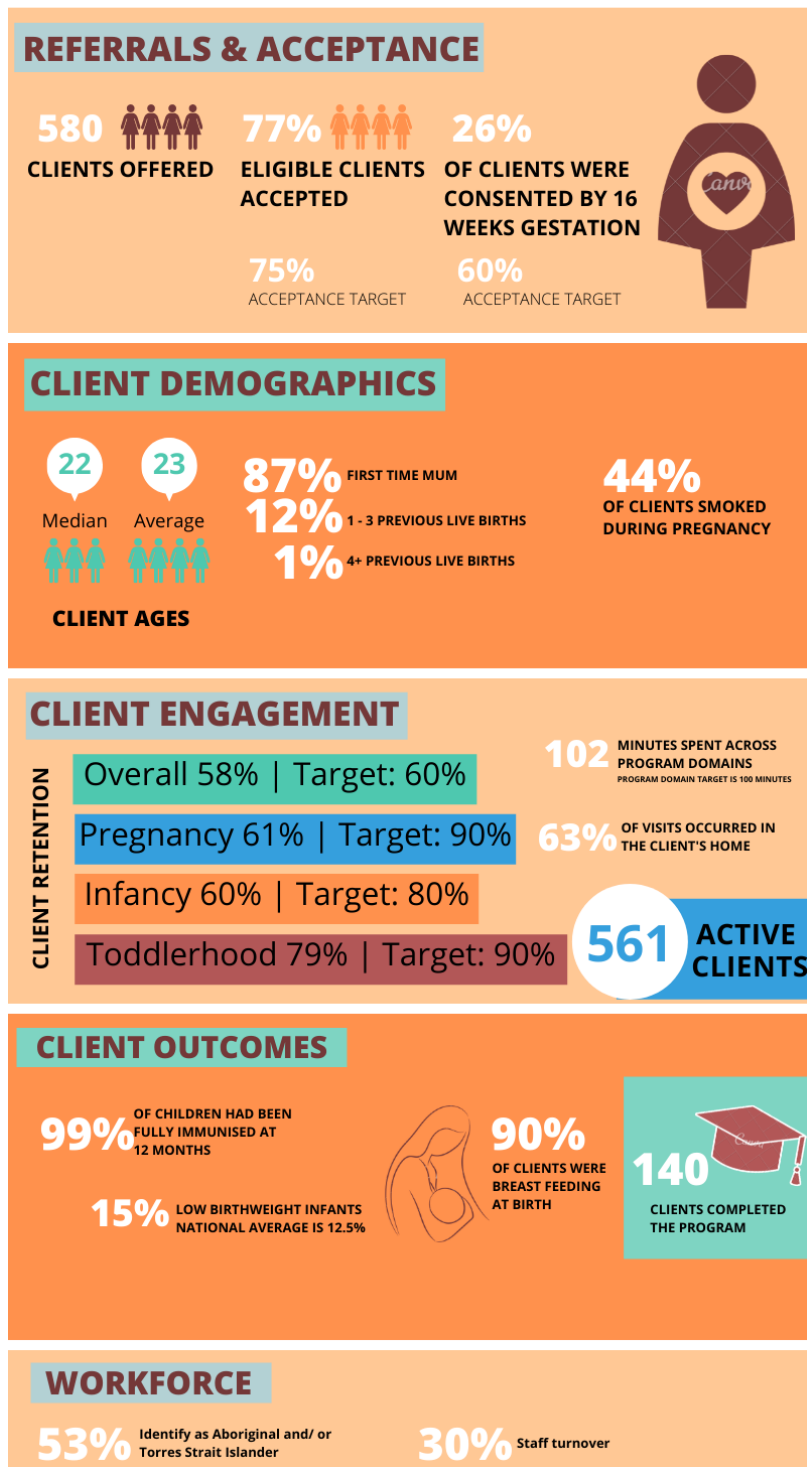
Figure 1 shows, at a glance, a summary of key ANFPP program metrics for 2020-21.

FIGURE 1: ANFPP DATA SUMMARY JULY 1 2020 – JUNE 30 2021



# AUSTRALIAN NURSE-FAMILY PARTNERSHIP PROGRAM

PROGRAM DATA SUMMARY FROM 1 JULY 2020- 30 JUNE 2021



# 1. Introduction

## 1.1 Program Overview

The ANFPP program was implemented in Wave 1 sites in Australia in 2009 (Table 1) to support mothers and babies in Aboriginal and Torres Strait Islander communities (ANFPP 2021). Funded by the Commonwealth Department of Health as part of the Closing the Gap Strategy, the program is a component of the Federal Government’s commitment to improving the health of Aboriginal and Torres Strait Islander people with a focus on maternal health and early childhood development. The ANFPP is a home visiting program delivered at 13 program sites across all five geographic remoteness categories in the Australian Statistical Geography Standard framework (Figure 2); ten within Aboriginal Community Controlled Health Organisations (ACCHOs), and one with a government provider (Table 1). The Brisbane-based ANFPP National Support Service supports the program sites by providing broad operational, technical and data support, and specialised education and training for home visitors on ANFPP program elements.

Home visiting teams work together with mothers during pregnancy, infancy and toddlerhood, identifying strengths and opportunities, and delivering program content to support a healthy pregnancy and confident parenting. Specially trained Nurse Home Visitors (NHV) and Family Partnership Workers (FPW) regularly visit mothers-to be, preferably from early in pregnancy, continuing through until the child is two years of age.

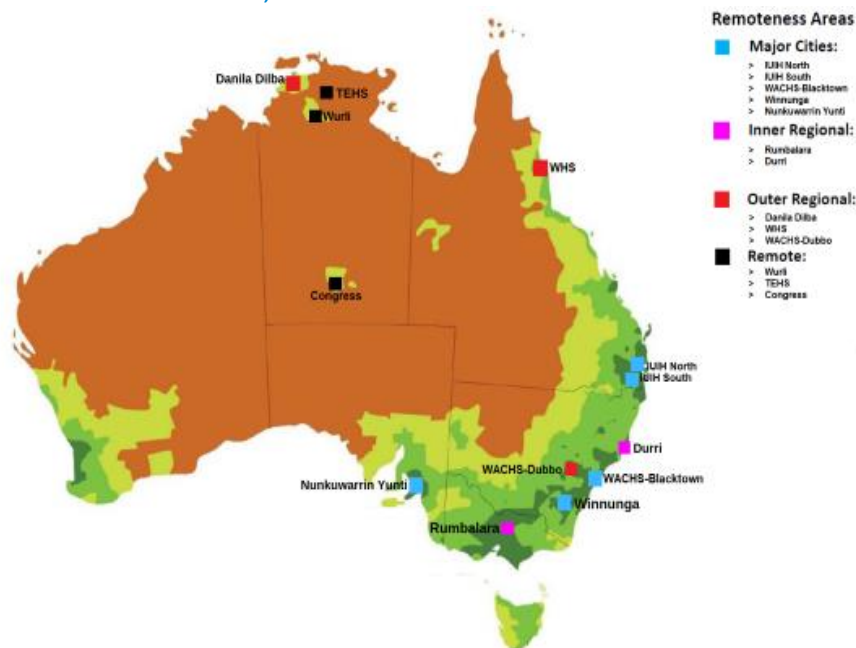
**TABLE 1: ANFPP PROGRAM SITE ORGANISATIONS, BY WAVE AND COMMENCEMENT DATE**

Wave	Commencement of the Program at site	Program site organisation
<b>Wave 1</b>  <b>12 years established</b>	2009	Central Australian Aboriginal Congress, (Congress), Alice Springs, Northern Territory.
		Wuchopperen Health Service (WHS), Cairns, Queensland.
		Wellington Aboriginal Corporation Health Service - Dubbo (WACHS-Dubbo), Wellington, New South Wales.
<b>Wave 2</b>	May 2016	Institute for Urban Indigenous Health (IUIH-North), North Brisbane, Queensland.
	May 2016	Top End Health Services - Northern Territory Department of Health (TEHS), based in Casuarina, Northern Territory, and providing

Wave	Commencement of the Program at site	Program site organisation
<b>5 years established</b>		outreach services to Wadeye, Wurrumiyanga, Gunbalanya, and Maningrida.
<b>Wave 3</b>  <b>4 years established</b>	April 2017	<p>Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, (Danila Dilba) based in Darwin and Palmerston, Northern Territory.</p> <p>Nunkuwarrin Yunti of South Australia Inc, (Nunkuwarrin Yunti) based in Adelaide, South Australia.</p> <p>Institute for Urban Indigenous Health (IUIH-South), South Brisbane, Queensland.</p>
<b>Wave 4</b>  <b>4 years established</b>	June 2017	<p>Wurli Wurlinjang Aboriginal Corporation (Wurli), Katherine, Northern Territory.</p> <p>Wellington Aboriginal Corporation Health Service - Blacktown (WACHS-Blacktown), Blacktown, Western Sydney, New South Wales.</p> <p>Winnunga Nimmityjah Aboriginal Health Clinic/Health Service (Winnunga), Canberra, Australian Capital Territory.</p> <p>Durri Aboriginal Corporation Medical Service (Durri), Kempsey, New South Wales.</p> <p>Rumbalara Aboriginal Cooperative Ltd (Rumbalara), Shepparton, Victoria.</p>



FIGURE 2: ANFPP PROGRAM SITES, BY REMOTENESS AREA



## ANFPP program origins

The ANFPP is based on the Nurse-Family Partnership (NFP) model of home visiting developed in the United States (US) by Professor David Olds (Nurse Family Partnership 2021a). A cornerstone of the NFP is extensive research targeting first-time, low-income mothers and their children in New York, Tennessee and Denver from 1977-1994 (Nurse Family Partnership 2021b). The NFP has been developed and tested using rigorous research methods and replicated in community settings. Apart from the US and Australia, the program has been implemented in the Netherlands, England, Canada, Scotland, Northern Ireland, Norway and Bulgaria.

## ANFPP objectives

The objective of the ANFPP is to improve maternal and child health and wellbeing for Aboriginal and Torres Strait Islander families through:

- supporting engagement in preventative health practices
- supporting child health and development practices
- supporting parents in developing a vision for their own future.

The Australian program has Core Model Elements (CMEs) (See Appendix 1 for a 2020-21 summary) based on the US model to ensure service delivery achieves the desired program outcomes including:

- improved pregnancy outcomes
- improved child health and development outcomes
- improved parental life course.

Two key variations have been permitted to adapt the NFP model to meet needs in the Australian context.

- ANFPP is delivered to first-time mothers, pregnant with an Aboriginal and/or Torres Strait Islander baby. Multiparous women are included if i) it is their first opportunity to parent, ii) at the discretion of the home visiting team at a program site.
- A unique Australian 15<sup>th</sup> CME was added to the list of 14 International NFP CMEs. 'ANFPP teams must employ Aboriginal and/or Torres Strait Islander Family Partnership Workers (FPW) to support delivery of the program and who participate in reflective supervision.' The FPW plays an essential role, bringing an understanding of the local Indigenous community and cultural safety to program delivery.

## The five principles of the ANFPP

At the heart of the program is acceptance of client autonomy. The client is the expert in her own life, and she can identify the solutions that work for her. The five client-centred principles play a pivotal role by focusing on her strengths, focusing on solutions, understanding only a small change is necessary, realising that the client is the expert and empowering the client to follow her heart's desire. Home visiting teams prioritise the five client-centred principles as they deliver the program.



Focus on strengths

**Focus on strengths** - Home visiting teams recognise and respect the clients' strengths. A program aim is to reframe challenging situations with a focus on what the client is doing well and acknowledging the clients' strengths.



Focus on solutions

**Focus on solutions** - Focus is shifted from the problem, to working with the client to envisage success by focusing on solutions. How does the client want to move forward rather than remaining stuck in the difficulties of the past and the present?



Only a small change  
is necessary

**Only a small change is necessary** - Behaviour change is fundamental to the ANFPP model. Life-transforming changes often begin with the smallest steps and small steps in a purposeful direction are of value.



You are an expert  
in your own life

**You are an expert in your own life** - In the ANFPP, the focus is on what the client knows will work in her life, culture and environment. Home visiting teams give information and support, listen to the client, learn what information she knows and how she wants to be supported. Individualising support to meet the needs she identifies will increase collaboration and facilitate culturally safe care.



Follow your heart's desire

**Follow your heart's desire** - The client's energy, time and attention will be devoted to changes in her life based on the desires deep in her heart. Home visiting teams discover what matters most to the client. This assists momentum and a desire to begin change processes.



## 1.2 COVID-19

During 2020 and 2021, program sites have continued to respond to the COVID-19 pandemic and utilised innovative methods to deliver the ANFPP with continuity and fidelity to the Core Model Elements. Innovations have been varied based on government protocols, location, organisational policy, community needs, client availability and team capacity.

Telehealth and videoconferencing technology have been utilised and feedback from affected teams indicated that many clients accepted a telehealth model of program visits in place of face-to-face delivery. Figure 3 represents the 2020 transition from face-to-face home visiting to program delivery by telehealth as required. Some sites reported an increase in contact frequency with a number of their clients via telephone and videoconference.

**FIGURE 3: ANFPP HOME VISITING TEAM’S 2020 TELEHEALTH RESPONSE TO COVID-19**

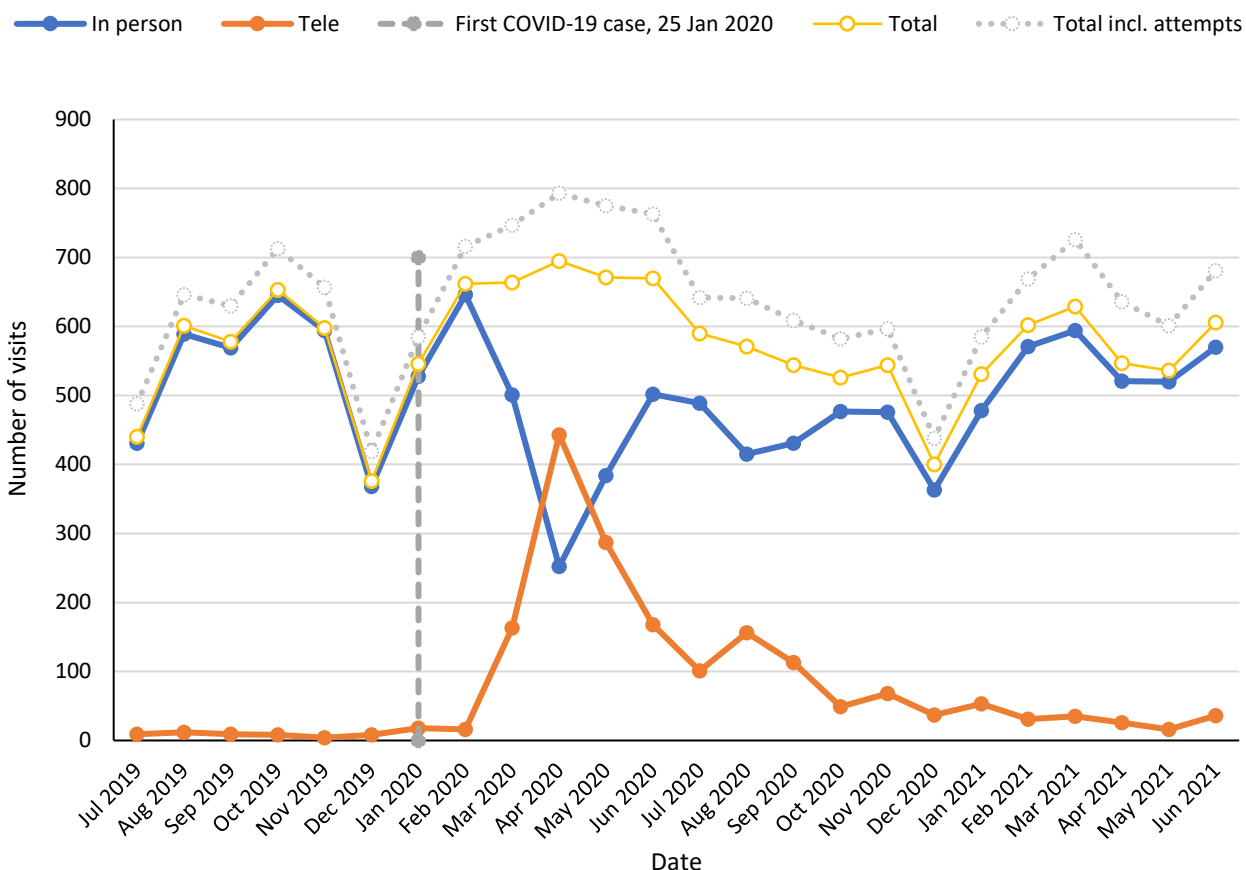


Figure 3 also provides visual representation of how home visiting teams were able to maintain ANFPP program continuity with telehealth throughout the COVID-19 response during 2020.

- During the first national COVID-19 response between March and July 2020 the total number of completed program visits increased (yellow line).
- The grey dotted line on the graph represents total visits including ‘attempted visits’ and captures additional efforts made by teams to support their clients throughout the 2020 response.

The ANFPP team members can be commended for their additional and continued efforts in providing care for clients and their families through difficult circumstances. During periods of the pandemic, for some families, the ANFPP Nurse Home Visitors and Family Partnership Workers may be their only contact with professionals or support organisations.

The National Support Service acknowledges the challenges that COVID-19 presents for program delivery by ANFPP teams, including data collection.

## 2. An ANFPP Data Summary 2009-2021

### 2.1 Women who had a Singleton Baby

Since the ANFPP first began in Wave 1 sites at Alice Springs NT, Cairns Qld and Dubbo NSW, ten additional sites have been added, and more than 1880 women have had a baby while they were enrolled in the program. The following descriptive analysis provides a snapshot of the characteristics and experiences of the clients who have participated in the program over the past 12 years. Live births of singleton babies that were more than 20 weeks gestation and 400g at birth are included. Multiple births, and birth records without a gestational age at birth or birthweight are excluded.

#### **Selected client demographics for program duration**

Table 2 shows selected demographic characteristics of the women who have had a baby in the ANFPP from 2009 when the program commenced to June 30, 2021.

- The average age of mothers when they enrolled in the program was 22 years. More than a third of the mothers were aged between 13 and 19 years.
- There has been a similar proportion of births across major city, outer regional and remote program site locations. There have been fewer babies born at inner regional ANFPP sites because these sites were not established until Wave 4 ANFPP implementation in 2017.
- Enrolled clients have included 11% non-Indigenous women pregnant with an Indigenous baby.
- Most mothers (77%) reported having a current partner at intake to the program.
- Over half the clients reported completing Year 11 or 12 at secondary school and 15.2% reported leaving school after Year 8 or 9.
- Twenty percent of enrolled mothers reported living in large households with seven or more people.

**TABLE 2: SELECTED DEMOGRAPHIC CHARACTERISTICS OF ANFPP CLIENTS WHO HAD A SINGLETON BABY, FOR PROGRAM DURATION**

	<b>ANFPP clients who had a baby n=1880 n (%)</b>
<b>Maternal age at referral -years mean, SD, (range)</b>	22.1 years, 5.1, 13-43
<b>Maternal age at referral</b>	
13-19 years	678 (36.1%)
20-34 years	1151 (61.2%)
35+ years	51 (2.7%)
<b>Remoteness area</b>	
Major cities	543 (28.9%)
Inner regional	61 (3.2%)
Outer regional	679 (36.2%)
Remote	597 (31.8%)
<b>Indigenous status</b>	
Aboriginal	1511 (80.4%)
Torres Strait Islander	79 (4.2%)
Aboriginal & Torres Strait Islander	67 (3.6%)
Non-Indigenous (Indigenous baby)	210 (11.2%)
Missing (<1%)	13 (<1%)
<b>Current partner n= 1442 (76.7%)</b>	
Yes	1116 (77.4%)
No	326 (22.6%)
Missing (23.3%)	438
<b>Secondary education n=1490 (79.3%)</b>	
Year 8 or equivalent	96 (6.4%)
Year 9 or equivalent	131 (8.8%)
Year 10 or equivalent	443 (29.7%)
Year 11 or equivalent	272 (18.3%)
Year 12 or equivalent	548 (36.8%)
Missing (20.7%)	390
<b>Post-secondary education n=664 (35.3%)</b>	
Associate diploma	24
Bachelor	37
TAFE or University or other	291
Vocational, technical or trade	312
Missing (64.7%)	1216



Number of people in household n=1428 (76%)	
0	50 (3.5%)
1-4	778 (54.5%)
5-6	290 (20.3%)
7-10	267 (18.7%)
>10	43 (3%)
Missing (24%)	452

### Selected pregnancy characteristics for program duration

Table 3 shows selected pregnancy characteristics of the women who have had a baby in the ANFPP from 2009 when the program commenced to June 30, 2021.

- One third (29.8%) of ANFPP clients were enrolled in the program by 16 completed weeks gestation or earlier (CME 4 benchmark – 60% of pregnant women are enrolled by 16 weeks gestation or earlier).
- Eighty percent of clients had their first home visit no later than the 28<sup>th</sup> week of pregnancy (CME 4 benchmark – 100% of clients receive their first home visit no later than the 28<sup>th</sup> week of pregnancy).
- Smoking at any point in pregnancy was reported as 48.7%.
- About half the women (54.1%) were recorded as being screened for antenatal depression at intake when they enrolled in the program. Only 12.5% were reported as being screened at 36 weeks gestation. Missing data includes women who declined Edinburgh Postnatal Depression Scale (EPDS) screening.
- Of the women screened with the EPDS, 6.1% had a score of  $\geq 13$  suggestive of antenatal depressive systems. This is similar to the 6.2% prevalence reported in a 2014 retrospective cohort of 17,564 mothers from a culturally diverse study setting in New South Wales (Ogbo et al 2018). The ANFPP rate is lower than the 16.7% of 136 Aboriginal and Torres Strait Islander women found to be at risk when they were screened in a 2008 study in Townsville, Queensland (Campbell et al. 2008).
- About half the women were recorded as being screened for antenatal anxiety at intake to the program using the EPDS, and 6.5% had a score of 6 or more suggestive of anxiety symptoms. Less than 10% of enrolled women were reported as being screened for anxiety at the 36 weeks gestation milestone (Note: 36 week EPDS is not recorded in Communicare).

**TABLE 3: SELECTED PREGNANCY CHARACTERISTICS OF ANFPP CLIENTS WHO HAD A SINGLETON BABY, FOR PROGRAM DURATION**

	<b>ANFPP clients who had a baby n=1880 n (%)</b>
<b>Gestational age at enrolment (consent date) n=1876 (&gt;99%)</b>	
≤16 completed weeks	559 (29.8%)
17 or more weeks	1317 (70.2%)
<b>Missing (e.g. enrolled after pregnancy phase) (&lt;1%)</b>	4
<b>Gestational age at 1<sup>st</sup> home visit n=1876 (&gt;99%)</b>	
≤28 completed weeks	1506 (80.3%)
29 or more weeks	370 (19.7%)
<b>Missing (e.g. enrolled after pregnancy phase) (&lt;1%)</b>	4
<b>Smoking in pregnancy n=1480 (78.7%)</b>	
Yes	722 (48.7%)
No	758 (51.2%)
<b>Missing (21.3%)</b>	400
<b>EPDS* (Depression) at Intake n=1017 (54.1%)</b>	
Low risk - <10	894 (87.9%)
Possible risk- 10-12	62 (6.1%)
High risk – 13+	61 (6%)
<b>Missing (45.9%)</b>	863
<b>EPDS (Depression) at 36 weeks n=234 (12.5%)</b>	
Low risk - <10	214
Possible risk – 10-12	7
High risk -13+	13
<b>Missing (87.5%)</b>	1646
<b>EPDS3 (Anxiety) at intake n=976 (51.9%)</b>	
<6	913 (93.5%)
≥6	63 (6.5%)
<b>Missing (48.1%)</b>	904
<b>EPDS3 (Anxiety) at 36 weeks n=168 (8.9%)</b>	
<6	153
≥6	15
<b>Missing (91.9%)</b>	1712

\*EPDS: Edinburgh Postnatal Depression Scale

## Selected outcomes for program duration

Table 4 shows selected outcomes for women who had a baby from 2009 to 30<sup>th</sup> June, 2021.

- The rate of preterm births for the ANFPP program duration was 12%. This is similar to the nationally reported figure of 12.2% of Indigenous babies born preterm in 2019 (AIHW 2021b) (Table 4).
- The rate of low birthweight births for the ANFPP program duration was 12.6%. This is higher than the national reported figure of 10.6% of Indigenous babies born <2500g in 2019 (AIHW 2021b).
- Less than 1% of data was missing for the 'Ever breastfed' ANFPP variable and 87.8% of mothers were reported as 'ever' breastfeeding. This is similar to the 87% of Indigenous children aged 0-2 reported as ever breastfed in the National Aboriginal and Torres Strait Islander Health Survey (2018-19).
- Of the mothers who were reported as 'ever' breastfeeding, less than half (40.8%) had data reported about whether they were still breastfeeding at 6 months. Of those women with data, 63.6% (427/671) were reported as still breast feeding at 6 months.

**TABLE 4: SELECTED OUTCOMES OF CLIENTS WHO HAD A SINGLETON BABY, FOR PROGRAM DURATION**

	<b>All ANFPP clients who had a baby N=1880 n (%)</b>
<b>Gestation at birth (preterm)</b>	
<37 weeks	225 (12%)
37 weeks or more	1655 (88%)
<b>Infant birthweight (low birthweight)</b>	
<2500 g	236 (12.6%)
2500g or more	1644 (87.4%)
<b>Breastfeeding n=1872 (99.6%)</b>	
Ever breastfeed -yes	1643 (87.8%)
-no	229 (12.2%)
Missing (<1%)	8
<b>Of mothers who ever breastfed n=671 (40.8%)</b>	
Still breastfeeding 6 months-yes	427 (63.6%)
-no	244 (36.4%)
Missing (59.2%)	972

## 2.2 Comparing Multiparous and Primiparous Women

Most of the clients enrolled in the ANFPP are women who are pregnant for the first time with an Aboriginal or Torres Strait Islander baby. Multiparous mothers are also enrolled at the discretion of program sites, including women for whom it is their first opportunity to parent.

- For the ANFPP program duration (2009-2021), 15.7% (295/1880) of all mothers in the program who had a singleton baby have been multiparous mothers (Table 5).

**Overall, the multiparous mothers in the program were more likely to access the ANFPP in a remote area, therefore many of their characteristics are more similar to other Indigenous women of childbearing age who live in remote areas of Australia.**

The following tables show that many characteristics of multiparous mothers in the program differ from first-time mothers.

**It's likely we would find many of the same differences in a comparison between women from remote areas and the other Australian remoteness areas.**

### **Multiparous mothers: selected demographics for program duration**

Table 5 shows selected demographics of multiparous and primiparous women who had a baby in the ANFPP from 2009 to 30 June 2021.

- The multiparous mothers in the program, on average, were five years older than first-time mothers.
- Multiparous mothers in the program were less likely to complete Years 11 or 12 than first-time mothers (p value <0.000). Data about post-secondary education was available only for approximately 1/3 of all mothers.
- Approximately 30% of multiparous mothers reported living in a household with seven or more people, compared with 20% of first-time mothers (p value 0.002).

**TABLE 5: DEMOGRAPHIC CHARACTERISTICS OF MULTIPAROUS AND PRIMIPAROUS CLIENTS WHO HAD A SINGLETON BABY, FOR PROGRAM DURATION**

	<b>Primiparous clients who had a baby</b>  <b>N =1585 (84.3%) n (%)</b>	<b>Multiparous clients who had a baby</b>  <b>N=295 (15.7%) n (%)</b>
<b>Maternal age at referral -years mean, SD, (range)</b>	21.3 years, 4.7 (13-42)	26.4 years, 5.3 (15-43)
<b>Maternal age at referral</b>		
<b>13-19 years</b>	660 (41.6%)	18 (6.1%)
<b>20-34 years</b>	897 (56.6%)	254 (86%)
<b>35+ years</b>	28 (1.8%)	23 (7.8%)
<b>Remoteness area</b>		
<b>Major cities</b>	493 (31.1%)	50 (16.9%)
<b>Inner regional</b>	43 (2.7%)	18 (6.1%)
<b>Outer regional</b>	646 (40.8%)	33 (11.2%)
<b>Remote</b>	403 (25.4%)	194 (65.8%)
<b>Indigenous status</b>		
<b>Aboriginal</b>	1246 (78.6%)	265 (90%)
<b>Torres Strait Islander</b>	79 (5%)	<5
<b>Aboriginal &amp; Torres Strait Islander</b>	64 (4%)	<5
<b>Non-Indigenous (Indigenous baby)</b>	189 (11.9%)	21 (7%)
<b>Missing (&lt;1%)</b>	7	6
<b>Current partner n= 1442 (76.7%)</b>		
<b>Yes</b>	952 (77.2%)	164 (78.5%)
<b>No</b>	281 (22.8%)	45 (21.5%)
<b>Missing (23.3%)</b>	352	86
<b>Secondary education n=1490 (79.3%)</b>		
<b>Year 8/9 or equivalent</b>	171 (13.2%)	56 (28.7%)
<b>Year 10 or equivalent</b>	374 (28.9%)	69 (35.4%)
<b>Year 11/12 or equivalent</b>	750 (57.9%)	70 (35.9%)
<b>Missing (20.7%)</b>	290	100
<b>Post-secondary education n=664 (35.3%)</b>		
<b>Associate diploma</b>	22	<5
<b>Bachelor</b>	33	<5
<b>TAFE/technical/vocational/trade</b>	533	70
<b>Missing (64.7%)</b>	997	219

Number of people in household n=1428 (76%)		
0	43 (3.5%)	7 (3.4%)
1-4	683 (55.8%)	95 (46.6%)
5-6	250 (20.4%)	40 (19.6%)
7-10	218 (17.8%)	49 (24%)
>10	30 (2.5%)	13 (6.4%)
Missing (24%)	361	91

## Multiparous mothers: selected pregnancy characteristics for program duration

Table 6 shows selected pregnancy characteristics of multiparous and primiparous women who had a baby in the ANFPP from 2009 to 30 June 2021.

- Early enrolment, by 16 weeks gestation, has been achieved for approximately 30% of multiparous and primiparous women over the duration of the program.
- Overall, smoking in pregnancy was reported as high among all ANFPP mothers (48.7% reported as smoking at some point during pregnancy). Multiparous mothers were more likely to be reported as smoking in pregnancy than first-time mothers (58.4% versus 47%, (RR 1.2 (1.09-1.40), p value=0.001).
- For the duration of the program, just over half the mothers, 54.1%, (1017/1880) were screened for depression at intake to the program. Missing data includes women who declined EPDS screening.
- From screening at intake, multiparous women were more likely to score 10 or more than primiparous women (p value=0.02) indicating either a possible or high risk of depression.
- Only 12.5% of women had an EPDS screening result recorded for 36 weeks gestation (Note: 36 week EPDS screening is not currently recorded in Communicare systems).
- Just over half of all the women who enrolled in the ANFPP (51.9%) were screened for anxiety at intake. Using the EPDS, the multiparous women were more likely than the primiparous women to score 6 or more indicating possible anxiety (p value 0.04).
- Less than 10% of mothers had an anxiety screening result recorded at 36 weeks gestation.

**TABLE 6: SELECTED PREGNANCY CHARACTERISTICS OF MULTIPAROUS AND PRIMIPAROUS CLIENTS WHO HAD A SINGLETON BABY, FOR PROGRAM DURATION**

	<b>Primiparous clients who had a baby</b>	<b>Multiparous clients who had a baby</b>
	<b>N =1585 (84.3%)</b>	<b>N=295 (15.7%)</b>
	<b>n (%)</b>	<b>n (%)</b>
<b>Gestational age at enrolment (consent date) n=1876 (&gt;99%)</b>		
≤16 completed weeks	483 (30.6%)	76 (25.8%)
17 or more weeks	1098 (69.4%)	216 (74.2%)
Missing (e.g. enrolled after pregnancy phase) (<1%)	4	0
<b>Gestational age at 1<sup>st</sup> home visit n=1876 (&gt;99%)</b>		
≤28 completed weeks	1270 (80.3%)	236 (80%)
29 or more weeks	311 (19.7%)	59 (20%)
Missing (e.g. enrolled after pregnancy phase) (<1%)	4	0
<b>Smoking in pregnancy n=1480 (78.7%)</b>		
Yes	587 (47%)	135 (58.4%)
No	662 (53%)	96 (41.6%)
Missing (21.3%)	336	64
<b>EPDS (Depression) at Intake n=1017 (54.1%)</b>		
Low risk - <10	794 (88.8%)	100 (81.3%)
Possible risk- 10-12	50 (5.6%)	12 (9.8%)
High risk – 13+	50 (5.6%)	11 (8.9%)
Missing (45.9%)	691	172
<b>EPDS (Depression) at 36 weeks n=234 (12.5%)</b>		
Low risk - <10	188	26
Possible risk – 10-12	5	<5
High risk -13+	11	<5
Missing (87.5%)	1381	265
<b>EPDS3 (Anxiety) at intake n=976 (51.9%)</b>		
<6	808 (94.2%)	105 (88.9%)
≥6	50 (5.8%)	13 (11.1%)
Missing (48.1%)	727	177
<b>EPDS3 (Anxiety) at 36 weeks n=168 (8.9%)</b>		
<6	132	21
≥6	13	2
Missing (91.9%)	1440	272

## Multiparous mothers: selected outcomes for program duration

Table 7 shows selected outcomes for multiparous and primiparous women who had a baby in the ANFPP from 2009 to 30<sup>th</sup> June 2021

- Multiparous mothers in the program had a higher rate of preterm birth (14.6%) compared to primiparous mothers (11.5%). (p value 0.07)
- Multiparous mothers had a higher rate of low birthweight births (15.6% versus 12%) (p value 0.05).
- Close to 88% of multiparous and primiparous mothers reported 'ever' breastfeeding.
- Of mothers who reported 'ever' breastfeeding, and had data available about breastfeeding at 6 months, multiparous mothers were more likely to be still breastfeeding (p value 0.02).

**TABLE 7: SELECTED OUTCOMES OF PRIMIPAROUS & MULTIPAROUS CLIENTS WHO HAD A SINGLETON BABY, FOR PROGRAM DURATION**

	Primiparous clients who had a baby N =1585 (84.3%) n (%)	Multiparous clients who had a baby N=295 (15.7%) n (%)
<b>Gestation at birth (preterm)</b>		
<37 weeks	182 (11.5%)	43 (14.6%)
37 weeks or more	1403 (88.5%)	252 (85.4%)
<b>Infant birthweight (low birthweight)</b>		
<2500 g	190 (12%)	46 (15.6%)
2500g or more	1395 (88%)	249 (84.4%)
<b>Breastfeeding n=1872 (99.6%)</b>		
Ever breastfeed -yes	1384 (87.7%)	259 (88.1%)
-no	194 (12.3%)	35 (11.9%)
Missing (<1%)	7	1
<b>Of mothers who ever breastfed n=671 (40.8%)</b>		
Still breastfeeding 6 months-yes	365 (62.3%)	62 (72.9%)
-no	221 (37.7%)	23 (27.1%)
Missing (59.2%)	798	174



## 3. Program Implementation

### 3.1 Active ANFPP Clients by Location

- At June 30, 2021 there were 561 active clients in the ANFPP program. This is similar to the previous reporting period when there were 594 active clients.
- The 2020-21 geographical distribution of active clients across Australian Remoteness Areas also remains similar to 2019-20, with half (51%) living in major cities (Table 8).

**TABLE 8: SUMMARY OF ACTIVE CLIENTS AT 30 JUNE 2021, BY REMOTENESS AREA**

	Major Cities	Inner Regional	Outer Regional	Remote	Total
Active Clients	285	33	90	153	561

**TABLE 9: SUMMARY OF CLIENT REFERRALS, OFFERS & ACCEPTANCES, HOME VISITS, EXITS AND GRADUATIONS 2020-21, BY REMOTENESS AREA**

	Referrals	Offered	Accepted (%)	Home Visits	Attempted home visits	Left the program (prior to graduation)	Graduated
Major Cities	348	288	230 (80%)	3940	226	168	68
Inner Regional	35	29	21 (73%)	364	107	24	11
Outer Regional	140	117	87 (74%)	1015	101	65	21
Remote	184	148	111 (75%)	1307	347	72	40
<b>Total</b>	<b>707</b>	<b>580</b>	<b>449 (77%)</b>	<b>6626</b>	<b>781</b>	<b>329</b>	<b>140</b>

- In 2020-21, the ANFPP was delivered with 6626 visits; there were 781 attempted visits (Table 9).
- A total of 140 clients successfully completed the program and graduated. This is double the 70 graduations reported in 2019-20.
- There were 707 referrals received by the program in 2020-21, which is less than in 2019-20 (808). However, despite 101 fewer referrals, the number of accepted clients in 2020-21 at 449, was only 19 fewer than 2019-20. This could be an indication that eligibility of referrals received by the program sites may have increased during 2020-21.

- The proportion of eligible referrals (offered) who enrolled in the program (accepted) remained stable at 77%, slightly above the CME 4 target benchmark of 75%.

Reasons that received referrals are not offered a place in the program, and numbers, are shown in Figure 5 in Section 3.2 of the report. The most frequent reason by far is ineligibility. To be eligible to enter the program, the women must be pregnant for the first time with an Aboriginal or Torres Strait Islander baby. Multiparous women having an Aboriginal or Torres Strait Islander baby are accepted in the program at the discretion of the program site ANFPP team, particularly if it is her first opportunity to parent. Sometimes, home visiting teams are unable to locate the referred woman, and on rare occasions, program places at the site are full at the time of the referral.

- The number of clients who left the program prior to graduation in 2020-21 (329) was 11 more than in 2019-20 (318).

Reasons for leaving the program are shown in detail in Section 3.6 of the report at Figures 8 and 9. In 2020-21 the most common recorded reasons were being unable to locate the client (84), she moved out of the service area (50), or missed an excessive number of appointments (50). For program duration, the most common reason for leaving the program has been because the client moved out of the program site service area.

**TABLE 10: SUMMARY OF CLIENT REFERRALS, OFFERS & ACCEPTANCES, EXITS, GRADUATIONS AND HOME VISITS FOR PROGRAM DURATION, BY REMOTENESS AREA**

	Referrals	Offered	Accepted (%)	Home Visits	Attempted home visits	Left the program (prior to graduation)	Graduated
<b>Major Cities</b>	1371	1198	904 (75%)	12296	824	509	110
<b>Inner Regional</b>	146	123	93 (76%)	1017	143	49	11
<b>Outer Regional</b>	1622	1237	983 (79%)	14413	2825	696	195
<b>Remote</b>	1561	1178	853 (72%)	15111	6034	493	204
<b>Total</b>	<b>4700</b>	<b>3736</b>	<b>2833 (76%)</b>	<b>42837</b>	<b>9826</b>	<b>1747</b>	<b>520</b>

- Excluding current active clients (561), over the program duration and across all remoteness areas, 520/2273, or just over 1 out of 4 accepted clients, have successfully graduated (Table 10).
- Again, excluding active clients in each remoteness area, the graduation rate of accepted clients for the program duration has been 18% (110/619) in major city and inner regional sites (11/61), 22% (195/893) at outer regional sites and nearly 30% (204/700) at remote sites.
- Overall, 61.6% of accepted clients left the program prior to graduation, indicating an overall retention rate of 38.4% for program duration. The CME 5 target benchmark is program attrition is 40% or less through to the child's 2<sup>nd</sup> birthday (60% retention) as an average across program sites. Reasons for leaving the program are analysed and discussed at Section 3.6 on pages 32-35 of this report.

### 3.2 Client Referrals and Acceptance Trend

FIGURE 4: CLIENT REFERRALS, OFFERS AND ENROLMENTS FOR PROGRAM DURATION

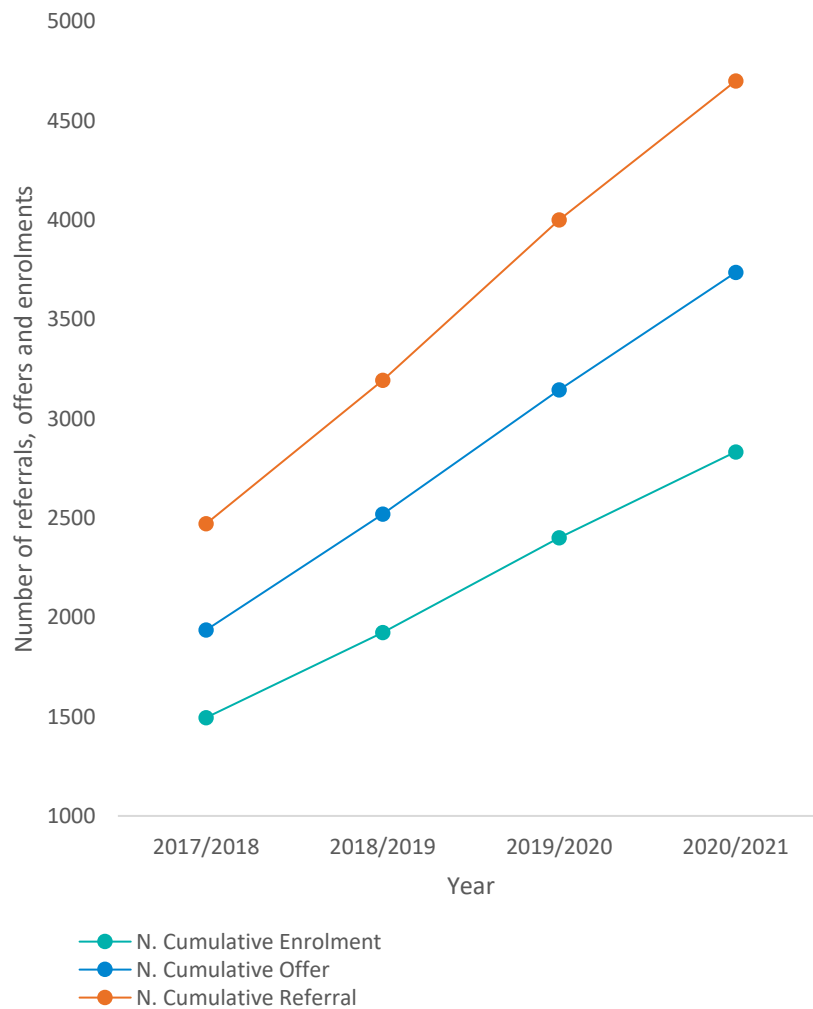
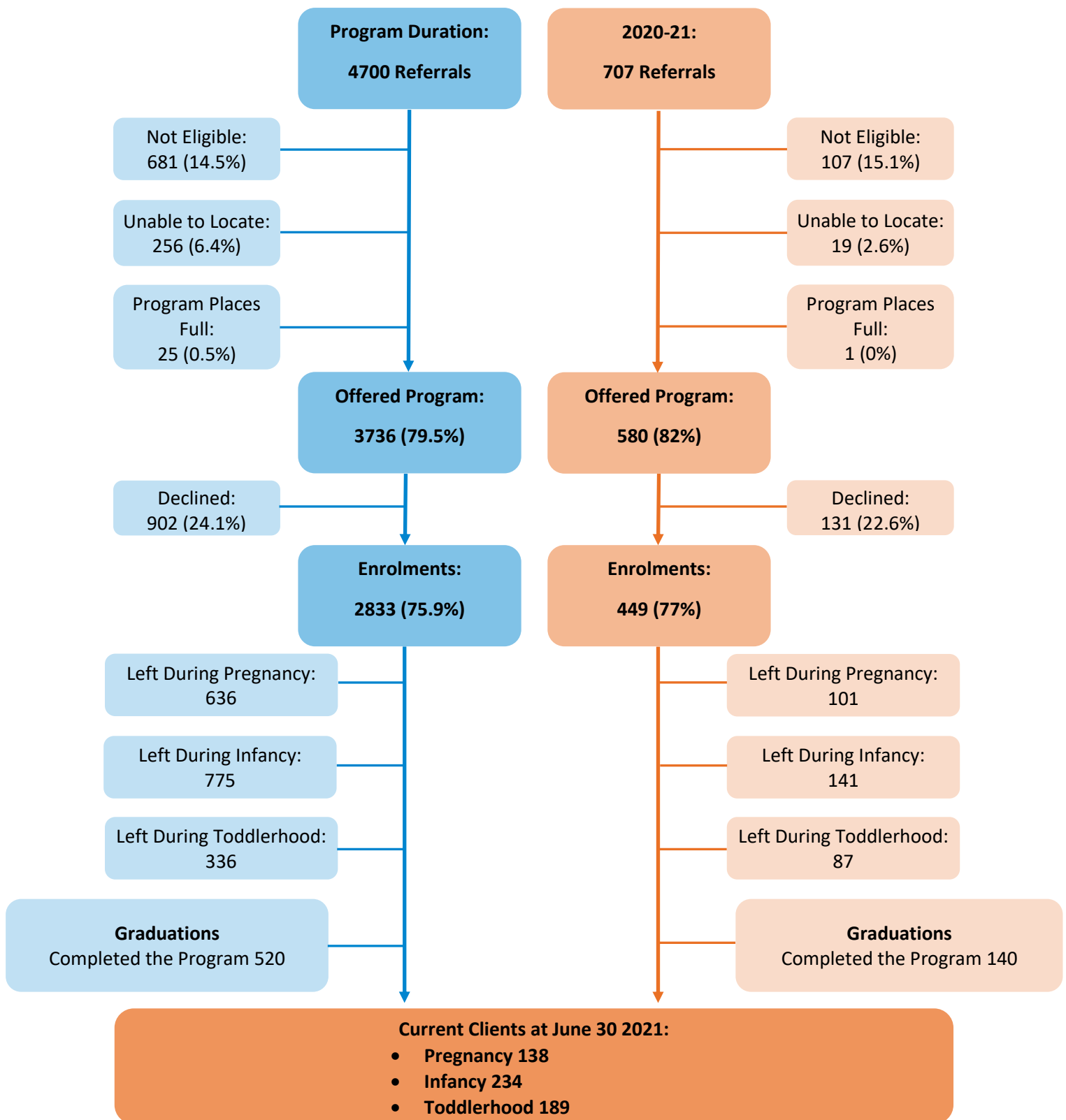


Figure 4 shows ANFPP growth in terms of program referrals, offers and enrolments over the past 4 reporting periods. The program cumulative enrolments have increased from 1483 in 2017-18 to 2833 in 2020-21.

FIGURE 5: SUMMARY OF CLIENT REFERRAL OUTCOMES

b. Program Duration

a. 2020 - 2021



The following Tables 11, 12 and 13 show the number of referrals, offers and accepted clients enrolled at each program site during 2021, respectively. The cumulative total number of referrals for program duration at each site are also shown – for the end of the 2019-20 and 2020-21 reporting periods. The number of referrals received at each program site is related to the size of the Aboriginal and Torres Strait Islander community it serves. The number of offers a program site can make is highly dependent on the eligibility of the referrals received by that site.

**TABLE 11: NUMBER OF REFERRALS 2020-21, AND FOR PROGRAM DURATION BY PROGRAM SITE**

Referrals	Program site 1	Program site 2	Program site 3	Program site 4	Program site 5	Program site 6	Program sites 7	Program site 8	Program site 9	Program site 10	Program site 11	Program site 12	Program site 13
WAVE program commenced (Table 1)	2nd	3rd	4th	4th	4th	2nd	3rd	4th	4th	3rd	1st	1st	1st
Number of Referrals (2020-21)	106	61	32	59	17	62	43	30	18	114	39	40	88
Program duration (2019-20)	438	139	69	138	68	187	98	63	43	286	703	640	1123
Program duration (2020-21)	544	200	101	197	85	249	141	93	61	400	742	680	1211

TABLE 12: NUMBER OF OFFERS 2020-21, AND FOR PROGRAM DURATION, BY PROGRAM SITE

Offers	Program site 1	Program site 2	Program site 3	Program site 4	Program site 5	Program site 6	Program sites 7	Program site 8	Program site 9	Program site 10	Program site 11	Program site 12	Program site 13
Number of Offers 2020-21	100	61	25	47	14	61	39	22	15	80	32	24	60
Proportion of referrals receiving an Offer	94%	100%	78%	80%	82%	98%	91%	73%	83%	70%	82%	60%	68%
Program duration (2019-20)	392	128	65	130	51	155	85	57	43	246	525	467	812
Program duration (2020-21)	492	189	90	177	65	216	124	79	58	326	557	491	872

TABLE 13: NUMBER OF ACCEPTED\* CLIENTS 2020-21, AND FOR PROGRAM DURATION, BY PROGRAM SITE

Accepted clients	Program site 1	Program site 2	Program site 3	Program site 4	Program site 5	Program site 6	Program sites 7	Program site 8	Program site 9	Program site 10	Program site 11	Program site 12	Program site 13
Number of Accepted clients 2020-21	81	30	16	42	11	45	37	16	10	54	30	19	30
Proportion of Offered who accepted	81%	49%	64%	89%	79%	74%	95%	73%	67%	68%	94%	79%	50%
Program duration (2019-20)	273	80	58	108	40	124	65	45	33	183	405	411	580
Program duration (2020-21)	354	118	74	150	51	169	102	61	42	237	435	430	610

\* clients who have voluntarily accepted an offer to participate in the program

- The proportion of program referrals receiving an offer in 2020-21 ranged from 68% to 100% across program sites (Table 12).
- The proportion of offers accepted ranged from 49% to 95% (Table 13).

### 3.3 Client Referral Sources

Table 14 shows the top five referral sources for the ANFPP during 2020-21 which account for 91% (641/707) of referrals to the program.

- In 2020-21 the majority of ANFPP clients were referred from a local primary health care organisation. This referral pattern is similar to the previous reporting period.

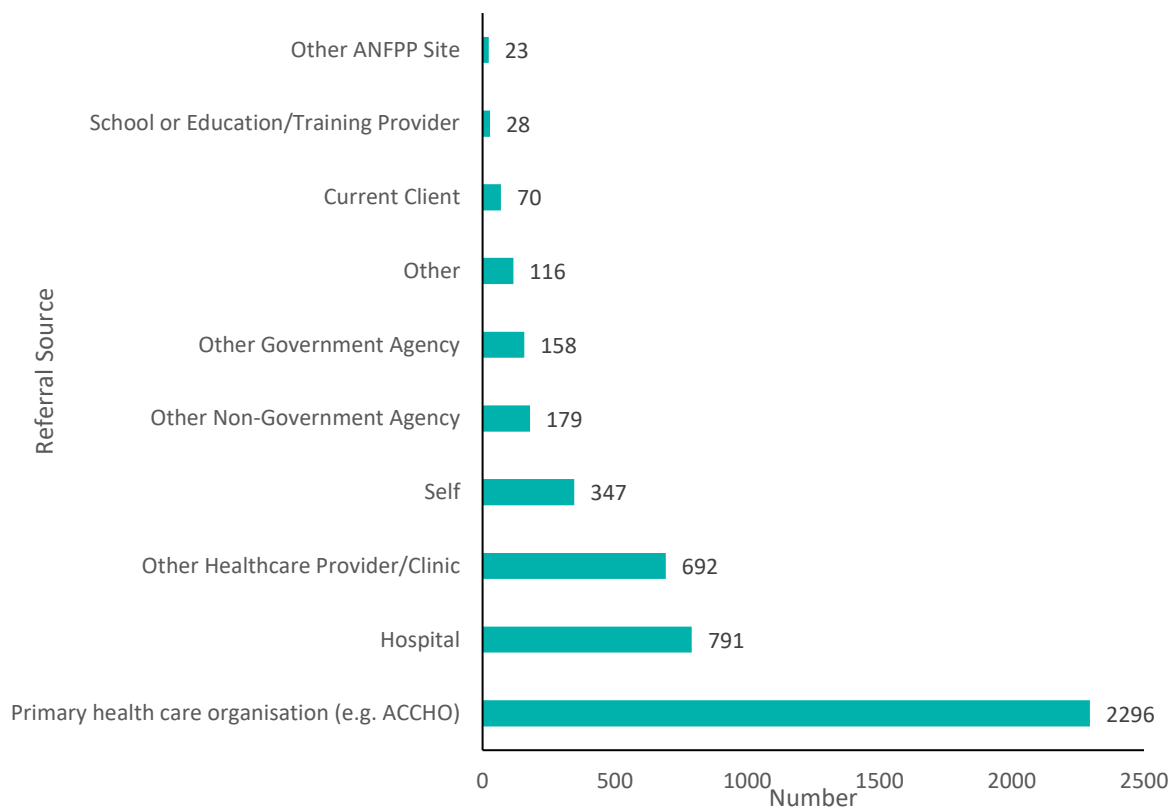
**TABLE 14: TOP FIVE REFERRAL SOURCES 2020-21, BY PROGRAM SITE**

Partner Organisation	Primary health care organisation (e.g. ACCHO)	Hospital	Other healthcare provider/ clinic	Self-Referral	Other government agency
Program site 1	25	71*	0	8	1
Program site 2	48*	1	8	2	1
Program site 3	30*	0	0	0	2
Program site 4	10	5	15*	15*	9
Program site 5	3	3	4	5*	0
Program site 6	9	0	51*	0	0
Program site 7	12*	11	2	4	11
Program site 8	15*	0	7	3	2
Program site 9	15*	0	0	1	1
Program site 10	58*	37	1	5	7
Program site 11	19*	2	5	5	1
Program site 12	1	6	19*	1	5
Program site 13	48*	0	0	8	3
<b>Total (Referral Source)</b>	<b>293</b>	<b>136</b>	<b>112</b>	<b>57</b>	<b>43</b>

\* top referral source for each program site



FIGURE 6: CLIENT REFERRAL SOURCES FOR PROGRAM DURATION



- Primary health care organisations and hospitals have been the primary referral sources for the ANFPP program sites for the program duration (Figure 6).

### 3.4 Home Visits Analysis

Under CME 10, the ANFPP NHVs and FPWs, using professional knowledge, judgement and skill, apply Home Visit Guidelines, individualising them to the strengths and risks of each family. The team apportions time in visits across the ANFPP domains of My Child, My Family & Friends, My Health, My Home and My Life. Program delivery is designed according to recommended domain benchmarks which vary with the program phases of pregnancy, infancy and toddlerhood. For example, it is recommended that the domain of My Child makes up 23-25% of a pregnancy home visit, which increases to 45-50% once the child is born and the women is in the infancy phase of the program.

**TABLE 15: TIME APPORTIONED ACROSS PROGRAM DOMAINS 2020-21, BY PROGRAM PHASE AND REMOTENESS AREA**

(duration is estimated proportion (%) of visit) <b>Remoteness</b>	<b>Phase</b>	<b>My Child and Me</b>	<b>My Family &amp; Friends</b>	<b>My Health</b>	<b>My Home</b>	<b>My Life</b>
	<b>Benchmark</b>	<b>23-25%</b>	<b>10-15%</b>	<b>35-40%</b>	<b>5-7%</b>	<b>10-15%</b>
<b>Major Cities</b>	Pregnancy	23	13	34	11	13
<b>Inner Regional</b>	Pregnancy	22	11	24	12	15
<b>Outer Regional</b>	Pregnancy	20	15	41	7	8
<b>Remote</b>	Pregnancy	22	16	30	12	15
	<b>Benchmark</b>	<b>45-50%</b>	<b>10-15%</b>	<b>14-20%</b>	<b>7-10%</b>	<b>10-15%</b>
<b>Major Cities</b>	Infancy	42	12	19	9	11
<b>Inner Regional</b>	Infancy	33	10	12	9	13
<b>Outer Regional</b>	Infancy	38	15	19	7	11
<b>Remote</b>	Infancy	37	12	17	11	13
	<b>Benchmark</b>	<b>40-45%</b>	<b>10-15%</b>	<b>10-15%</b>	<b>7-10%</b>	<b>18-20%</b>
<b>Major Cities</b>	Toddlerhood	39	12	15	9	15
<b>Inner Regional</b>	Toddlerhood	28	10	10	10	19
<b>Outer Regional</b>	Toddlerhood	32	16	17	11	14
<b>Remote</b>	Toddlerhood	39	14	19	11	15

**Key**  Below range  Within range  Above range

Table 15 shows the estimated proportion of time spent in each program domain, by program phase. **IMPORTANT NOTE: In Table 15, the totals reported by ANFPP home visiting teams do not always add up to 100%.** While the benchmarks and time apportioned to each domain are expressed as percentages, they are reported subjectively by the home visitor, usually after reflecting on the content of a home visit. Because the recommended benchmarks are estimates and they cover a range of values, for example 10-15% or 40-45%, the totals do not necessarily add up to 100%.

**TABLE 16: VISITS IN THE CLIENT’S HOME 2020-21, BY REMOTENESS AREA**

Remoteness	Visits in the Client’s Home	
	n*	%
Major Cities	2740/3464	79%
Inner Regional	149/256	58%
Outer Regional	520/893	58%
Remote	292/1292	23%
<b>Total</b>	<b>3701/5905</b>	<b>63%</b>

*\*Excluding 721 telehealth visits*

ANFPP home visiting teams acknowledge the importance of conducting visits in the place a mother and her child sleep most often while they are enrolled in the program. Under CME 6, a client is visited face-to-face in her home, or from time to time, in another suitable setting mutually determined with the client. In some program sites, the woman’s home is not always deemed to be the appropriate setting for successful face-to-face program delivery for a range of reasons including the number of others residing there. Women may have a preference, or requirement, for the visits to take place in a park, a coffee shop, in the car, on the veranda, or outside in the yard or another outdoor setting. Importantly, due to COVID-19 there were more telehealth ANFPP visits than usual during 2020-21. Phone and videoconferencing visits are excluded from Table 16.

- Women who live in major cities are more likely than women who live in other remoteness areas to have most of their program visits recorded as taking place in their home (Table 16).
- In 2020-21, 63% of the total ANFPP home visits were recorded as taking place in the woman’s home.

**TABLE 17: CLIENTS WHO HAD A FIRST HOME VISIT BEFORE 28 WEEKS 2020-21, BY REMOTENESS AREA**

Remoteness	First home visit before 28 completed weeks of pregnancy	
	n*	%
Major Cities	150/207	72%
Inner Regional	9/18	50%
Outer Regional	49/73	67%
Remote	59/96	61%
<b>Total</b>	<b>267/394</b>	<b>68%</b>

*\*Denominator: Clients who had a first home visit completed in 2020-21*

Under CME 4, women are enrolled in the program early in pregnancy and receive their first home visit no later than the 28<sup>th</sup> completed week of pregnancy. Program sites are reliant on referral sources making referrals early in pregnancy to achieve this benchmark for 100% of their clients. In turn, referral sources are reliant on women presenting early for confirmation of pregnancy and establishment of clinical antenatal care. In some communities, particularly in remote areas, the timing of a pregnancy becoming known is bound by cultural considerations.

- In major city sites, two thirds of women who had a first home visit in 2020-21 were less than 28 completed weeks of gestation at the time of that visit (Table 17).
- Women in inner regional and remote sites were less likely to have a first home visit by 28 weeks.

### 3.5 Home Visits Dosage

In the ANFPP, the client is visited throughout her pregnancy and the first two years of her child’s life in accordance with a standard program visit schedule, or an alternative visit schedule agreed upon between the client and nurse. The current ANFPP data collection does not differentiate standard and alternative schedules.

The standard visit schedule of visits is established as:

- Weekly visits upon initial antenatal enrolment for four weeks, then every second week until the infant is born.
- Weekly visits after infant birth for six weeks, followed by visits every second week until the baby is 21 months of age, then monthly visits from 21-24 months of age (infancy 0-12 months – 28 visits; toddlerhood 12-24 months – 22 visits).

**TABLE 18: HOME VISITS COMPLETED (RANGE AND MEDIAN) 2020-21, BY COMPLETED PROGRAM PHASE**

	<b>Pregnancy</b> n = 209	<b>Infancy</b> n = 188	<b>Toddlerhood</b> n = 140	<b>Entire Program</b> n =537*
<b>Range; median</b>	(1-15) 5	(1-41) 13	(1-35) 11	(1-41) 11

*\*Active clients who have not completed a program phase excluded*

The clients included in Table 18 are restricted to active program clients. The home visit calculations for each phase are completed for clients when they have moved to the next phase of the program. For example, to determine the number of clients that completed the pregnancy phase, they must have moved to the infancy phase of the program.

- The median number of visits received per woman during 2020-21 was below the standard visit schedule in pregnancy, infancy and toddlerhood (Table 18).
- The range number of visits was wide, especially in infancy and toddlerhood, indicating that a proportion of the 2020-21 ANFPP clients were complex or with a high level of program needs.

### 3.6 Client Attrition Analysis

Participation in the ANFPP, from pregnancy through to graduation when the baby reaches two years of age, requires considerable commitment on behalf of the women who enrol.

- The number of clients who left the program during the 2020-21 reporting period totalled 329. This is slightly more than the last reporting period when 318 clients left the program before graduation.

Table 19 shows the number of clients who left during 2020-21 for each program site as well as the cumulative total number that have left for the program duration to the end of the current (2020-21) and previous (2019-20) reporting periods.

**TABLE 19: NUMBER OF CLIENTS WHO LEFT THE PROGRAM 2020-21, AND CUMULATIVE ATTRITION FOR PROGRAM DURATION, BY PROGRAM SITE**

Attrition	Program site 1	Program site 2	Program site 3	Program site 4	Program site 5	Program site 6	Program sites 7	Program site 8	Program site 9	Program site 10	Program site 11	Program site 12	Program site 13	Total
<b>2020-21</b>	52	24	10	32	12	21	18	16	12	50	20	21	41	329
<b>Program duration (2019/20)</b>	161	48	25	43	15	57	15	20	9	102	311	272	339	1417
<b>Program duration (2020/21)</b>	213	72	25	75	27	78	33	36	21	152	331	293	380	1746

Tables 20 & 21 show the number and percentage of clients who left during pregnancy, infancy and toddlerhood, for 2020-21 and program duration respectively. The data is presented by remoteness area.

- In 2020-21, client attrition was lowest among women who were in the toddlerhood phase of the program.

Because client attrition is consistently higher in the pregnancy and infancy phases of the program, there are also proportionally fewer clients enrolled in the toddlerhood phase. It's not possible to present client attrition as a proportion of the clients in each program phase because across the

reporting year, the number of women in each phase (denominators) is continually changing as the women move in and out of the program and in and out of phases within the program.

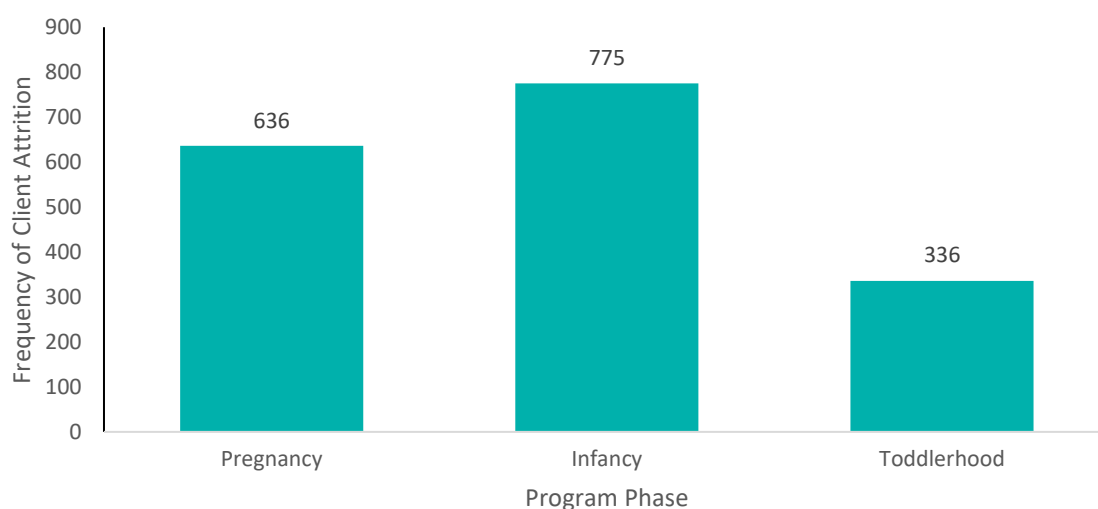
**TABLE 20: CLIENTS WHO LEFT IN EACH PROGRAM PHASE 2020-21, BY REMOTENESS AREA**

Remoteness	Pregnancy		Infancy		Toddlerhood		All Phases n
	n	%	n	%	n	%	
Major Cities	53	(32%)	78	(46%)	37	(22%)	168
Inner Regional	5	(21%)	10	(42%)	9	(38%)	24
Outer Regional	27	(42%)	23	(35%)	15	(23%)	65
Remote	11	(15%)	35	(49%)	26	(36%)	72
<b>Total</b>	<b>96</b>	<b>(30%)</b>	<b>146</b>	<b>(44%)</b>	<b>87</b>	<b>(26%)</b>	<b>329</b>

**TABLE 21: CLIENTS WHO LEFT IN EACH PROGRAM PHASE FOR PROGRAM DURATION, BY REMOTENESS AREA**

Remoteness	Pregnancy		Infancy		Toddlerhood		All Phases n%
	n	%	n	%	n	%	
Major Cities	219	(43%)	212	(42%)	78	(15%)	509
Inner Regional	18	(38%)	19	(40%)	11	(23%)	48
Outer Regional	250	(36%)	338	(49%)	108	(16%)	696
Remote	149	(30%)	206	(42%)	139	(28%)	493
<b>Total</b>	<b>636</b>	<b>(36%)</b>	<b>775</b>	<b>(44%)</b>	<b>336</b>	<b>(19%)</b>	<b>1747</b>

**FIGURE 7: CLIENTS WHO LEFT IN EACH PROGRAM PHASE FOR PROGRAM DURATION**



Home visiting teams report the primary reason for women leaving the program prior to graduation. Figure 8 shows the reasons for leaving in 2020-21 and Figure 9 is for program duration.

- Overall, for program duration, the most frequently reported reason for leaving has been the woman moved out of the program service area (Figure 9). In some cases, she has moved to a location that was also an ANFPP site and was able to continue with the program.
- Other frequently reported reasons were leaving following excessive missed appointments, the home visiting team was no longer able to locate their client, or because the woman felt she had received what she needed from the program.

The category 'Other' as a reason for leaving the program is selected by home visiting teams at a site level and the specific reason is not always provided.

FIGURE 8: RECORDED REASONS FOR LEAVING THE PROGRAM 2020-21

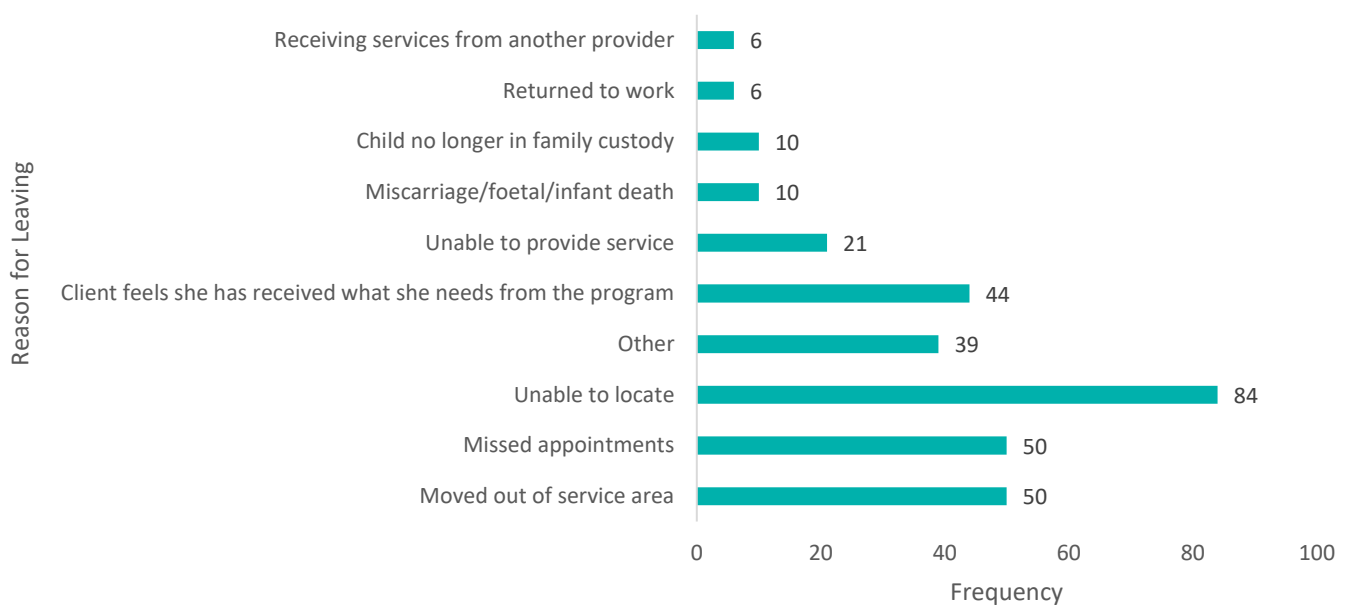
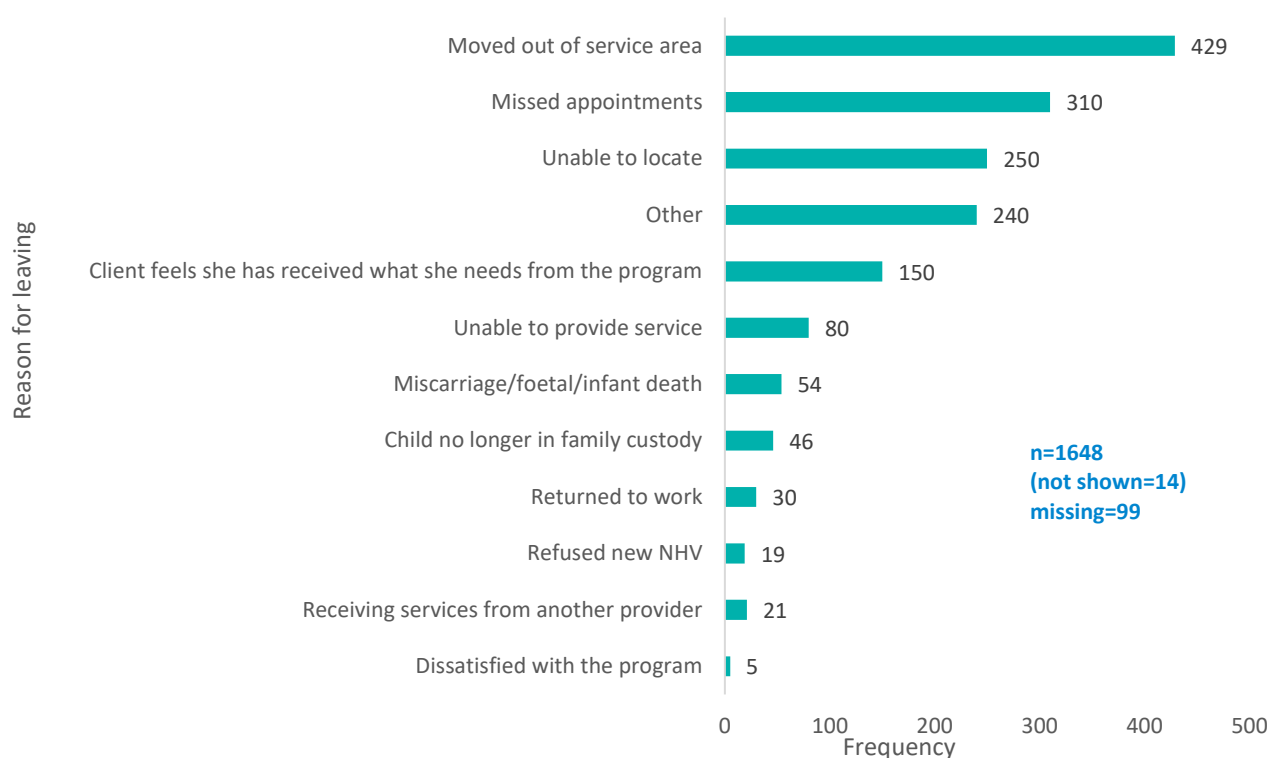




FIGURE 9: RECORDED REASONS FOR LEAVING THE PROGRAM FOR PROGRAM DURATION



Some of the recorded reasons for leaving the program occur infrequently. To protect the privacy and confidentiality of ANFPP clients and program sites, 'Reason for Leaving' with a count of less than 5 in Figures 8 and 9 are 'not shown' in the graphs. This applies to the following recorded reasons: 'Returned to education', 'Pressure from family members', 'Maternal death', 'Incarcerated or other out of home placement for mother', 'Refused new NHV', and 'Refused new FPW'.

During 2020-21, 14 women were recorded as leaving the program for positive reasons including 'Returned to education', 'Client felt she has received what she needs from the program', or, 'Receiving services from another provider'. In addition, serious life events including miscarriage, and infant or maternal deaths represent a small but unavoidable proportion of client attrition. The program site being 'Unable to provide service' due to resourcing or other issues accounts for additional program attrition.

## 4. Workforce

ANFPP program sites have home visiting teams comprising: a Nurse Supervisor, Family Partnership Workers and Nurse Home Visitors.

This section of the report describes:

- ANFPP workforce makeup by site
- Proportion of Indigenous and non-Indigenous staff
- ANFPP workforce retention

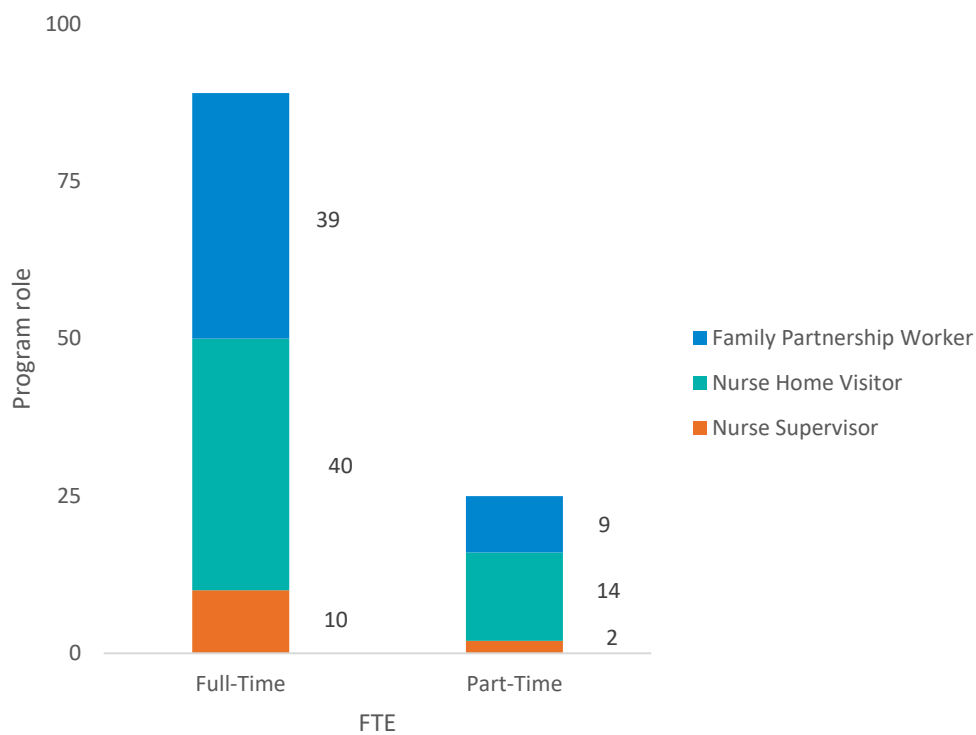
Core Model Element 12 requires that each ANFPP team has an assigned Nurse Supervisor who leads and manages the team and provides regular clinical and reflective supervision. A Nurse Supervisor should lead a team of no more than eight home visiting staff and a team administrator.

**TABLE 22: HOME VISITING TEAMS 2020-21, BY PROGRAM ROLE AND SITE**

Program Site	NS	NHV	FPW	Total
Program site 1	1	7(2*)	4	12
Program site 2	1	4	4	9
Program site 3	1(1*)	2(1*)	4(2*)	7
Program site 4	1	4	5	10
Program site 5	1	2	2(1*)	5
Program site 6	1	6	5(5*)	12
Program site 7	1	5 (2*)	4	10
Program site 8	0	3	3	6
Program site 9	1(1*)	3	3	7
Program site 10	1	5(1*)	4	10
Program site 11	1	3	3	7
Program site 12	1	1(1*)	3	5
Program site 13	1	9(7*)	4(1*)	14
<b>Total</b>	<b>12</b>	<b>54</b>	<b>48</b>	<b>115**</b>

*\*part-time FTE; \*\* Congress also employs a social worker as a member of their ANFPP team*

FIGURE 10: HOME VISITING TEAMS 2020-21, BY FTE (FULLTIME EQUIVALECE)



The total ANFPP workforce at 30 June 2021, at 115, is slightly more than the previous reporting period (113).

- The 2020-21 workforce included a total of 12 Nurse Supervisors, 54 Nurse Home Visitors and 48 Family Partnership Workers.
- There were 25 part-time positions: 2 NSs, 14 NHVs and 9 FPWs (Figure 10).

FIGURE 11: HOME VISITING TEAMS 2020-21, BY INDIGENOUS STATUS

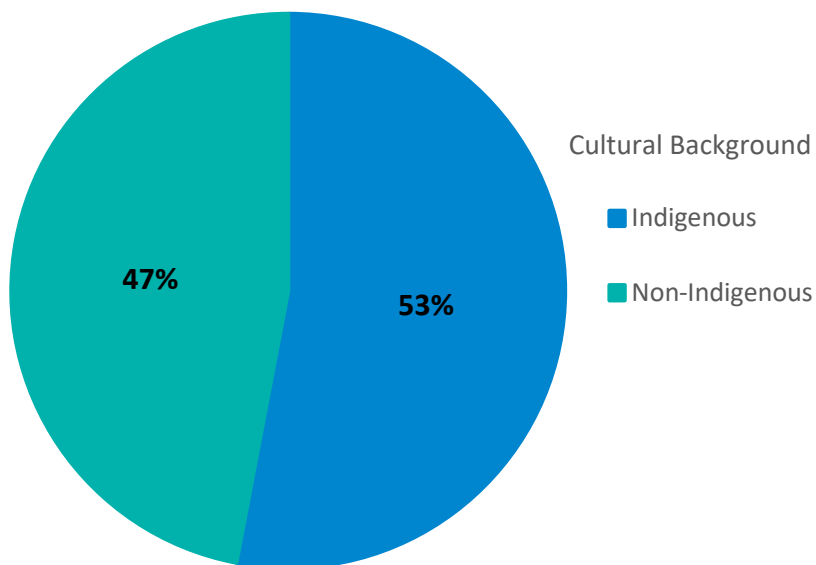


Figure 11 shows the proportion of Indigenous and non-Indigenous team members that made up the home visiting teams in 2020-21.

- Just over half, 53%, of the home visiting team workforce were Indigenous Australians.

**TABLE 23: HOME VISITING TEAMS 2020-21, BY INDIGENOUS STATUS AND PROGRAM ROLE**

Home visiting role	Indigenous	Non-Indigenous	Total (Indigenous %)
Family Partnership Worker	48	0	48 (100%)
Nurse Home Visitor	10	44	54 (19%)
Nurse Supervisor	2	10	12 (17%)
<b>Total (N, %)</b>	<b>60</b>	<b>54</b>	<b>114 (53%)</b>

**FIGURE 12: HOME VISITING TEAMS 2020-21. BY INDIGENOUS STATUS AND PROGRAM ROLE**

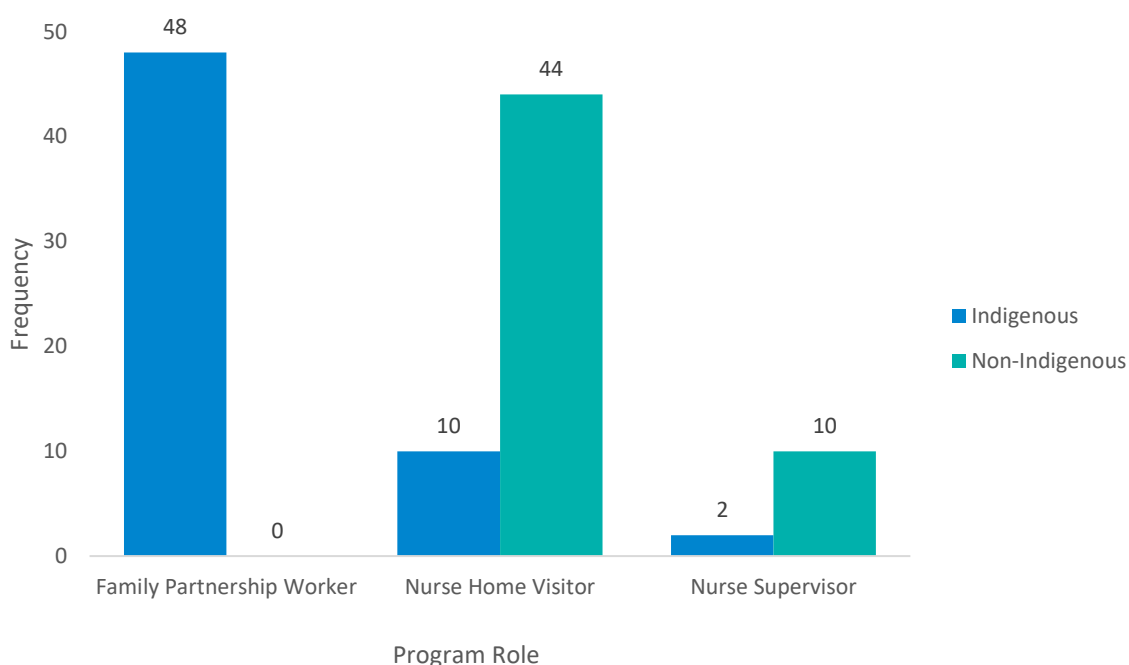


Table 23 and Figure 12 show the proportion of Indigenous and non-Indigenous team members according to program role.

- The number of Indigenous NHVs in the teams increased from seven in 2019-20, to 10 in 2020-21, with Indigenous NHVs making up 19% of the workforce in this role.
- Over half the ANFPP home visiting team positions were filled by Indigenous Australians.

Staff recruitment and retention has been an ongoing challenge in the ANFPP, particularly in rural and remote areas. Table 24 shows the number of positions per role and the proportion of staff who left in that role in 2020-21.

**TABLE 24: STAFF TURNOVER 2020-21, BY PROGRAM ROLE**

Program role	ANFPP positions per role	Left in 2020-21
	n	n (%)
Family Partnership Worker	48	8 (17%)
Nurse Home Visitor	54	23 (43%)
Nurse Supervisor	12	3 (25%)
<b>Total</b>	<b>114</b>	<b>34 (30%)</b>

Staff turnover in the ANFPP in 2020-21 was similar to the previous reporting period (in 2019-20 ANFPP staff turnover was 35/113).

- Program sites reported there were 34 staff who left the program in 2020-21. Most of the staff turnover was among Nurse Home Visitors.
- Family Partnerships Workers were the most stable section of the ANFPP workforce (Table 24).

**TABLE 25: STAFF TURNOVER 2020-21, BY REMOTENESS AREA**

Remoteness area	ANFPP positions per area	Left in 2020-21
	n	n (%)
Major cities	49	20 (41%)
Inner regional	12	4 (33%)
Outer regional	21	7 (33%)
Remote	33	3 (9%)
<b>Total</b>	<b>114</b>	<b>34 (30%)</b>

Table 25 shows ANFPP staff turnover by remoteness area.

- Turnover in remote areas was lower (9% of home visiting workforce) than program sites in other areas. This is a marked difference from the previous reporting period when remote areas had the highest turnover (i.e. 41% of home visiting workforce turnover in 2019-20 was in remote areas).

FIGURE 13: STAFF TURNOVER 2020-21, BY PROGRAM ROLE & REMOTENESS AREA

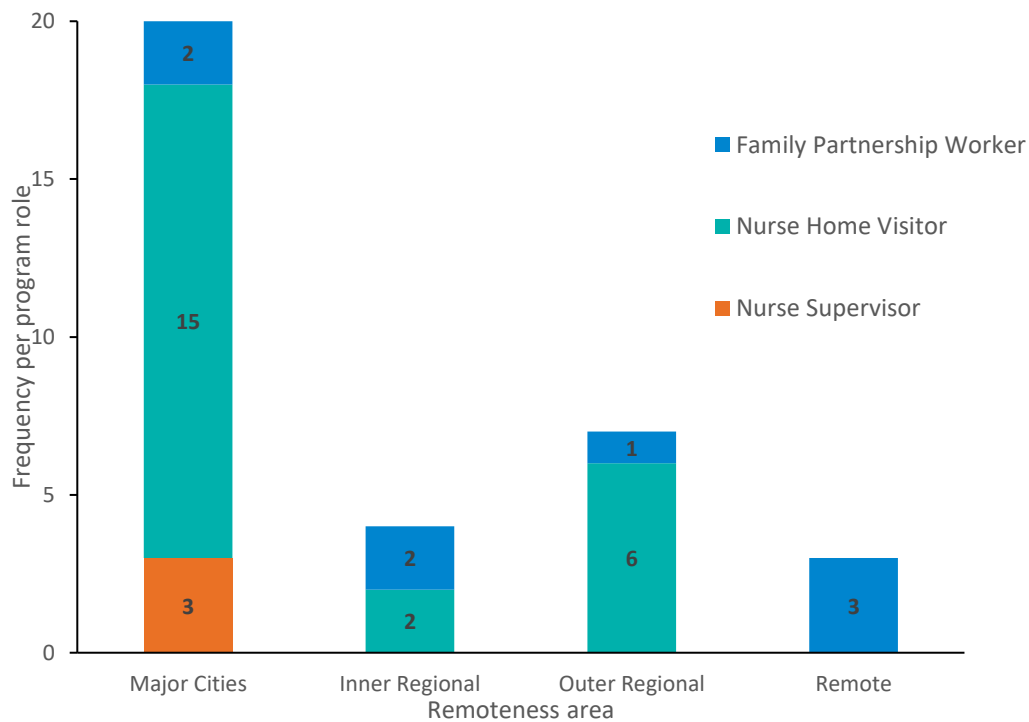


Figure 12 shows staff turnover in 2020-21 by program role and remoteness area

- In 2020-21, staff turnover as a proportion of the home visiting workforce was highest in major cities.

## ANFPP client characteristics

Australia's colonial history and the ongoing effects of detrimental government policies shape the health and wellbeing of Aboriginal and Torres Strait Islander peoples. While there is diversity of life experiences and circumstances among Aboriginal and Torres Strait Islander women having their first baby, history and politics contribute to poorer overall perinatal outcomes than those experienced by other Australian women (Australian Government Department of Health, 2021). It is important to acknowledge that pregnancies in which only the father is Aboriginal or Torres Strait Islander may have similarly poorer overall perinatal outcomes (Clarke & Boyle, 2014).

Section 1.2, towards the start of this report includes a descriptive analysis of selected client demographics, pregnancy characteristics and pregnancy outcomes of 1880 mothers enrolled in the ANFPP who have had an Aboriginal and/or Torres Strait Islander baby. Most of these women experienced healthy pregnancies and had a healthy baby. For women who experienced adverse pregnancy events, the reasons are likely to be varied and complex (Clarke & Boyle 2014).

Socioeconomic factors (lower income, higher unemployment, lower educational levels, increased rates of incarceration, inadequate infrastructure, e.g. affordable housing), health factors (diabetes, cardiovascular, respiratory and kidney diseases, infections, injuries, poor mental health) and lifestyle factors (smoking, poor nutrition, and higher psychosocial stressors, e.g. deaths in families, financial pressure, contact with the justice system) contribute to the perinatal characteristics and outcomes in Aboriginal and Torres Strait Islander families (Australian Government Department of Health, 2021). Racism, and other challenges in accessing services and culturally safe health care constitute an additional burden on young Aboriginal and Torres Strait Islander women having a baby (Kildea et al, 2016).

The following section is a description of selected characteristics of the mothers who were enrolled in the ANFPP during 2020-21 (including maternal cultural background, parity, age, household size, EPDS screening and access to clinical antenatal care).



## 5.1 Client cultural background and parenting status

Table 26 shows the cultural background of 449 women who enrolled in the program in 2020-21.

- Most clients identified as Aboriginal women (82%).
- The program was also offered to non-Indigenous women pregnant with an Aboriginal or Torres Strait Islander baby who made up 13% of enrolled/accepted clients in 2020-21.

**TABLE 26: INDIGENOUS STATUS OF ACCEPTED CLIENTS 2020-21**

Indigenous status	n	%
Aboriginal	369	82
Aboriginal and Torres Strait Islander	15	3
Non-Indigenous (having an Aboriginal or Torres Strait Islander baby)	56	13
Torres Strait Islander	9	2
Missing	0	0
<b>Total</b>	<b>449</b>	<b>100</b>

ANFPP is delivered to first-time mothers, however, multiparous women are included at the discretion of program sites (Table 27).

- In 2020-21, most program clients were first time mothers (87%).
- The remainder of program clients were multiparous mothers (13%) for whom it may have been their first opportunity to parent.

**TABLE 27: PARITY (PREVIOUS LIVE BIRTHS) OF ACCEPTED CLIENTS 2020-21**

Parity (Live Births)	n	%
0	388	87
1	34	8
2	13	3
3	<5	<1
4+	6	1
Missing	5	1
<b>Total</b>	<b>449</b>	<b>100</b>

## 5.2 Client Age

The ages of active clients enrolled in the program in 2020-21 ranged from 14 to 42 years with a mean of 23 years (Table 28). Most women (70%) were between 20 and 34 years at intake and almost a third (28%) were aged less than 20 years (Table 28). The age distribution of active clients in 2020-21 is similar to the previous reporting period.

**TABLE 28: AGE OF ACCEPTED CLIENTS AT INTAKE 2020-21**

	<b>Age in Years n=449</b>
<b>Mean age at intake</b>	23
<b>Median age at intake</b>	22
<b>Minimum age</b>	14
<b>Maximum age</b>	42

**TABLE 29: AGE DISTRIBUTION OF ACCEPTED CLIENTS AT INTAKE 2020-21**

<b>Age range</b>	<b>n</b>	<b>(%)</b>
<b>14-19</b>	125	28
<b>20-34</b>	314	70
<b>35+</b>	10	2
<b>Missing</b>	0	0
<b>Total</b>	449	100

### 5.3 Housing and Living Arrangements

A safe secure home with facilities for daily living in good working order is a key factor for promoting good health and wellbeing. Household overcrowding is associated with a range of health problems including otitis media, trachoma, scabies, gastroenteritis and respiratory infections. Mental health issues and domestic violence are potentially exacerbated among individuals living in circumstances of overcrowding (Royal Australian College of General Practitioners, 2018). Whether or not a household is overcrowded is not necessarily related to the number of people who live there, but to the size of the dwelling and the number of bedrooms available.

**FIGURE 14: NUMBER OF PEOPLE SLEEPING (AT LEAST 4 NIGHTS PER WEEK) AT THE CLIENT'S HOUSEHOLD 2020-21, BY REMOTENESS AREA**

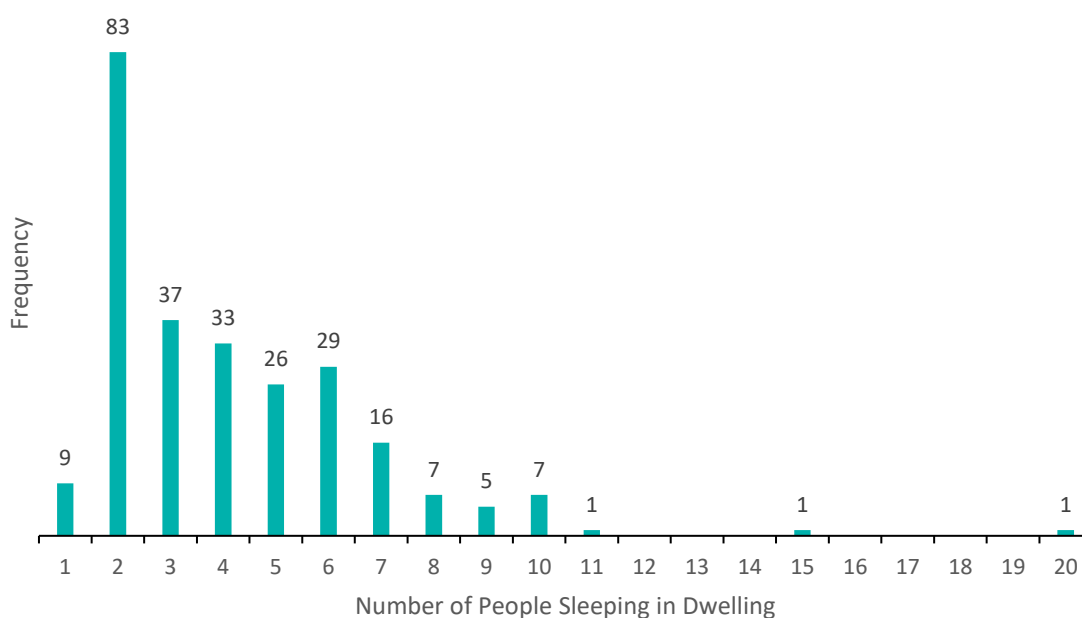


Figure 14 shows the number of people (including the ANFPP client) sleeping in client households. Individuals are considered to dwell in the residence if they are present four nights or more per week.

- 38 clients or 15% (38/255) reported living in larger households with at least 7 people sleeping at the dwelling.

ANFPP data about the housing and living arrangements is collected differently between the ANKA and Communicare data collection systems. The variables related to living arrangements are aggregated in Table 30: ‘Living alone’ = Alone or with infant/child; ‘Living with family’ = Living with own mother, husband/partner only, husband partner and others, one family or other families related to me; ‘Living with others’ = living with people not related and may include living in a group home or shelter.

- 5 active clients (2%) have reported that they experienced homelessness in 2020-21.
- Most clients, 86%, (234/271) reported living with family

**TABLE 30: NUMBER OF CLIENTS WHO REPORTED HOMELESSNESS, LIVING ALONE, LIVING WITH OTHERS 2020-21, BY REMOTENESS AREA**

Remoteness area	Reported homelessness	Living alone	Living with Family	Living with others
Remote	<5	0	57	4
Outer regional	0	0	50	0
Major cities	< 5	8	117	19
Inner regional	< 5	< 5	10	0
<b>Total</b>	<b>2%</b>	<b>3%</b>	<b>86%</b>	<b>8%</b>

*n=449: missing = 178*

## 5.4 Perinatal Mental Health

Maternal perinatal mental health refers to the psychological wellbeing of mothers during pregnancy and up to 12 months after birth. Perinatal depression and anxiety when they occur, can represent a significant health burden to expectant and new mothers.

The prevalence of antenatal and postnatal depressive symptoms was 6.2% and 3.3% respectively in a large (N=17,564) cohort of women from a culturally diverse population in Sydney, New South Wales in 2014 (Ogbo et al 2018). There is little evidence however, on the prevalence of perinatal depression and anxiety among Aboriginal and Torres Strait Islander women (Carlin et al 2019). A 2008 study in Townsville, Queensland screened 136 Aboriginal and Torres Strait Islander women and 16.7% were found to be at risk (Campbell et al 2008). Importantly, women who experience antenatal anxiety are three times more likely to report severe postpartum depression symptoms compared to those without anxiety (Highet & Goddard, 2014), highlighting the potential value of antenatal screening.

In the ANFPP, during pregnancy there are two timepoints when perinatal mental health screening is recommended; at intake to the program, or as soon after intake as practical, and at 36 weeks gestation. The recommended screening tools are the Edinburgh Postnatal Depression Scale (EPDS) or the Kimberley Mum's Mood Scale. Items 3,4 & 5 of the EPDS represent a subscale for assessing anxiety.

**TABLE 31: PERINATAL MENTAL HEALTH SCREENING DURING PREGNANCY USING THE EPDS 2020-21, BY REMOTENESS AREA**

Remoteness area	No. of women screened at intake only	No. of women screened at 36 weeks only	No. of women screened at intake AND 36 weeks	Total women screened (at intake and/OR 36 weeks)
<b>Remote</b> Not screened=22	11	4	10	25
<b>Outer regional</b> Not screened=26	3	1	1	5
<b>Major cities</b> Not screened=63	55	10	24	89
<b>Inner regional</b> Not screened=7	1	2	6	9
<b>Total</b> Not screened=118	<b>70</b>	<b>17</b>	<b>41</b>	<b>128</b>

Denominator: Clients at ANKA sites who completed pregnancy phase (had a baby) in 2020-21 n=246.

In Tables 31 to 33, ANFPP clients who had their perinatal screening results recorded in Communicare are excluded because screening at 36 weeks gestation is not recorded in that system. ‘Not screened’ includes women who were offered, but declined screening. Table 31 shows,

- There were 41 or 17% (41/246) of women who had a baby in 2020-21, who had perinatal screening results recorded at both intake to the program and 36 weeks gestation.
- Another 70 women were screened at intake only, and 17 at 36 weeks only.
- Overall, 128 or 52% (128/246), had perinatal screening during pregnancy results recorded.

**TABLE 32: POSSIBLE DEPRESSIVE SYMPTOMS: EPDS SCORE OF 13 OR MORE DURING PREGNANCY 2020-21**

	Screened at intake only (n=70)	Screened at 36 weeks only (n=17)	Screened at intake & 36 weeks (n=41)	Total women (screened at intake and/OR 36 weeks) (n=128)
Possible depression symptoms	12	<5	<5	18

Denominator: Clients at ANKA sites who completed pregnancy phase in 2020-21 and were screened with EPDS n = 128

Table 32 shows the number of women who had perinatal mental health screening in pregnancy and had a score of 13 or more indicating possible depressive symptoms.

- Of 128 women screened, 14% (18) had a score of 13 or more.

**TABLE 33: POSSIBLE ANXIETY SYMPTOMS: SCORE 6 OR MORE (EPDS ITEMS 3,4 & 5) DURING PREGNANCY 2020-21**

	Screened at intake only (n=70)	Screened at 36 weeks only (n=17)	Screened at intake & 36 weeks (n=41)	Total women (screened at intake and/OR 36 weeks) (n=128)
Possible anxiety symptoms	14	<5	6	21

Denominator: Clients at ANKA sites who completed pregnancy phase in 2020-21 and were screened with EPDS n = 128

Table 33 shows the number of women screened who had a score of 6 or more on the anxiety subscale indicating possible anxiety symptoms during pregnancy.

- Of 128 women screened, 16% (21) had a score of 6 or more.

## 5.5 Clinical Antenatal Care

Early and regular antenatal care is associated with positive health outcomes for mothers and their babies, including improved maternal health during pregnancy, a lower rate of interventions in late pregnancy and better child health outcomes. Antenatal care is a planned visit between the pregnant woman and a midwife or doctor and does not include visits where the sole purpose is pregnancy confirmation (Australian Government Department of Health 2020).

ANFPP home visiting teams record their clients stage of pregnancy when she attended her first clinical antenatal visit (often self-reported by the woman).

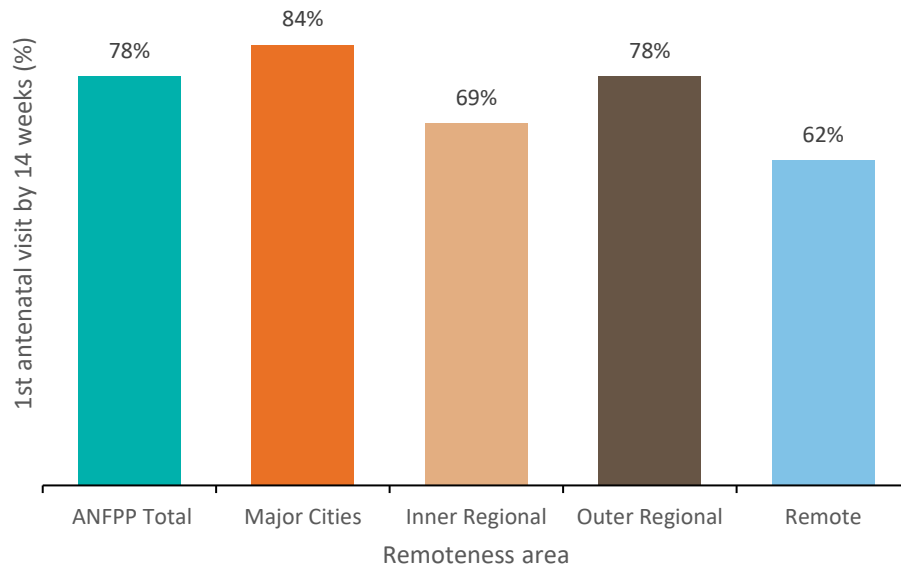
- Data about timing of first antenatal visit was missing for 48% (217/449) of clients who were enrolled/accepted in 2020-21 (Table 34).

**TABLE 34: FIRST CLINICAL ANTENATAL VISIT BEFORE 14 WEEKS 2020-21, BY REMOTENESS AREA**

Remoteness area	First clinical antenatal visit <14 weeks of pregnancy	
	n	%
Major cities	105/125	84%
Inner regional	9/13	69%
Outer regional	38/49	78%
Remote	28/45	62%
<b>ANFPP Total</b>	180/232	78%
Missing	217/449	48%

*Denominator: Clients who were enrolled/accepted in 2020-21 n = 449*

FIGURE 15: FIRST CLINICAL ANTENATAL VISITS OCCURRING BEFORE 14 WEEKS OF PREGNANCY 2020-21, BY REMOTENESS AREA



- Eighty-four percent of women in major cities & 62% of women in remote areas were recorded as having a first antenatal visit before 14 weeks of pregnancy (Table 33 & Figure 15).
- Overall, 78% of ANFPP clients had their first visit before 14 weeks.



**FIGURE 16: DURATION OF PREGNANCY AT FIRST ANTENATAL VISIT ANFPP CLIENTS 2020-2019, AND AIHW 2019 MOTHERS AND BABIES DATA COLLECTION**



Figure 16 shows duration of pregnancy at first antenatal visit for 2020-21 ANFPP clients compared with Aboriginal and Torres Strait Islander women and non-Indigenous women included in the AIHW Mothers and Babies national data collection (Australian Institute of Health and Welfare 2021b)

Of the clients with information about their first clinical antenatal visit recorded,

- a higher proportion of 2020-21 active ANFPP clients (78%) had accessed antenatal care before 14 weeks gestation than other Aboriginal and Torres Islander women (67%) and non-Indigenous Australian women (75%).

## 5.6 Multiparous Mothers

Multiparous mothers are enrolled in the program at the discretion of program sites.

- Over the last four years, from 2017-18 to 2020-21, the proportion of multiparous mothers who had a baby in the ANFPP has ranged from 10-17% (Table 35).

Information that differentiates multiparous clients having their first opportunity to parent from mothers who have parented previously is not currently available for clients from sites that use Communicare for ANFPP data storage (which accounts for the majority of multiparous women enrolled), so these data are not reported as a separate category.

**TABLE 35: BIRTHS TO MULTIPAROUS CLIENTS 2017-18 – 2020-21, AS A PROPORTION OF SINGLETON BIRTHS**

Year	Total singleton births	Multiparous clients (including First Opportunity to Parent)	
	n	n	(%)
2017/18	198	19	10%
2018/19	309	43	14%
2019/20	314	54	17%
2020/21	281	40	14%

All program sites have at some time enrolled multiparous mothers, but most enrolments have been in remote areas. However, in 2020-21, more multiparous women were enrolled in the ANFPP at major city sites (Table 36).

**TABLE 36: BIRTHS TO MULTIPAROUS CLIENTS 2017-18 – 2020-21, BY REMOTENESS AREA**

Year	Remote	Inner regional	Outer regional	Major cities
2017/18 n=19	14	0	5	0
2018/19 n=43	24	3	5	11
2019/20 n=54	25	12	4	13
2020/21 n=40	7	3	6	24

## 5. ANFPP Program Outcomes

### 6.1 Overview

TABLE 37: ANFPP OUTCOME MEASURES AND TARGETS

Outcome measures	Measured by	Program Target	ANFPP performance for 2020/21
<b>A. Pregnancy outcome</b>			
<b>Smoking</b>	Percentage of women smoking from intake to 36 weeks pregnancy	Reduction by 25% or greater	Among 90 women (active clients with completed pregnancy phase) with data about smoking available at both the beginning and end of pregnancy there was a 8% reduction of women smoking from intake to 36 weeks pregnancy
	Number of cigarettes smoked per day between intake and 36 weeks pregnancy	Average reduction by 83% for women who smoked 5 or more cigarettes at intake and 36 weeks pregnancy	There was very little data about the number of cigarettes smoked per day available at both the beginning and end of pregnancy. Among 14 women who reported smoking >5 cigarettes per day at intake, 10 reported smoking <5 cigarettes at 36 weeks
<b>Preterm births</b>	The percentage of infants born preterm	7.6% or less	12.5% of infants were preterm
<b>Low birthweight</b>	The percentage of infants born with low birthweight (LBW)	5% or less	<ul style="list-style-type: none"> <li>15% of infants were low birthweight</li> <li>After excluding preterm infants, the rate of low birthweight was 5%</li> </ul>
<b>B. Child health and development outcome</b>			
<b>Immunisation</b>	Completion rates for all recommended childhood immunisations by the second birthday	90% or greater	98% of infants had their recommended immunisations by their 2 <sup>nd</sup> birthday
<b>Breastfeeding</b>	The percentage of mothers who ever breastfed	No target set	90% of mothers reported having ever breastfed

<b>Outcome measures</b>	<b>Measured by</b>	<b>Program Target</b>	<b>ANFPP performance for 2020/21</b>
<b>Ages and Stages Questionnaire</b>	The percentage of toddlers who fall below the cut off score for further assessment or referral	No target set	Among toddlers assessed at 20 months: Communication: 27% Gross motor skills: 0% Fine motor skills: 0% Personal/Social: 0% Problem solving: 0%
<b>C. Improving parent's life-course outcomes</b>			
<b>Subsequent pregnancy frequency</b>	Percentage of women having subsequent pregnancies within two years of the infants' birth	<25%	(14/561) active clients) 3% of mothers reported a subsequent pregnancy within two years of the infants' birth

## 6.2 Immunisation

The aim of the National Immunisation Strategy 2019-24 is to achieve herd immunity against vaccine-preventable diseases (Australian Government Department of Health, 2018). Herd immunity is achieved when enough people are vaccinated so that the level of immunity in a population prevents spread of a disease. Herd immunity also provides protection to people who are unimmunised including those who are too young, those for whom immunisation is medically contraindicated, or those for whom immunisation was not effective.

To achieve herd immunity for highly infectious diseases (e.g. measles) requires an immunisation coverage rate of 92-94%, however, Australia's national target is 95% coverage (Australian Government Department of Health, 2021).

The latest reporting from the Australian Immunisation Register provides data on childhood immunisation coverage up to June 2021 (Australian Government Department of Health, 2021a). The percentage of Aboriginal and Torres Strait Islander children reported as fully immunised by 12 months of age is 93.4%; and by 24 months is 92% (Australian Government Department of Health, 2021b).

**TABLE 38: PERCENTAGE OF ANFPP CHILDREN FULLY IMMUNISED AT 12 AND 24 MONTHS 2017-18 – 2020-21**

Stage	ANFPP immunisation coverage by period				National rate for Aboriginal and Torres Strait Islander Children**
	2017–18	2018–19	2019–20	2020-21*	
<b>12 months</b>	94%	95%	98%	99%	93.4%
<b>24 months</b>	94%	94%	97%	98%	92%

\*Data completeness 2020/21 at 12 months (170/213) 80%, 2020/21 at 24 months (118/166) 71%

\*\*2020/21 data sourced from DOH (Australian Government Department of Health 2021b).

**FIGURE 17: PERCENTAGE OF ANFPP CHILDREN FULLY IMMUNISED AT 12 AND 14 MONTHS  
2017-18 – 2020-21**

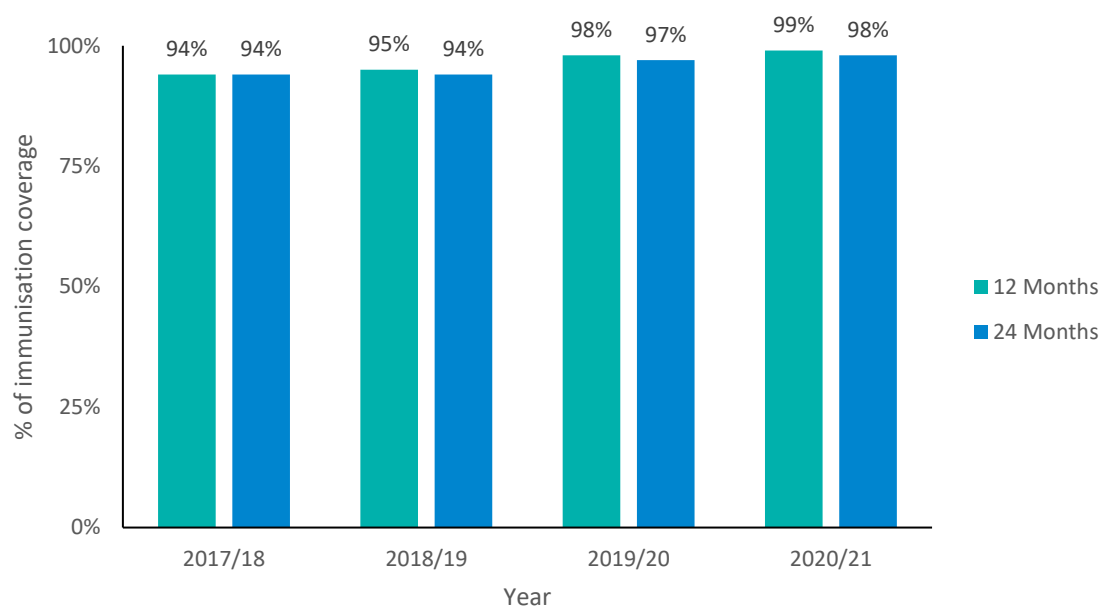
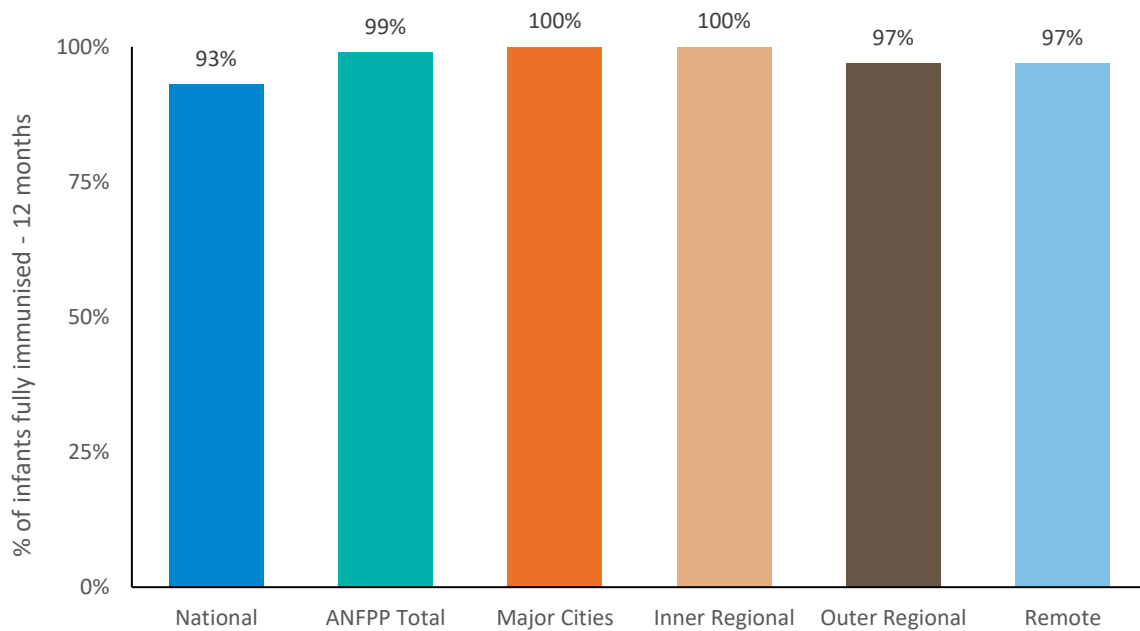


Table 38 and Figure 17 show the percentage of ANFPP children reported as fully immunised from 2017-18 through to the current reporting period, 2020-21.

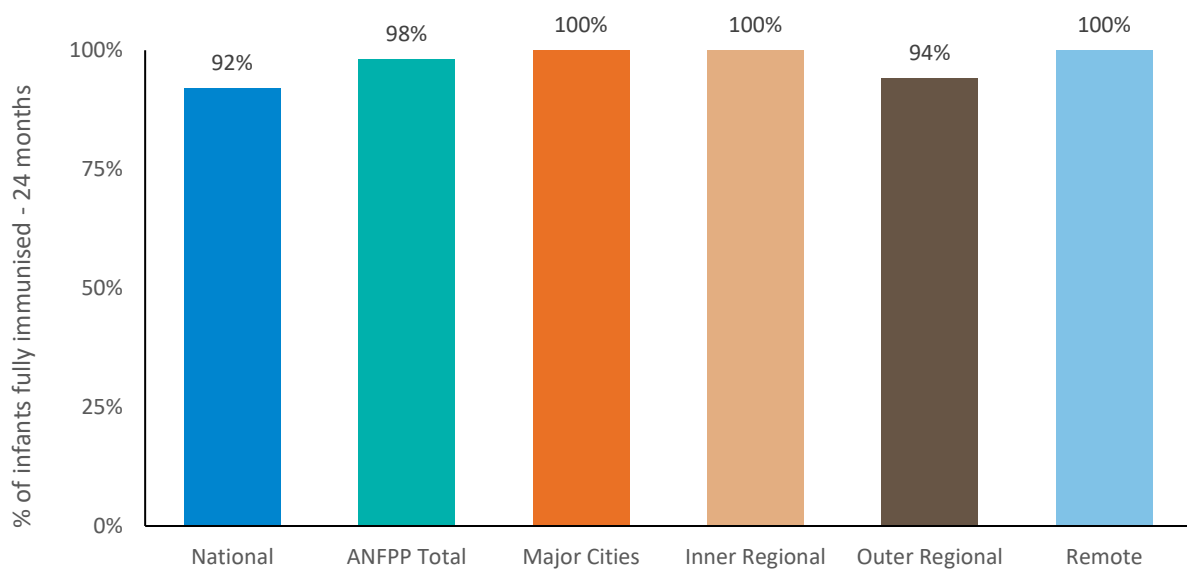
- Data completeness for reporting immunisation status in 2020-21 was 80% (170/213) for children aged 12 months of age in the reporting period, and 71% (118/166) for children aged 24 months (Table 38).
- The 2020-21 immunisation coverage was very high among children in the program with data available. Of children aged 12 months, 99% were reported as fully immunised and at 24 months, 98% of children were immunised (Table 38 & Figure 17).
- Immunisation coverage of children in the ANFPP has exceeded the national aspirational target of 95% in 2020-21 in all remoteness areas for infants aged 12 months (Figure 18).

**FIGURE 18: PERCENTAGE OF CHILDREN FULLY IMMUNISED AGED 12 MONTHS 2020-21, BY REMOTENESS AREA**



National Data: Sourced from DOH (Australian Government Department of Health 2021b).

**FIGURE 19: PERCENTAGE OF CHILDREN FULLY IMMUNISED AGED 24 MONTHS 2020-21, BY REMOTENESS AREA**



National Data: Sourced from DOH (Australian Government Department of Health 2021b).

### 6.3 Breastfeeding

The World Health Organization recommends that infants initiate breastfeeding in the first hour after birth and be breastfed exclusively, as often as the child wants, for the first six months (World Health Organization, 2020). In Australia, while most women intend to breastfeed and most initiate breastfeeding, only 15-25% continue exclusive breastfeeding until their baby is six months of age (COAG Health Council, 2019).

In a two-part Lancet series, Victora et al (2016) and Rollins et al (2016) reviewed the short-term and long-term maternal and child health consequences of breastfeeding and explored what is needed to improve breastfeeding practices. Key messages included:

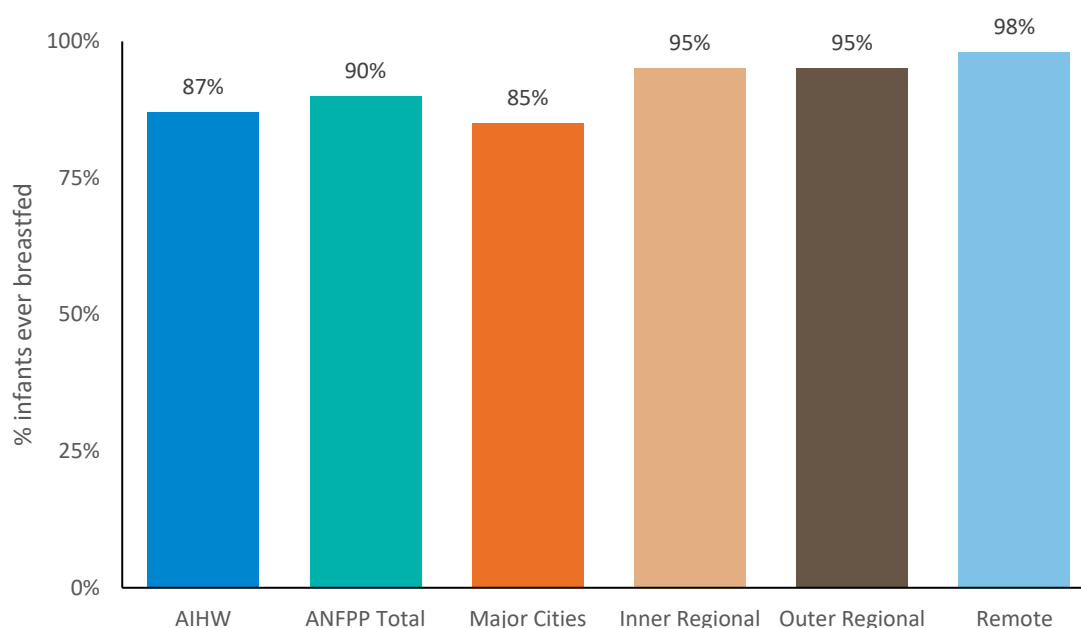
- Children with longer breastfeeding duration have lower morbidity and mortality from infections, better dental health, and higher intelligence. There is strengthening evidence that suggests breastfeeding provides protection against overweight and obesity later in life.
- Breastfeeding benefits mothers because it can reduce risk of breast cancer, improve birth spacing and may reduce her risk of diabetes and ovarian cancer.
- Women who want to breastfeed need a supportive and enabling environment.
- The promotion of breastfeeding is a societal responsibility. It is a cost-effective investment in society because it benefits human capital e.g. by improving school achievement and employment outcomes.

Figure 20 shows the percentage of singleton infants in the program in 2020-21 who were recorded as ever breastfeeding, by remoteness area.

- In remote and inner and outer regional areas the rates range from 95% to 98%. In major cities the overall rate of 'ever breastfed' was reported as 85%.



FIGURE 20: PERCENTAGE OF INFANTS EVER BREASTFED 2020-21, BY REMOTENESS AREA



AIHW Data: Tier 2 Determinants of health Breast feeding practices. (Australian Institute of Health and Welfare 2020)  
 ANFPP Data: Women who had a baby in 2020-21 n=281 missing data =17

Table 39 shows the ‘ever breastfed’ data for the years 2017-18 to 2020-21 by remoteness area.

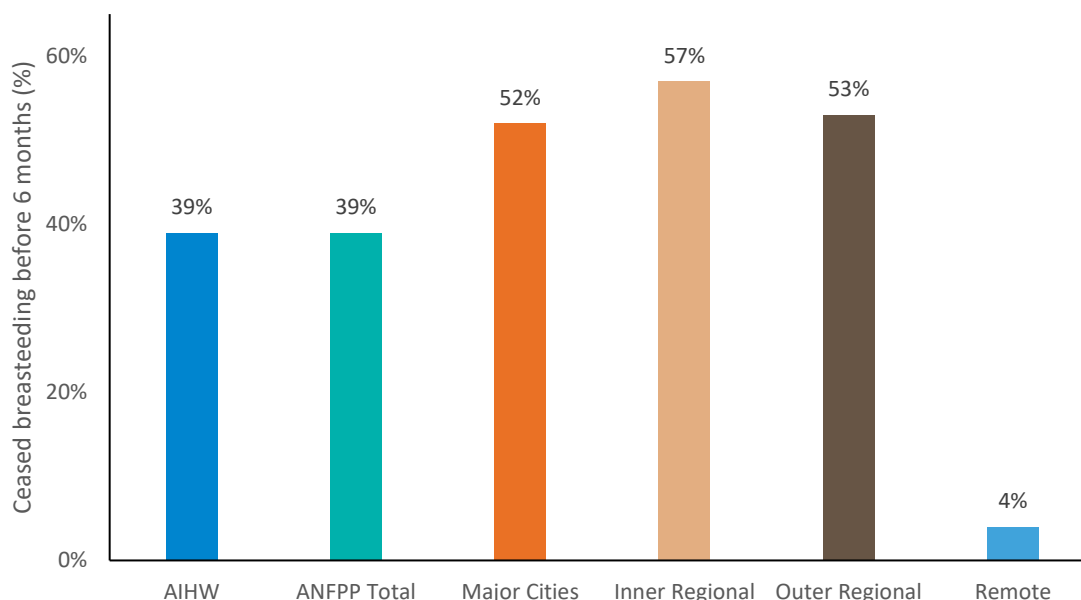
- Breastfeeding initiation rates in remote areas have remained consistently high over the last four reporting periods.

TABLE 39: PERCENTAGE OF INFANTS EVER BREASTFED 2017-18 – 2020-21, BY REMOTENESS AREA

Remoteness Area	ANFPP % Ever Breastfed Rates			
	2017–18	2018-19	2019–20	2020–21*
Major Cities	89%	93%	89%	85%
Inner Regional	*	81%	83%	80%
Outer Regional	92%	98%	89%	95%
Remote	97%	97%	99%	98%
ANFPP Total	93%	94%	97%	90%

\*Denominator: Women who had a baby in 2020-21. Missing data = 17

**FIGURE 21: PERCENTAGE OF BREASTFEEDING CESSATION BEFORE SIX MONTHS 2020/21, BY REMOTENESS AREA**



AIHW Data: Tier 2 Determinants of health Breast feeding practices. (Australian Institute of Health and Welfare 2020)

Figure 21 and Table 40 present the same data for 2020-21 from two perspectives. Figure 21 shows breastfeeding cessation prior to six months and Table 40 shows continued breastfeeding at 6 months.

**TABLE 40: INFANTS STILL BREASTFEEDING AT 6 MONTHS (24 WEEKS), 2017-18-2010/21, BY REMOTENESS AREA**

Remoteness Area	ANFPP % Still Breastfeeding at 6 months			
	2017–18	2018–19	2019–20	2020–21
<b>Mothers who ever breastfed</b>	n=48	n=71	n=138	n=314
<b>Major Cities</b>	50% (2/4)	38% (8/13)	66% (28/44)	48% (52/109)
<b>Inner Regional</b>	-	-	50% (2/4)	43% (10/23)
<b>Outer Regional</b>	43% (3/7)	43% (6/14)	42% (10/24)	47% (16/34)
<b>Remote</b>	95% (21/22)	78% (18/23)	100% (30/30)	96% (67/70)
<b>Missing</b>	n=15	n=21	n=36	n=78
<b>ANFPP Total</b>	78%	58%	69%	61%

## 6.4 Infants: Birthweights and Preterm Births

### Low birthweight babies

Birthweight is an important indicator of infant health. Babies who are born low birthweight are at a higher risk of illness, disability and death than other babies (McGovern, 2019; Australian Institute of Health and Welfare, 2018). Health effects of low birthweight can persist across the lifespan with increased risk of metabolic and cardiovascular diseases in adulthood.

Factors that contribute to low birthweight include extremes of maternal age, maternal illness during pregnancy, low socioeconomic position, multiple pregnancy, poor nutrition, lifestyle factors including tobacco use or excessive alcohol consumption, and poor antenatal care (Australian Institute of Health and Welfare, 2018). Preterm birth is a principal determinant of low birthweight (Paneth, 1995).

Table 41 shows the percentage of low birthweight babies in the ANFPP from 2017-18 to 2020-21.

- The rate of low birthweight (<2500g) in the ANFPP program in 2020-21 was 15% (42/281).
- Of 213 mothers with data about smoking in pregnancy,
  - mothers who reported any smoking in pregnancy were more likely to have a low birthweight baby - 20% (19/93) than mothers who didn't smoke - 7.5% (9/120) (p value 0.003).

For comparison, in national data about women who had a baby in 2019 (Australian Institute of Health and Welfare, 2019b)

- Of women who had an Indigenous baby in 2019, 10.6% (1,905/17,917) were born low birthweight.
- Of Indigenous women who had a baby in 2019, 11.7% (1,669/14,315) were born low birthweight.

In Australia, among all babies, Indigenous and non-Indigenous in 2019

- Mothers who reported any smoking in pregnancy were more likely to have a low birthweight baby (12.2%) than mothers who didn't smoke (6.0%).

**TABLE 41: LOW BIRTHWEIGHT SINGLETON BIRTHS 2017-18 – 2020-21**

	Total singleton births n	Low birthweight <2500g	
		n	%
<b>2017/18</b>	198	23	12%
<b>2018/19</b>	309	45	15%
<b>2019/20</b>	314	41	13%
<b>2020/21</b>	281	42	15%

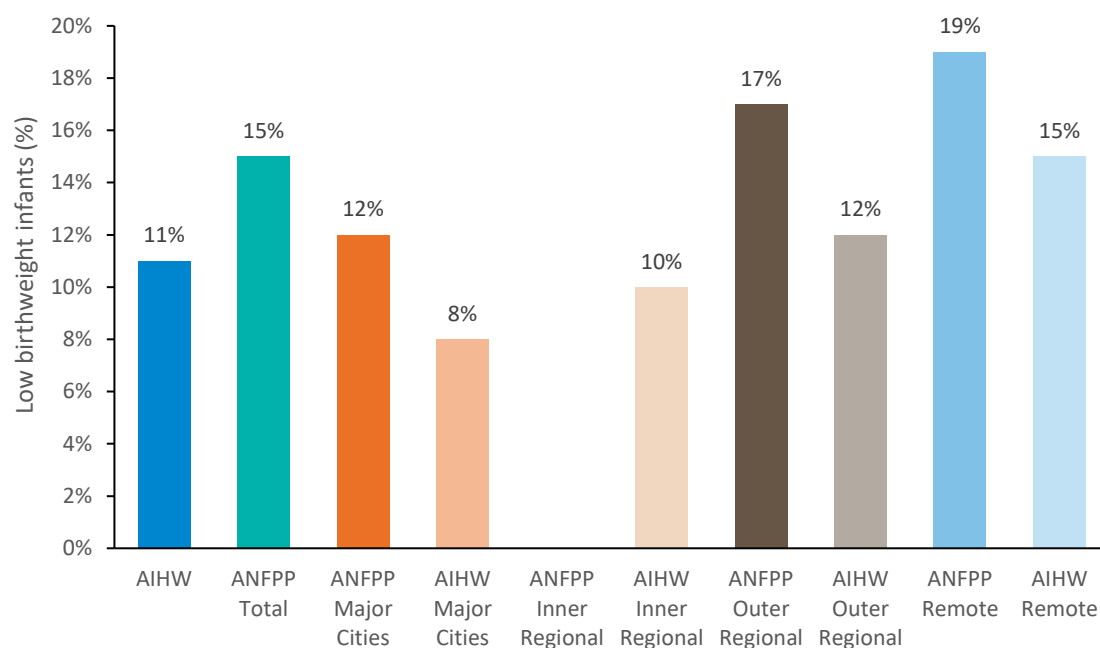
Table 42 shows different categories of birthweight including very low <1500g and high ≥4500g. In table cells where the number is very small, it is represented by '<5'.

- The rate of very low birthweight (<1500g) in 2020-21 was 5% (14/281).
- Very low birthweight as a proportion of all low birthweight in 2020-21 was 33% (14/42). This is higher than in previous years when very low birth weight babies were 1-2% of all births and 7-15% as a proportion of the low birthweight births between 2017-18 and 2019-20.

**TABLE 42: VERY LOW/LOW/NORMAL/HIGH BIRTHWEIGHT SINGLETON BIRTHS 2017-18 – 2020-21**

Year	Total singleton births n	Very Low <1500g		Low 1500-2449g		Normal 2500-4449g		High ≥4500	
		n	%	n	%	n	%	n	%
<b>2017/18</b>	198	<5	(2%)	20	(10%)	174	(88%)	<5	(<1%)
<b>2018/19</b>	309	<5	(1%)	42	(14%)	259	(84%)	5	(2%)
<b>2019/20</b>	314	<5	(1%)	37	(12%)	269	(86%)	<5	(1%)
<b>2020/21</b>	281	14	(5%)	28	(10%)	237	(84%)	<5	(1%)

FIGURE 22: LOW BIRTHWEIGHT SINGLETON BIRTHS 2020/21, BY REMOTENESS AREA



In Figure 22, low birthweight births are shown by ANFPP remoteness area, compared with the AIHW 2020 Aboriginal and Torres Strait Islander primary health care data (Australian Institute of Health and Welfare, 2020).

- In 2020-21 there were 12% (18/146) low birthweight births in major city ANFPP program sites, 17% (10/59) low birthweight births in outer regional and 19% (12/62) in remote sites (Figure 22). *Low birthweight births in inner regional sites are not reported here due to small numbers.*

TABLE 43: LOW BIRTHWEIGHT SINGLETON BIRTHS 2017-18 – 2020-21, EXCLUDING PRETERM BIRTHS

	Total singleton births	Low birthweight <2500g EXCLUDING PRETERM BIRTHS	
	n	n	%
2017/18	198	5	2.5%
2018/19	309	19	6.1%
2019/20	314	26	8.2%
2020/21	281	15	5.3%

Table 43 shows low birthweight births excluding preterm births, giving an indication of the contribution of preterm birth to the rate of low birthweight in the ANFPP from 2017-18 to 2020-21.

## Preterm births

Preterm birth is defined as birth before 37 completed weeks of pregnancy (World Health Organization, 2012).

Table 44 shows the number and percent of preterm births among singleton babies born in the ANFPP from 2017-18 to 2020-21.

Among the 281 ANFPP clients who had a singleton Indigenous baby in 2020-21

- 12.5% (35/281) were born preterm.
- The majority of preterm infants (71%) were born between 32 and 36 completed weeks (Table 45). However, at 71%, the proportion of late preterm births (32-36 weeks) is lower than in previous years (88-93%).
- Of 213 mothers with data about smoking in pregnancy,
  - mothers who reported any smoking in pregnancy were more likely to have a preterm baby 13.9% (13/93) than mothers who didn't smoke 7.5% (9/120) (p value 0.06 -borderline statistical significance).

For comparison, in national data about women who had a baby in 2019 (Australian Institute of Health and Welfare, 2019b)

- Of women who had an Indigenous baby in 2019, 12.2% (2,209/18,086) were born preterm.
- Of Indigenous women who had a baby in 2019, 13.2% (1,911/14,467) were born preterm.

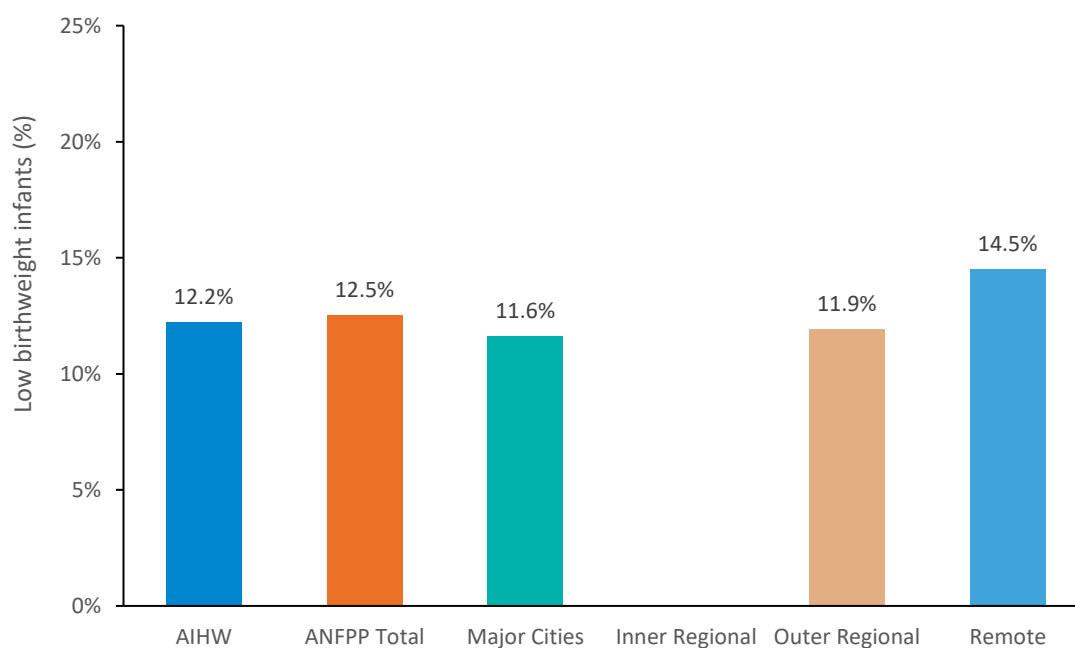
In Australia in 2019, among all babies, Indigenous and non-Indigenous,

- 8.6% were born preterm and the majority were born between 32 and 36 weeks gestation.
- Mothers who reported any smoking in pregnancy were more likely to have a preterm baby (12.8%) than mothers who didn't smoke (8.0%).

TABLE 44: PRETERM SINGLETON BIRTHS 2017-18 – 2020-21

	Total singleton births n	Preterm births <37 weeks	
		n	%
2017/18	198	26	13.1%
2018/19	309	42	13.6%
2019/20	314	26	8.3%
2020/21	281	35	12.5%

FIGURE 23: PRETERM SINGLETON BIRTHS 2020-21, BY REMOTENESS AREA



In Figure 23, ANFPP preterm births are shown beside 2019 national data (Australian Institute of Health and Welfare, 2021b).

- In 2020-21 there were 11.6% (17/146) preterm births in major city program sites, 7/59 preterm births in outer regional and 9/62 in remote sites (Figure 23). *Preterm births in inner regional sites are not reported here due to small numbers.*

**TABLE 45: PRETERM SINGLETON BIRTHS 2017-18 – 2020-21, BY PRETERM CATEGORIES**

	Preterm Births <37 weeks n	Proportion of very preterm & extremely preterm <32 weeks %	Proportion of preterm born at 32-36 weeks %
2017/18	26	12%	88%
2018/19	42	7%	93%
2019/20	26	12%	88%
2020/21	35	29%	71%

The majority of preterm births have been between 32 and 36 weeks gestation (Table 45).

- In 2020-21, there was a higher proportion of very preterm and extremely preterm births than in the previous three reporting periods.
- In 2020-21, nearly a third of the preterm births were less than 32 weeks gestation.

**TABLE 46: PRETERM SINGLETON BIRTHS 2017-18 – 2020-21, BY BIRTHWEIGHT**

	Preterm Births n	Proportion of preterm low birthweight %	Proportion of preterm NOT low birthweight %
2017/18	26	69%	31%
2018/19	42	62%	38%
2019/20	26	58%	42%
2020/21	35	77%	23%

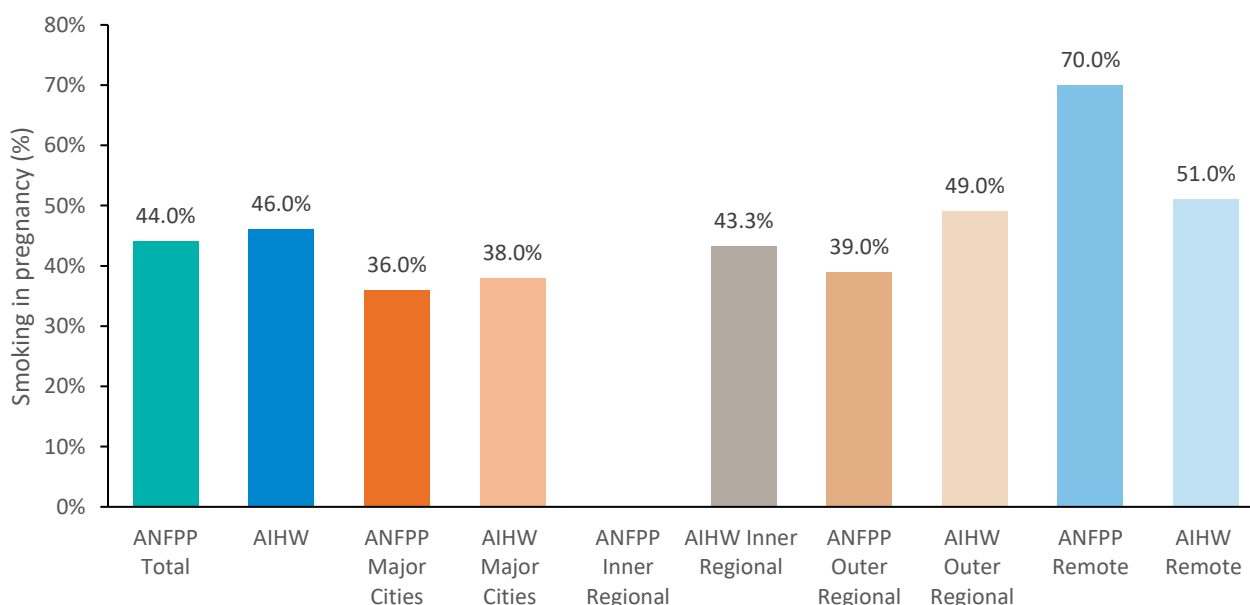
Preterm babies have a greater chance of weighing <2500g at birth. Overall, more than one third of preterm births over the past four years (except for 2020-21) have not been low birthweight (Table 46).



## 6.5 Maternal Smoking

Maternal smoking during pregnancy is associated with significantly poorer obstetric and perinatal outcomes and should be considered and managed as high risk (Li et al, 2019). Paternal smoking and passive smoking also increase adverse neonatal outcomes. Cigarette smoke is a reproductive toxicant associated with maternal obstetric complications including miscarriage, placental abruption, placenta praevia, preterm labour, premature rupture of membranes and ectopic pregnancy (Gould, 2017; Leybovitz-Haleluya et al, 2018). Women who smoke are more likely to require emergency caesarean section due to fetal distress (Li et al. 2019) and have postnatal complications including poorer healing, as well as shorter breastfeeding duration (Cope, 2015)

**FIGURE 24: CLIENTS WHO REPORTED SMOKING DURING PREGNANCY 2020-21, BY REMOTENESS AREA**



*ANFPP Data: Clients who had a singleton baby in 2020-21 n=281; missing data = 68*

*AIHW Data: Aboriginal and Torres Strait Islander specific primary health care results: Smoking during pregnancy, by smoking status (current smoker) and remoteness June 2020. (Australian Institute of Health and Welfare, 2021a)*

**TABLE 47: CLIENTS WHO REPORTED SMOKING DURING PREGNANCY 2017-18 - 2020-21, BY REMOTENESS AREA**

<b>% Clients who reported smoking during pregnancy, at intake and/or 36 weeks gestation</b>				
<b>Remoteness Area</b>	<b>2017–18</b> <b>n=198</b>	<b>2018–19</b> <b>n=308</b>	<b>2019–20</b> <b>n=314</b>	<b>2020-21</b> <b>n=281</b>
<b>Major Cities</b>	30% (12/40) n=66 missing=26	36% (31/86) n=145 missing=59	25% (26/106) n=145 missing=39	36% (40/112) n=146 missing=34
<b>Inner Regional</b>	*	*	45% (10/22) n=30 missing=8	17% (2/12) n=14 missing=2
<b>Outer Regional</b>	54% (28/52) n=65 missing=13	57% (27/47) n=60 missing=13	55% (17/31) n=43 missing=12	39% (14/36) n=59 missing=23
<b>Remote</b>	37% (19/51) n=66 missing=15	52% (34/66) n=88 missing=22	60% (49/82) n=96 missing=14	70% (37/53) n=62 missing=9
<b>ANFPP Total</b>	42% (60/144) n=198 missing=54	45% (95/213) n=309 missing=96	42% (102/241) n=314 missing=73	44% (93/213) n=281 missing=68
<b>Missing data: All sites</b>	27%	31%	23%	24%

*Denominators: Clients who had a singleton baby in each reporting period*

*\*Total count <5*

ANFPP data shows that maternal smoking presents an ongoing challenge.

Of 213 women who had a baby in 2020-21 and who had data about smoking in pregnancy, 93 were reported as smoking at some time during pregnancy (Figure 24 & Table 47).

Figure 24 presents ANFPP smoking data compared with 2020 national Aboriginal and Torres Strait Islander primary health care data published by the Australian Institute of Health and Welfare. Figure 24 shows,

- Maternal smoking reported among women who had a baby ranged from 36% in major cities to as high as 70% in remote areas.
- Overall smoking among ANFPP mothers was similar to Aboriginal and Torres Strait Islander mothers nationally.

Table 47 shows detailed smoking data by remoteness area for women who have had a singleton baby in the past four reporting periods from 2017-18 to 2020-21, including the amount of missing data in each year and remoteness area.

Additional smoking data for 2020-21 (not included in tables) shows that,

- Of 93 women who were recorded as smoking at some time during pregnancy, the number of daily cigarettes smoked at *intake* to the program included:
  - 19 women reported as smoking 10-24 cigarettes per day
  - 21 women reported as smoking 5-9 cigarettes per day
  - 24 women reported as smoking 1-4 cigarettes per day, and
  - 29 women reported as smoking 0 cigarettes per day.
- Of the 93 women who were recorded as smoking at some time during pregnancy, 47 had the number of daily cigarettes smoked at both *intake* and *36 weeks* of pregnancy:
  - 17/47 were recorded as smoking 0 cigarettes per day at 36 weeks
  - 4 women were recorded as smoking fewer daily cigarettes at 36 weeks compared to intake
  - The remaining 26/47 women had no decrease in number of daily cigarettes recorded, that is, they were reported as smoking the same or more at 36 weeks than at intake.

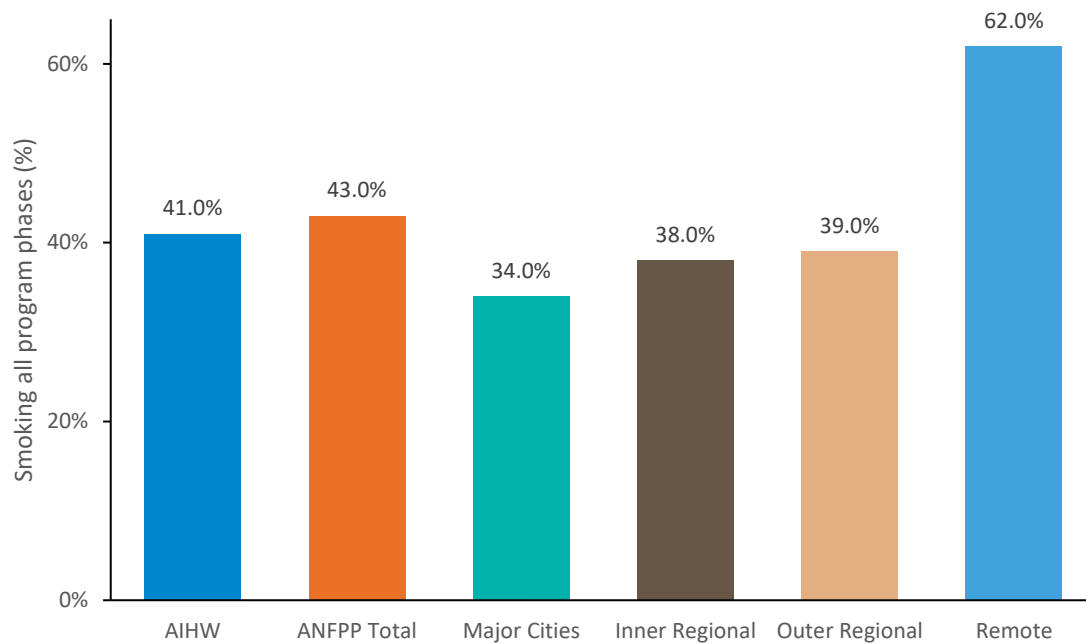
There was missing smoking data for 68 of the 281 (24% missing data) women who had a baby in 2020-21.

**TABLE 48: CLIENTS WHO REPORTED SMOKING IN PREGNANCY AND LOW BIRTHWEIGHT  
2017-18 – 2020-21**

Year	Total singleton births n	Maternal smoking in pregnancy: All singleton births %	Low birthweight <2500g		Maternal smoking in pregnancy: Low birthweight births %	Smoking in pregnancy data missing %
			n	%		
2017/18	198	42%	23	12%	25%	27%
2018/19	309	45%	45	15%	56%	31%
2019/20	314	42%	41	13%	61%	23%
2020/21	281	44%	42	15%	68%	24%

Table 48 shows smoking rates among women who had a singleton baby, by reporting period, as well as the smoking rate among women whose baby was born low birthweight. Both smoking and low birthweight births are characteristics that seem to impact women from remote areas to a greater degree.

**FIGURE 25: CLIENTS WHO REPORTED SMOKING ACROSS ALL PROGRAM PHASES 2020-21, BY REMOTENESS AREA**



*ANFPP Data: 2020-21 Enrolled clients (449) + Graduates (140): n=589*

*AIHW Data: Indigenous females aged 25-34: Smoking one or more cigarettes per day 2018-19 (van der Sterren et al, 2020)*

Figure 25 shows the rates of smoking reported among women who enrolled in the program in 2020-21 as well as the women who graduated. The amount of missing smoking data in the current reporting period is approximately 25%.

## 6.6 Child Development

In the ANFPP, *Ages and Stages Questionnaires (ASQ)* are used to monitor child development outcomes for infants and toddlers. The ASQ is a parent-reported standard developmental screening instrument with items in five domains: i) communication, (ii) gross motor, (iii) fine motor, (iv) personal/social and (v) problem solving. ASQ assessment produces a score for the child in each of the five domains. For each item, 'Yes', 'Sometimes' or 'Not Yet' can be marked for each item response. Yes = 10 points; Sometimes = 5 points; Not Yet = 0 points. The maximum score for normal development in each domain is 60, and most children are expected to be at that level.

In most cases, the ASQ questionnaires accurately identify children who may need further evaluation, assessment or referral to an intervention service.

In the ANFPP, children are screened using the ASQ on four occasions, at or as close as practicable to the following timepoints:

- Infancy phase at 4 months
- Infancy phase at 10 months
- Toddlerhood phase at 14 months
- Toddlerhood phase at 20 months

Tables 49 -51 show ASQ results for children who were in the Infancy phase of the ANPP during 2021.

Table 49 shows:

- 64% of eligible infants had an ASQ assessment reported at 4 months and 50% at 10 months.
- 23% and 20% scored in the grey area zone at 4 months and 10 months respectively
- A further 8% and 11% respectively were assessed as requiring further assessment/referral

For the children assessed as requiring further assessment/referral Tables 50 and 51 shows details of assessments according to domains. In these Tables, some individual children scored below the cut off score in more than one domain.

Tables 52 -54 show ASQ results for children who were in the toddlerhood phase

- 39% of eligible toddlers had an ASQ assessment reported at 14 months and 48% at 20 months.
- Very few children were assessed as requiring further assessment/referral.

**TABLE 49: SUMMARY OF ASQ ASSESSMENTS 2020-21: INFANCY**

ASQ	4 months	10 months
Number of infants for active clients	227	159
Infants with ASQ data recorded (n/%)	145/227 (64%)	80/159 (50%)
ASQ scores requiring monitoring (grey zone)	23%	20%
ASQ score requiring further assessment/referral	8% (12)	14% (11)

**TABLE 50: AGES AND STAGES QUESTIONNAIRE 2020-21, INFANCY AT 4 MONTHS**

PARAMETER	Mean	n	Min	Max	Median	SD	Cut-off score	Below cut-off score, n (%)*
Communication	55	145	30	60	60	6.4	34.6	(7%)*
Gross Motor	55	145	15	60	60	7.8	29.6	(1.4%)*
Fine motor	52	145	15	60	55	9.8	38.4	12 (8.3%)
Personal/Social	55	145	30	60	60	7.2	33.2	(2.1%)*
Problem-Solving	56	145	20	60	60	6.4	35.0	(<1%)*

\*numerical values <5 not presented

**TABLE 51: AGES AND STAGES QUESTIONNAIRE SCORES 2020-21, INFANCY AT 10 MONTHS**

Parameter	Mean	n	Min	Max	Median	SD	Cut-off score	Below cut-off score, n (%)*
Communication	54	80	40	60	55	6.8	22.9	0 (0%)
Gross Motor	54	80	10	60	60	11.0	38.0	7 (9%)
Fine Motor	57	80	40	60	60	5.1	30.1	0 (0%)
Personal/Social	52	80	30	60	55	7.9	27.2	0 (0%)
Problem-Solving	54	80	20	60	55	7.8	35.2	(5%)*

\*numerical values <5 not presented

**TABLE 52: SUMMARY OF ASQ ASSESSMENTS 2020-21: TODDLERHOOD**

ASQ	14 months	20 months
Number of infants for active clients	96	23
Infants with ASQ data recorded (n/%)	37/96 (39%)	11/23 (48%)
ASQ scores requiring monitoring (grey zone)	14%	36%
ASQ score requiring further assessment/referral	5%	18%

**TABLE 53: AGES AND STAGES QUESTIONNAIRE SCORES 2020-21, TODDLERHOOD AT 14 MONTHS**

Parameter	Mean	n	Min	Max	Median	SD	Cut-off score	Below cut-off score, n (%)*
Communication	51	37	25	60	55	9.6	17.4	0 (0%)
Gross Motor	54	37	0	60	60	12.3	25.8	(2.7%)*
Fine Motor	53	37	20	60	55	9.3	23.06	(2.7%)*
Personal/Social	54	37	30	60	55	8.0	22.56	0 (0%)
Problem-Solving	49	37	25	60	50	9.4	29.18	(2.7%)*

\*numerical values <5 not presented

**TABLE 54: AGES AND STAGES QUESTIONNAIRE SCORES 2020-21, TODDLERHOOD AT 20 MONTHS**

PARAMETER	Mean	n	Min	Max	Median	SD	Cut-off score	Below cut-off score, n (%)*
Communication	48	11	15	60	60	17.6	20.5	(18%)*
Gross Motor	55	11	40	60	60	7.0	39.89	0 (0%)
Fine Motor	56	11	40	60	60	6.4	36.05	0 (0%)
Personal/Social	56	11	45	60	60	5.5	28.84	0 (0%)
Problem-Solving	55	11	40	60	60	6.9	33.36	0 (0%)

\*numerical values <5 not presented



The Ages and Stages Questionnaire: Social and Emotional (ASQ-SE) screening tool is used to assess the social-emotional behaviours of children. In the ANFPP, it is implemented in the Infancy phase at 6 & 12 months of age and in the Toddlerhood phase at 18 and 24 months. Tables 55 shows,

- In 2020-21, 55% of eligible infants were screened at 6 months and 54% at 12 months.
- There were few toddlers eligible for screening.

**TABLE 55: SUMMARY OF ASQ-SE ASSESSMENTS 2020-21: INFANCY & TODDLERHOOD**

ASQ - SE	6 months	12 months
Number of infants for active clients	195	121
Infants with ASQ-SE data recorded (n/%)	107/195 (55%)	65/121 (54%)
ASQ-SE score requiring further assessment/referral	2%	8%

ASQ - SE	18 months	24 months
Number of toddlers for active clients	7	7
Toddlers with ASQ-SE data recorded (n/%)	5/7 (71%)	5/7 (71%)
ASQ-SE score requiring further assessment/referral	0%	0%

## 6. Conclusions and directions for 2021-22

The NSS vision for ANFPP data is to build and maintain a high-quality dataset that fulfils end-user (Program sites including families) needs and other stakeholders in Australia (Department of Health, Evaluators and NSS internal requirements) and internationally (UoC).

Data presented in this National Annual Data Report was provided by 13 ANFPP program sites collected in one of two data systems - ANKA and Communicare. All sites enter a broad range of program data and make it available to the NSS for analysis and reporting purposes. The collection, analysis and reporting of program data is central to measuring program success.

There are ongoing challenges related to having two information systems. Combining the data from these systems, known as 'data aggregation' is an important step in presenting the ANFPP data at the national level, and in enabling comparisons. Some program variables are different between the two systems, and others only exist in one system, making data aggregation unachievable, or resulting in loss of information due to aggregation. Data loss in aggregation contributes further to the amount of missing data inherent in the ANFPP data collection. In an additional challenge, when the ANKA system was launched in 2017, ongoing support and development of the ANFPP Communicare data collection was suspended. This combined with prohibitive costs associated with further development of the ANKA system, has resulted in that necessary extension of the ANFPP dataset to reflect contemporary program implementation has not occurred.

In working towards maintaining a high-quality ANFPP dataset that fulfils end-user needs, the NSS is focusing on the following areas in 2021-22:

- Regular distribution of Data Quality and Completeness reports to continue the downward trend in missing data and data errors already noted over 2020-21.
- Ongoing implementation of additional education regarding data across all three units in the ANFPP curriculum.
- In collaboration with program sites and Telstra Health, review and update Communicare data collection forms.
- Work towards extending the ANFPP data collection to capture;

- maternal responsiveness including improved empowerment and self-efficacy of mothers as they progress through the program using a tool developed for Aboriginal and Torres Strait Islander people i.e. the Growth and Empowerment Measure
- more appropriate measures of childhood development using screening tools developed for Aboriginal and Torres Strait Islander families e.g ASQ Trak; Plums & Hats
- assessments of perinatal mental health using a screening tool developed for Aboriginal and Torres Strait Islander mothers i.e. the Kimberley Mums Mood Scale
- reporting the quality of parent-child interactions through DANCE – Dyadic Assessment of Naturalistic Caregiver-child Experiences
- capture and reporting of STAR, the Strengths and Risks framework to characterise and organise client strengths and risks.
- Maintain good communication about data activities between the NSS and the ANFPP program sites with regular meetings of the Data User Group, the ANFPP Leadership & Program Managers Groups, and the ANFPP Communities of Practice.

Additionally, the Department of Health in collaboration with the University of Colorado and the ANFPP Leadership group has identified five areas of particular focus for 2021-2022. The NSS will contribute to focus areas and support data collection to demonstrate effectiveness. The five focus areas are:

1. The ANFPP data collection system (above)
2. Multiparous mothers
3. Recruitment and retention of staff
4. Low birthweight and tobacco use
5. Partner involvement.

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## 8. Appendices

### Appendix 1: ANFPP Core Model Elements & Benchmarks 2020-21

**TABLE: 2020/21 CORE MODEL ELEMENTS AND BENCHMARKS.**

ANFPP CME	Performance benchmark/Target	2020/21 outcome
1. Client participates voluntarily in the Australian Nurse-Family Partnership Program	100%	100%
2. Client is a first-time mother. Variation to include multiparous mothers on a case-by-case basis has been accepted.	100%	100% (incl. first opportunity to parent and multiparous mums)
3. Client meets socioeconomic disadvantage criteria at intake.	100% are women pregnant with an Aboriginal and/or Torres Strait Islander child.	100%
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy	<ul style="list-style-type: none"> <li>• 100% of clients receive their first home visit no later than the 28th week.</li> <li>• 75% of eligible referrals who are intended to be recruited to ANFPP are enrolled in the program.</li> <li>• 60% of pregnant women are enrolled by 16 weeks gestation or earlier</li> </ul>	<ul style="list-style-type: none"> <li>• 68%</li> <li>• 77%</li> <li>• 26%</li> </ul>

ANFPP CME	Performance benchmark/Target	2020/21 outcome
<p>5. Each client is assigned an identified ANFPP nurse who establishes a therapeutic relationship through individual ANFPP home visits.</p>	<p>100% of clients are assigned an identified ANFPP nurse. The ANFPP home visiting team has a caseload range of between 15–20 clients. Technical, workforce, cultural and contextual guidance and funding considerations are considered in determining final caseload benchmarks appropriate for ANFPP.</p> <p><b>Client Retention:</b></p> <ul style="list-style-type: none"> <li>• Program retention is 60% or more through to the child’s 2<sup>nd</sup> birthday as an average across program sites</li> <li>• ≥ 90% retention for pregnancy phase</li> <li>• ≥ 80% retention for infancy phase</li> <li>• ≥ 90% retention for toddler phase</li> </ul>	<p>100% of clients are assigned an ANFPP nurse.</p> <ul style="list-style-type: none"> <li>• In the 2020/21 reporting period program retention was 58%</li> <li>• 61%</li> <li>• 60%</li> <li>• 79%</li> </ul>
<p>6. Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the ANFPP nurse and client) when this is not possible.</p>	<p>Home visiting teams acknowledge the importance of conducting visits in the place the client and her child sleeps most often on a regular basis throughout the program.</p>	<p>63% of clients were visited in their home. In some ANFPP sites, the home is not always considered the best place for home visits. Program content is often delivered in a car, on the veranda or in another suitable outdoor environment.</p>
<p>7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.</p>	<p>Dosage: as per UCD Guidance Document, no benchmark is set for expected number of completed visits.</p> <p>Visit Schedule: as per UCD Guidance Document, the standard visit schedule will guide delivery of the ANFPP unless an alternative visit schedule is developed between a home visiting team and the client.</p>	<p>In 2020/21 the following dosages were observed in each program phase (Section 3.5):</p> <p>Pregnancy: 59%*;          Infancy: 47%;          Toddlerhood: 53%.</p> <p>*Based on 9 visits per client</p>



ANFPP CME	Performance benchmark/Target	2020/21 outcome																																																				
8. ANFPP nurses and supervisors are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree.	100%	100% Records kept by individual sites; recruitment is a site responsibility.																																																				
9. ANFPP nurses, Family Partnership Workers (FPW), and supervisors will complete the required ANFPP educational curricula and participate in on-going learning activities.	100% of ANFPP Nurse Home Visitors, Family Partnership Workers and Nurse Supervisors will complete the required ANFPP educational curricula and participate in on-going learning activities.	All core education attendance and progress are monitored through internal systems. 100% of ANFPP NHV, FPW and Nurse Supervisors currently working in the program have completed or are currently completing core education curricula.																																																				
10. ANFPP nurses, using professional knowledge, judgment and skill, utilise the Home Visit Guidelines, individualising them to the strengths and risks of each family and apportioning time across the six program domains	<table border="1"> <thead> <tr> <th>Domain</th> <th>Pregnancy</th> <th>Infancy</th> <th>Toddler</th> </tr> </thead> <tbody> <tr> <td>My Health</td> <td>35-40%</td> <td>14-20%</td> <td>10-15%</td> </tr> <tr> <td>My Home</td> <td>5-7%</td> <td>7-10%</td> <td>7-10%</td> </tr> <tr> <td>My Life</td> <td>10-15%</td> <td>10-15%</td> <td>18-20%</td> </tr> <tr> <td>My Child</td> <td>23-25%</td> <td>45-50%</td> <td>40-45%</td> </tr> <tr> <td>My Family and Friends</td> <td>10-15%</td> <td>10-15%</td> <td>10-15%</td> </tr> <tr> <td>Total</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table>	Domain	Pregnancy	Infancy	Toddler	My Health	35-40%	14-20%	10-15%	My Home	5-7%	7-10%	7-10%	My Life	10-15%	10-15%	18-20%	My Child	23-25%	45-50%	40-45%	My Family and Friends	10-15%	10-15%	10-15%	Total	100%	100%	100%	<table border="1"> <thead> <tr> <th>Domain</th> <th>Pregnancy %</th> <th>Infancy %</th> <th>Toddler %</th> </tr> </thead> <tbody> <tr> <td>My Health</td> <td>33%</td> <td>17%</td> <td>15%</td> </tr> <tr> <td>My Home</td> <td>11%</td> <td>9%</td> <td>10%</td> </tr> <tr> <td>My Life</td> <td>13%</td> <td>12%</td> <td>16%</td> </tr> <tr> <td>My Child</td> <td>22%</td> <td>38%</td> <td>35%</td> </tr> <tr> <td>My Family and Friends</td> <td>14%</td> <td>12%</td> <td>13%</td> </tr> </tbody> </table>	Domain	Pregnancy %	Infancy %	Toddler %	My Health	33%	17%	15%	My Home	11%	9%	10%	My Life	13%	12%	16%	My Child	22%	38%	35%	My Family and Friends	14%	12%	13%
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11. ANFPP Nurses and supervisors and Family Partnership	It is expected that ANFPP nurses and supervisors will apply the theories through current clinical methods/delivery of the	This CME is not directly measurable. However, these theories are incorporated across the training																																																				

ANFPP CME	Performance benchmark/Target	2020/21 outcome
<p><b>Workers apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.</b></p>	<p>program. There is no specific benchmark for this CME</p>	<p>curriculum and provide a focus for Community of Practice meetings.</p>
<p><b>12. Each ANFPP team has an assigned ANFPP supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision.</b></p>	<p>A full time ANFPP supervisor can lead a team of no more than eight ANFPP nurses (including community mediators or similar positions where applicable) and a team administrator</p> <p>The minimum team size is four ANFPP nurses with a half time supervisor</p> <p>100%</p>	<p>ANFPP teams for 2020-21 are tabulated by role and program site at Table 22.</p>
<p><b>13. ANFPP teams, implementing agencies, and the national units collect and utilise data to guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.</b></p>	<p>Although there are no objectives that relate to the collection and use of data, all the ANFPP benchmarks for the program are measured through use of regular standardised data collection</p>	<p>Quarterly program fidelity reporting is used to track program fidelity.</p> <p>In 2020-21 a robust program of Quality Site Self-Assessments (QSSA) has been established and implemented.</p>
<p><b>14. High quality ANFPP implementation is developed and</b></p>	<p>In principle at least 85% of clients and their children should receive 100% of</p>	<p>Monthly exception reporting is used to support program site data quality and identifying where required actions</p>

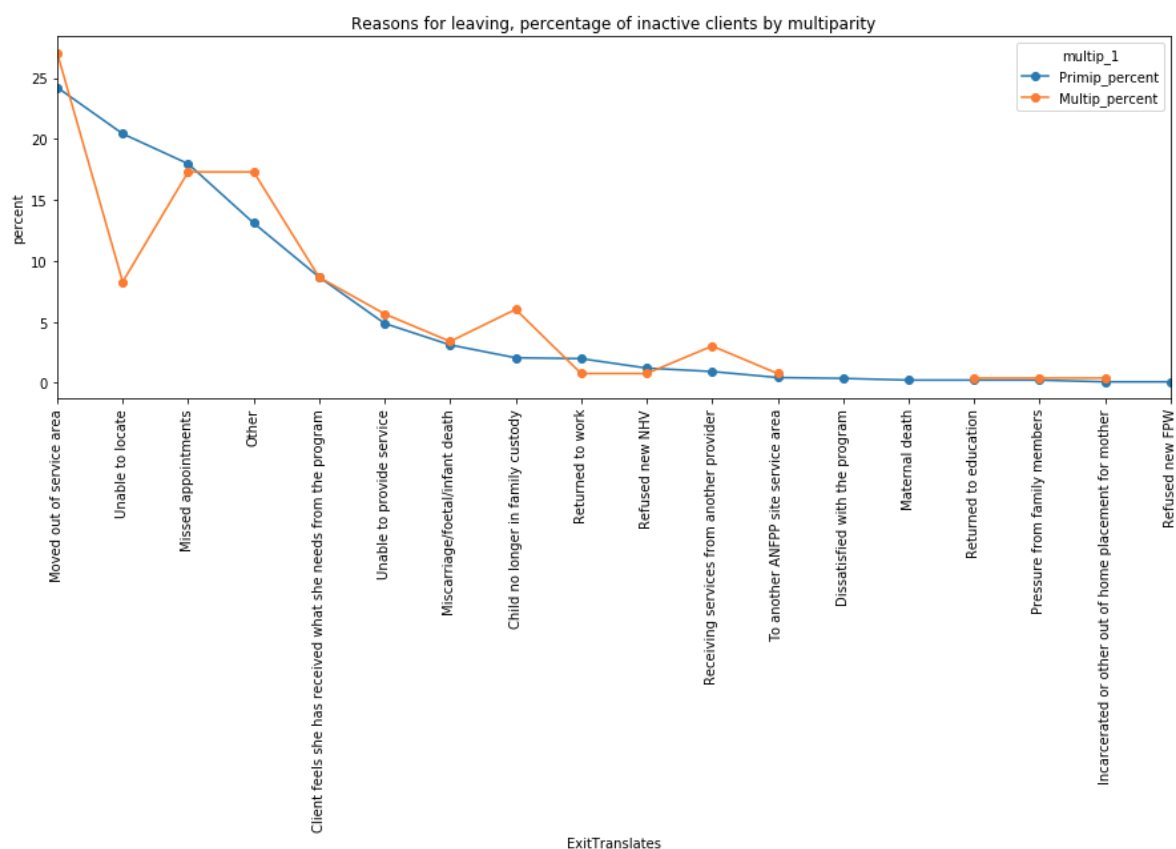
<b>ANFPP CME</b>	<b>Performance benchmark/Target</b>	<b>2020/21 outcome</b>
<b>sustained through national and local organised support.</b>	assessments and have their client record complete.	have been missed (e.g. smoking in pregnancy, ASQ, and EPDS).
<b>15. ANFPP teams must employ Aboriginal/and or Torres Strait Islander Family Partnership Workers to support delivery of the program.</b>	100% of ANFPP teams employ Aboriginal and/or Torres Strait Islander Family Partnership Workers (FPWs) to support delivery of the program and who participate in reflective supervision.	100% of ANFPP teams employ Aboriginal and/or Torres Strait Islander FPWs.

## Appendix 2: Client attrition: multiparous and first-time mothers

The ANFPP data collection 2009-2021 was interrogated to ascertain if multiparous mothers who enrolled in the program were more (or less) likely to leave the program prior to graduation.

- There was no relationship between parity (multiparous versus primiparous mothers) and graduation rate (p value = 0.35). That is, multiparous mothers were no more or less likely than first-time mothers to leave the program prior to graduation.
- There was no relationship between parity and phase of leaving the program (p value = 0.26)

**FIGURE A:**



There were some differences (qualitatively) on the reasons for leaving the program

- Multiparous mothers were less likely to be 'Unable to locate' than first time mothers in any phase (Figure A), and particularly among those who left in the infancy phase (Figure B).

- Of the clients who left in infancy, multiparous mothers were more likely to have ‘Other’ or ‘Missed appointments’ as the reason.
- Multiparous mothers were less likely to leave due to missed appointments in the pregnancy phase.
- Multiparous mothers were more likely to have ‘Child no longer in family custody as the reason for leaving in the toddlerhood phase.

**FIGURE B:**

