



Australian
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Helping First-Time Parents Succeed



Australian Family Partnership Program (AFPP)
National Support Service

NATIONAL ANNUAL DATA REPORT

1 July 2022 – 30 June 2023



Artwork - 'Together' (Produced on canvas with acrylic paint, September 2023)

Artist - Somma Cozzi-Delaney (Noonuccal/Nughi)

Story - The woman and child are depicted at the centre of the piece and represent the focus of the Australian Family Partnership Program (AFPP) and its ongoing commitment to supporting women to become the best mums they can be.

The woman and child are encircled by the AFPP National Support Service (NSS) and Molly Wardaguga Research Centre (MWRC) - represented by the arches of women outside the circle and the fifteen AFPP sites across the country - the 15 small circles. The pink roads connect the fifteen circles/sites to the National support service. The home-visiting teams at each site support the women and infants of their communities; the AFPP National Support Service supports the home-visiting teams at their sites, and the Molly Wardaguga Research Centre supports the AFPP NSS.

The background lines (topography) depict travel - the travel of the NSS when completing visits to each of the sites and the travel made by the home-visiting teams when attending home visits.

The hands of our ancestors surround the piece as a reminder of the holistic healthcare needs of our Peoples and ensure we remain focused on achieving improved outcomes for Aboriginal and/or Torres Strait Islander women and children and their families.

AFPP NATIONAL SUPPORT SERVICE

Molly Wardaguga Research Centre | Charles Darwin University



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CULTURAL ACKNOWLEDGEMENT

The Australian Family Partnership Program (AFPP) 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 levels¹.

ABBREVIATIONS

ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
AFPP	Australian Family Partnership Program
CME	Core Model Element
EPDS	Edinburgh Postnatal Depression Scale
FPW	Family Partnership Worker
NFP	Nurse-Family Partnership

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



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NHV	Nurse Home Visitor
NSS	National Support Service
PCIS	Patient Care Information System
US	United States
WHO	World Health Organization

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EXECUTIVE SUMMARY

Aboriginal and Torres Strait Islander cultures are the oldest living cultures in the world. The First Nations people of the land, seas and waterways can be traced back approximately 50,000 years or more. As the oldest living culture in the world, it is a culture that demands deep respect. However, British colonisation had adverse effects on Indigenous Australians and the Australian Government committed to introducing the AFPP as part of its 'Closing the Gap' health strategy to address the disadvantage in Aboriginal and Torres Islander families and communities that has resulted.

Charles Darwin University's (CDU's) Molly Wardaguga Research Centre (Molly Centre) host the National Support Service for the AFPP. The Molly Centre was established in honour of Burarra Elder and midwife who worked extensively to improve health outcomes, with a vision of returning birthing services to Indigenous communities and Indigenous control.

Considering the growing recognition of the need to balance the NFP's objectives with the context of implementation (University of Colorado, 2016), the NFP model was adapted to the Australian context in 2008 (ANFPP, 2014a). With a specific focus on Indigenous families and communities, the ANFPP was implemented at key IAHS sites in 2009 (ANFPP, 2014a). The most significant adaptation to the NFP model was the inclusion of a Family Partnership Worker (FPW) role into the AFPP team that was viewed as being integral to the success of the program within the IAHS context (ANFPP National Program Centre, 2016c).

During 2022-23, the NSS has been working on projects aimed at achieving program implementation and data reporting improvements. Three such projects are 1. the program name change, 2. Core Model Elements 2023 review project, and 3. the Communicare-MMEX AFPP data collection project.

Program name change - Australian Family Partnership Program

The program is now known as the Australian Family Partnership Program. This name was in response to recommendations in the West Report describing the 2018 ANFPP workforce development study (West, 2018), supported by the Leadership Group and is now inclusive of all the team members including the Family Partnership Worker providing the program in each service location, and the families they work with to achieve program outcomes. The program logo which has been updated to reflect the name change can be seen on the pages in this report.

3.3 Key Focus Area 1 - Recommendations

To better align the ANFPP with the IHS values, leadership, workforce and research, it is recommended that:

1.1 The name of the ANFPP, be adapted to the 'Family Partnership Program' (FPP) to reflect the joint ANFPP and IAH context values of a client centred model of care, in conjunction with consideration of the licensing requirements such as the need to identify the NFP logo on program materials. This recommendation would also provide benefits for facilitating partnerships and engagement with the IAH context more generally.

AFPP Core Model Elements (CME): 2023 Review and Revisions

The 2023 review of the AFPP CMEs commenced in response to recommendations in the West Report describing the 2018 ANFPP workforce development study (West, 2018), and concerns that some benchmarks associated with the AFPP CMEs have been consistently unachievable in the Australian context. The revised CMEs and benchmarks have been adjusted so that they continue to be aspirational for program continuous quality improvement, as well as achievable. Further information is provided in Section 6 of this report.

3.3 Key Focus Area 1 - Recommendations

To better align the ANFPP with the IHS values, leadership, workforce and research, it is recommended that:

1.5 All ANFPP program fidelities (University of Colorado, 2016) be strengthened with Indigenous values, leadership, workforce and research as a part of the NFP Model Elements Review Process (University of Colorado, 2016).

The Communicare-MMEX AFPP data collection project

In the year since the last annual data report, the NSS has continued to work towards our vision of building and maintaining a high quality AFPP dataset that fulfils end-user needs. To convey the most accurate information about the effectiveness of AFPP implementation and its impact on health outcomes, child development and parental life course, the dataset should be defined by the following elements: data collection of items that fit the AFPP purpose; high data accuracy, reliability and completeness; and data availability and accessibility for end users.

To this end, during 2022-23, the NSS has progressed the Communicare-MMEX AFPP data collection project. The AFPP data collection has been reviewed and extended for Communicare

and MMEX patient care information systems. Some AFPP sites have already commenced the transition from the cloud based ANKA system to data collection and storage in their own patient care information systems.

NOTES ABOUT THIS REPORT

The format of the 2022-23 AFPP Annual Data Report is similar to the previous reporting period. It is organised into sections.

The introduction in Section 1 provides a brief overview of the AFPP and our data system as well as detailed description of the Communicare-MMEX AFPP data collection project. Importantly, Section 1 contains the Molly Wardaguga Research Centre Indigenous Data Sovereignty statement.

Sections 2, 3, 4 & 5 report AFPP operational and client data. In 2022-23, major AFPP changes are in progress that have affected data collation and reporting procedures.

There are now 15 AFPP sites – 13 established and 2 new sites. One new site is in very early establishment with no data for inclusion in this report. The second new site has been operating for less than one year and only their workforce data is included at Section 3.

Data for the 13 established sites are included in program implementation reporting in Section 2. The section describes aspects of program implementation including client referrals and enrolments, and analyses of home visits and client attrition. Section 3 provides information about the ANFPP workforce.

Sections 4 and 5 are mainly focussed on the AFPP clients in 2022-23. In this section, an interim reporting decision was taken to only include data from 8 (out of 13) established AFPP sites that used the ANKA data collection during the reporting period. The transition of some sites from ANKA to Communicare data collection, and from 'old' Communicare to 'new' Communicare data collection started during 2022-23. The transition process means temporary disruptions to aggregation of data between multiple data sources. The NSS will work with sites through the transition phase to update and embed their AFPP data collection system. Annual data reporting in Sections 4 & 5 of this report can be updated to include the complete 2022-23 AFPP cohort as the transition progresses and technical issues of data collation are resolved.

In Section 6 of the report, we describe the implementation and outcomes of abovementioned ANFPP CMEs: 2023 review project. The section provides the updated program CMEs and benchmarks, the previous CMEs, rationale for changes, as well as supporting evidence from the AFPP program data.

1 INTRODUCTION

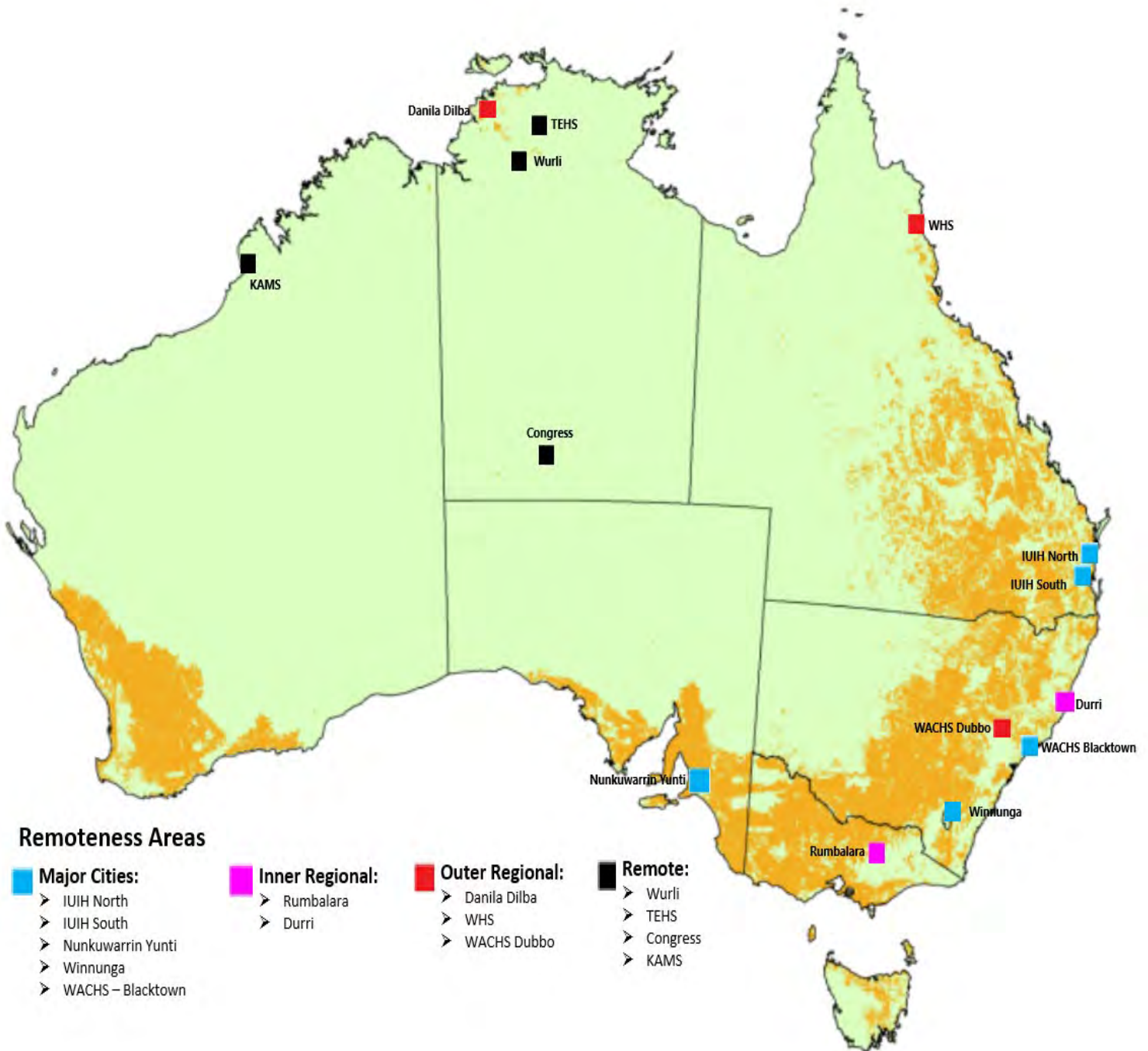
1.1 THE AFPP – A BRIEF OVERVIEW

The AFPP is a maternal and child health home visiting program for first time mothers and families of Aboriginal and Torres Strait Islander children (ANFPP, 2023). It is funded by the Commonwealth Department of Health and Aged Care (DoHAC) as part of the Government's commitment to Closing the Gap Outcome 2: Aboriginal and Torres Strait Islander children are born healthy and strong.

Specially trained Nurse Home Visitors (NHV) and Family Partnership Workers (FPW) work with mothers, identifying strengths and opportunities, and providing support and education during pregnancy, infancy and toddlerhood until the child is two years old.

In 2022-23, the AFPP has been delivered at program sites across all geographic remoteness categories in the Australian Statistical Geography Standard framework; at sites located in five states and both territories (Figure 1.1).

1.1.1 Figure 1.1: AFPP program sites, by remoteness area





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AFPP program origins

The AFPP is based on the Nurse-Family Partnership (NFP) model of home visiting developed by the University of Colorado in the United States (Nurse-Family Partnership 2023). The NFP was tested using rigorous research methods in New York, Tennessee, and Denver from 1977-1994 and replicated in community settings (Nurse Family Partnership 2023b). Apart from the US and Australia, the program is implemented in the Netherlands, England, Canada, Scotland, Northern Ireland, Norway, and Bulgaria.

AFPP objective

The objective of the AFPP 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 15 Core Model Elements (CMEs) 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.

The five principles of the AFPP

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. Home visiting teams prioritise five client-centred principles as they deliver the program.

Follow your heart's desire



You are the expert in your own life



Focus on solutions



Focus on strengths



Only a small change is necessary



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.

You are an expert in your own life

In the AFPP, 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.

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.

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.

Only a small change is necessary

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

IMPLEMENTATION

The AFPP was first implemented in Australia in 2009 in three 'Wave 1' sites. In Waves 2 & 3 in 2016 and 2017, 10 additional program sites were implemented. During 2021-22, the program was further extended to include a new remote site in Western Australia, with an additional very remote Western Australian site under establishment in 2022-23 (Table 1.1). AFPP service delivery is provided by the Aboriginal Community Controlled Health (ACCHO) sector in 14 of the 15 program sites, with the exception of a site in the Top End of the Northern Territory.

The Brisbane-based AFPP National Support Service (NSS) supports the program sites by providing broad operational, technical and data support, and specialised education and training on AFPP program elements for home visitors.

1.1.2 *TABLE 1.1: AFPP PROGRAM SITE ORGANISATIONS, BY WAVE AND COMMENCEMENT DATE*

Wave	Year	Program site organisation
Wave 1 13 years established	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.
	2016	Institute for Urban Indigenous Health (IUIH-North), North Brisbane, Queensland.
	2016	Top End Health Services - Northern Territory Department of Health (TEHS), based in Casuarina, Northern Territory, and providing outreach services to Wadeye, Wurrumiyanga, Gunbalanya, and Maningrida.
Wave 2 6 years established	2017	Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, (Danila Dilba) based in Darwin and Palmerston, Northern Territory. Nunkuwarrin Yunti of South Australia Inc, (Nunkuwarrin Yunti) based in Adelaide, South Australia. Institute for Urban Indigenous Health (IUIH-South), South Brisbane, Queensland.
	2017	Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, (Danila Dilba) based in Darwin and Palmerston, Northern Territory.
	2017	Nunkuwarrin Yunti of South Australia Inc, (Nunkuwarrin Yunti) based in Adelaide, South Australia.
Wave 3 5 years established	2017	Institute for Urban Indigenous Health (IUIH-South), South Brisbane, Queensland.

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Wave	Year	Program site organisation
Wave 4 5 years established	2017	<p>Wurli Wurlinjang Aboriginal Corporation (Wurli), Katherine, Northern Territory.</p> <p>Greater Western Aboriginal Health Service (Blacktown) GWAHS</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>
Wave 5 Under establishment	2023	<p>Kimberley Aboriginal Medical Services (KAMS), Broome, Western Australia.</p> <p>Pilbara Aboriginal Health Alliance (PAHA), Western Australia</p>

1.2 AFPP DATA COLLECTION

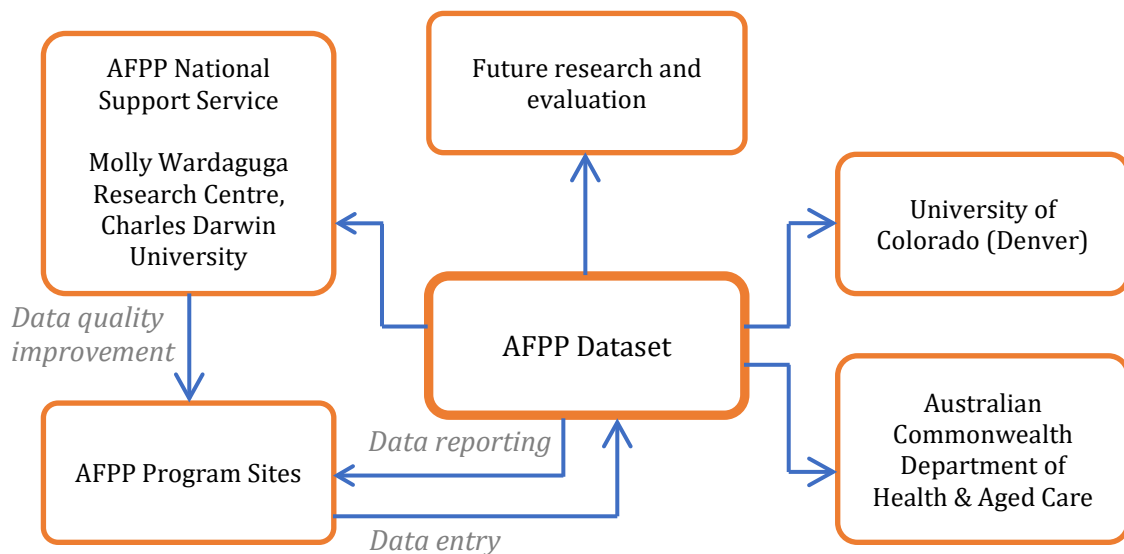
Collection and recording of data by AFPP home visiting teams about program implementation and outcomes is a key component of the AFPP. One of the roles of the NSS is to clean, collate and report deidentified program data to the AFPP program sites and the DoHAC. Importantly, as a Custodian of AFPP data, the NSS will adhere to the Molly Wardaguga Research Centre Indigenous Data Sovereignty Statement included below at

1.3 Indigenous Data Sovereignty.

The NSS vision for the AFPP data system is to achieve and maintain a high-quality dataset that fulfils the needs of end-users (program sites and families) and other stakeholders in Australia (Department of Health and Aged Care, research, and evaluation, NSS internal requirements) and internationally (University of Colorado, Denver).

An overview of the AFPP data flow is depicted at Figure 1.2

1.1.3 figure 1.2: AFPP DATA Flow



1.3 INDIGENOUS DATA SOVEREIGNTY

Molly Wardaguga Research Centre Indigenous Data Sovereignty Statement

Preamble: The Molly Wardaguga Research Centre (MWRC) recognizes the inherent rights of Indigenous peoples in data governance. Given the historical injustices faced by these communities, the MWRC is dedicated to upholding Indigenous Data Sovereignty principles.

1. Definitions:

- **Indigenous Data:** Information about and affecting Indigenous peoples.
- **Indigenous Data Sovereignty:** The right of Indigenous people to own and control their data.
- **Indigenous Data Governance:** The autonomous right of Indigenous peoples to decide on data collection, access, and use, reflecting their values and cultures.

Reference: [Maiam Nayri Wingara Definitions](#)

2. Principles: The MWRC supports the principles of the Maiam nayri Wingara Indigenous Data Sovereignty Collective and the OCCAAARS First Nations Data Sovereignty Framework (FNDSOV). These principles include:

- **Ownership:** Data ownership remains with Indigenous communities.
- **Control:** Indigenous communities control all data management aspects.
- **Custodianship:** Data security at MWRC maintained as per National Health and Medical Research Council guidelines and Charles Darwin University procedures.
- **Accessibility:** Access for Indigenous peoples to their own data.
- **Accountability:** Two-way commitment to data storage and usage.
- **Amplify Community Voice:** Prioritize Indigenous voices.
- **Relevance & Reciprocity:** Ensure data relevance and mutual benefits.
- **Sustainability:** Promote sustainable and self-determining practices.

3. Commitments:

- **Recognition:** MWRC acknowledges Australia's First Nations peoples' sovereignty over their data.
- **Acknowledge:** MWRC respects its role as a data custodian, not an owner.
- **Respect:** Indigenous knowledge systems, protocols, and values are upheld.
- **Partnership:** Active involvement of Indigenous communities in data-related decisions.
- **Consent:** Data collection requires the informed consent of the Indigenous community. **Protection:** Measures against data misuse and unauthorized access.
- **Benefit Sharing:** Equitable sharing of benefits from Indigenous data use.
- **Privacy & Confidentiality:** Secure data storage with restricted access.
- **Shared Decision Making:** Seek First Nations representation in all decisions.
- **Review:** Regularly update communication and reporting processes.

4. Capacity Building: MWRC aims to enhance the data management capabilities of Indigenous communities through resources, training, and support.

5. Review and Accountability: Regular reviews will ensure alignment with the Indigenous Data Sovereignty principles. An Indigenous Data Governance Committee will guide the Centre's data practices.

Conclusion: The MWRC is committed to Indigenous Data Sovereignty, aiming for a respectful research environment that honours Indigenous rights. This statement will be periodically reviewed in collaboration with Indigenous partners.

1.4 THE COMMUNICARE-MMEX AFPP DATA COLLECTION PROJECT

The high importance of Indigenous Data Sovereignty has been a driver of the Communicare-MMEX AFPP data collection project. The project aim is that AFPP client program data are owned, stored and permanently accessible at the AFPP service delivery site. In the AFPP in 2023, 14 of the 15 program sites are in the ACCHO sector.

Transfer of deidentified AFPP program data to the NSS for data monitoring and reporting purposes (Figure 1.2) is aligned with the Molly Wardaguga Research Centre Indigenous Data Sovereignty principles and commitments, and site-specific Indigenous Data Agreements.

Project background: When the AFPP started in Wave 1 sites in 2009 (Congress, Alice Springs; WACHS, Dubbo; Wuchopperen, Cairns), program data were collected and stored in their respective ACCHO Communicare patient care information systems (PCIS). The Wave 1 sites continue to use their organisational Communicare systems for AFPP data collection and provide the NSS with extracts of relevant deidentified program data for fidelity and annual data reporting. With the program’s subsequent expansion in 2016-17 (Table 1.1), a cloud based ANKA data system was developed and launched in July 2017. However, in practice, the ANKA data system has not provided a suitable solution for AFPP data collection.

There have been ongoing challenges with the ANKA system itself, as well as challenges related to having two disparate AFPP information systems. For example, the ANKA database provides cloud-based rather than site-based data storage; some program variables are collected differently between the ANKA and Communicare systems, and others only exist in one system, resulting in loss of data during collation, or making collation unachievable. Additionally, there are prohibitive costs associated with updating the ANKA system to include contemporary AFPP data collection which will be available in the new Communicare and MMEX collections (e.g., GEM, KMMS).

Project update: Throughout 2022-23, the NSS has worked with AFPP sites and Telstra Health to review and update the AFPP Communicare data collection forms. The new forms will be available to all AFPP sites where their umbrella organisation uses a Communicare PCIS. Additionally, the AFPP data collection has been replicated by ISA Healthcare Solutions for sites that use a MMEX PCIS.

The text box below shows the AFPP sites, the PCIS used at their umbrella organisation, and their current AFPP data system. In 2023, most sites use a Communicare PCIS, two use MMEX, and a non-community-controlled site uses a NT government provided patient information system.

Program Site	Organisation Patient Care Information System	July 2023 AFPP Data Collection System
Congress Aboriginal Health Service	Communicare	Communicare since 2009
Danila Dilba Health Service	Communicare	ANKA
Durri Aboriginal Corporation Medical Service	Communicare	ANKA
Institute of Urban Indigenous Health (North)	MMEX	ANKA
Institute of Urban Indigenous Health (South)	MMEX	ANKA

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Nunkuwarnin Yunti of South Australia Inc	Communicare	Previously ANKA. Communicare (since October 2022)
Rumbalara Aboriginal Co-Operative	Communicare	ANKA
Top End Health Service	NT govt system	ANKA
Greater Western Aboriginal Health Service (Blacktown) GWAHS	Communicare	ANKA
Wellington Aboriginal Corporation Health Service (Dubbo)	Communicare	Communicare (since 2009)
Winnunga Aboriginal Health and Community Service	Communicare	ANKA
Wuchopperen Health Service	Communicare	Communicare (since 2009)
Wurli-Wurlinjang Health Service	Communicare	In transition from ANKA to Communicare
Kimberley Aboriginal Medical Service	MMEX	MMEX site under establishment in 2023
Pilbara Aboriginal Health Alliance	Communicare	Communicare site under establishment in 2023

In addition to ensuring AFPP data are collected and stored at the service delivery organisation, the Communicare-MMEX AFPP data collection project aims to extend the 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 (GEM).
- Measures of childhood development using screening tools developed for Aboriginal and Torres Strait Islander families e.g., ASQ Trak; Plum and Hats - Parent-evaluated Listening & Understanding Measure and Hearing and Talking Scale.
- Assessment of perinatal mental health using a screening tool developed for Aboriginal and Torres Strait Islander mothers i.e., the KMMS -Kimberley Mums Mood Scale.
- Reporting the quality of parent-child interactions through DANCE – Dyadic Assessment of Naturalistic Caregiver-child Experiences.

Next Steps: In 2023-24 the NSS will dedicate resources to guiding transitions from ANKA to Communicare and MMEX AFPP data collection. A dedicated project officer will identify and resolve transition and implementation issues as they arise, as well as home-visiting staff data education needs.

The transition process will include temporary unavoidable data disruptions which may be evident in reporting processes, however, the final project outcomes will aim for:

- A focus on Indigenous data sovereignty
- Formalised Data Agreements between AFPP partner organisations and the NSS

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- A contemporary AFPP data collection that reflects current program implementation
- Uniformity of data collection between program sites to enhance and streamline program reporting.

AN IMPORTANT NOTE ABOUT THE AFPP NATIONAL ANNUAL DATA REPORT 2022-23

As indicated by in the textbox above, the transition from ANKA to Communicare has commenced at some program sites. As a result, AFPP data for 2022-23 includes ANKA data, 'new' Communicare data and 'old' Communicare data, and MMEX program data will also be added. The collation of these data sets is a complex process that requires implementation of new parameters for selected variables and considerable manual data manipulation to collate data between systems. Therefore, in some tables and figures in this report, in an interim reporting measure, only data for the ANKA system are included (e.g. tables and figures in Chapters 4 & 5) while internal NSS work on the collation parameters and processes continues.

2 PROGRAM IMPLEMENTATION

IMPORTANT NOTE: THE DATA PRESENTED IN THIS SECTION ONLY CAPTURES THE 13 SITES EXCLUDING KAMS AND PAHA.

2.1 ACTIVE AFPP CLIENTS BY LOCATION

- On June 30, 2023, there were 577 active clients in the AFPP program. In the previous reporting period (2021-22) there were 544 active clients.
- The 2022-23 geographical distribution of active clients across Australian Remoteness Areas remains similar to 2021-22, with approximately half (52%) living in major cities (Table 2.1).

2.1.1 *Table 2.1: Summary of active clients at 30 June 2023, by remoteness area*

	Major Cities	Inner Regional	Outer Regional	Remote	Total
Active Clients	301	43	99	134	577

2.1.2 *Table 2.2: Summary of client referrals, offers & acceptances, home visits, exits and graduations 2022-23, by remoteness area*

	Referrals	Offered	Accepted (%)	Home Visits	Attempted home visits	Left the program (prior to graduation)	Graduated
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Major Cities	299	217	180 (83%)	3,115	234	114	57
Inner Regional	40	25	22 (88%)	446	61	17	8
Outer Regional	126	110	82 (75%)	791	323	63	17
Remote	152	121	93 (77%)	1,417	439	80	22
Total	617	473	377 (80%)	5,769	1,057	274	104

- In 2022-23, the AFPP was delivered with 5,769 visits; there were 1057 attempted visits (Table 2.2). There were 586 less completed home visits reported in the current reporting period compared to 2021-22 (6,355). There was a decrease in reported attempted home visits from 1,264 in 2021-22, down to 1057 in 2022-23.
- A total of 104 clients successfully completed the program and graduated in 2022-23. This is less than the 136 graduations reported in 2021-22.
- There were 617 referrals received by the program in 2022-23, which is similar to 2021-22 (614). The number of offers and new enrolments in 2022-23 were also similar to the previous reporting period (473 versus 499, and 377 versus 399 respectively).
- The proportion of eligible referrals (473 offered) who enrolled in the program (377 accepted) was 80%. This is above the CME 4 target benchmark of 75%.
- The number of clients who left the program prior to graduation in 2022-23 (274) was similar to 2021-22 (282).

2.1.3 *Table 2.3: 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
Major Cities	1,987	1,674	1301 (78%)	18,985	1,492	765	239
Inner Regional	236	191	155 (81%)	1,849	356	79	32
Outer Regional	1,867	1,441	1142 (79%)	16,109	3,354	818	231
Remote	1,856	1,429	1050 (73%)	18,080	6,982	638	266
Total	5,946	4,735	3648 (77%)	55,023	12,184	2,300	768

- Excluding current active clients (3648-577=3071), over the program duration and across all remoteness areas, 25% (768/3071), or around under 1 out of 4 accepted clients, have successfully graduated (Table 2.3).

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- Again, excluding active clients in each remoteness area, the graduation rate of accepted clients for the program duration has been 24% (239/1000) in major cities, 29% (32/112) at inner regional sites, 22% (231/1043) at outer regional sites and 30% (245/805) at remote sites.

2.2 CLIENT REFERRALS AND ACCEPTANCE TREND

2.1.4 Figure 2.1: client referrals, offers and enrolments for program duration

2.1.5

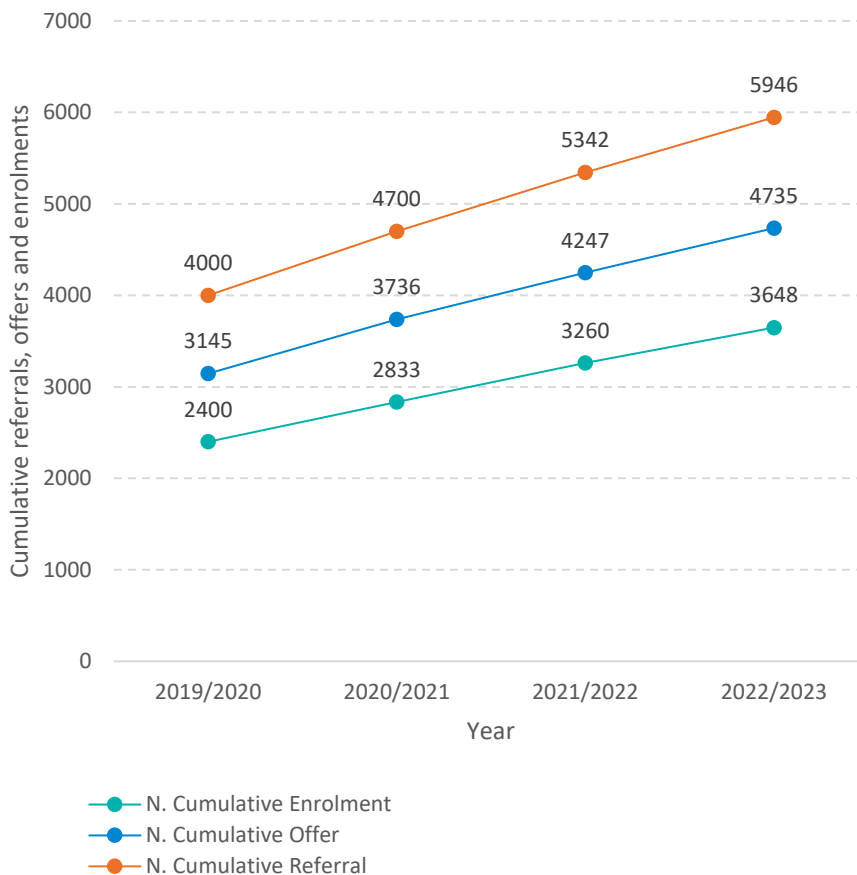
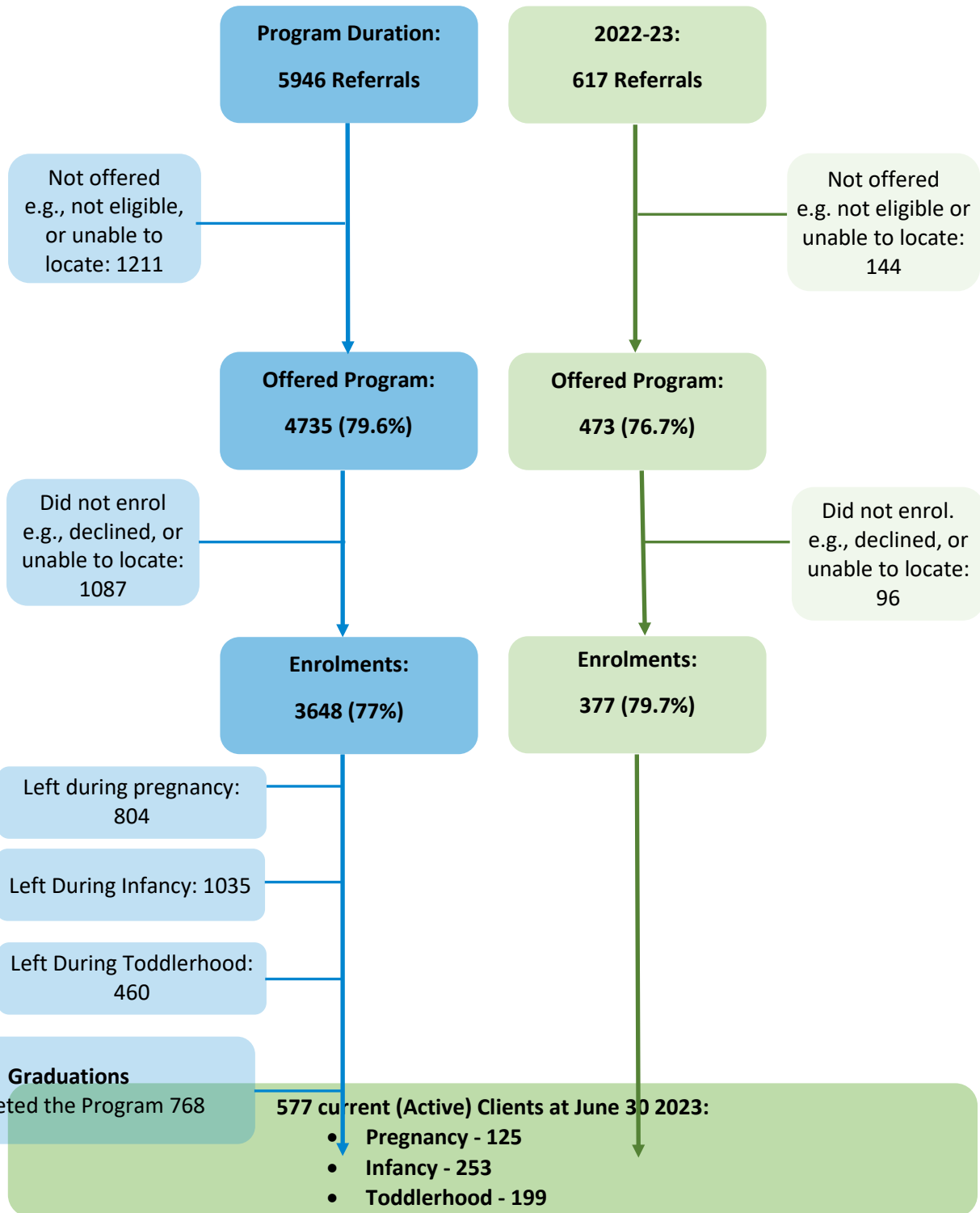


Figure 2.1 shows AFPP growth in terms of program referrals, offers and enrolments since 2019-20. The program cumulative enrolments have increased to 3648 in 2022-23, offers increased to 4735 and total referrals for program duration are 5946 (Figures 2.1 & 2.2).

Across program duration since 2009, nearly 80% of referrals have been offered a place in the program. Reasons that referred women are not offered a place are mostly due to ineligibility or the AFPP service being unable to locate the client. 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 program sites, particularly if it is her first opportunity to parent. Sometimes program places at the site are full at the time of the referral.

2.1.6 Figure 2.2: summary of client referral outcomes
a. Program Duration b. 2022-2023



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The following Tables 2.4, 2.5 and 2.6 show the number of referrals, offers and accepted clients enrolled at each program site during 2022-23, respectively. The cumulative total number of referrals for program duration at each site are also shown – for the end of the 2021-22 and 2022-23 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.

Legend for Tables 2.4 , 2.5 , 2.6 and 2.7



2.1.7 Table 2.4: number of Referrals 2022-23, 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 site 6	Program site 7	Program site 8	Program site 9	Program site 10	Program site 11	Program site 12
Number of Referrals (2022/23)	94	33	45	79	40	48	83	46	17	23	75	16	18
Program duration (2009 - 2021/22)	1304	704	797	630	280	240	491	201	84	112	243	123	120
Program duration (2009 - 2022/23)	1398	737	842	709	320	288	574	247	101	135	318	139	138

2.1.8 Table 2.5: number of offers 2022-23, 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 site 7	Program site 8	Program site 9	Program site 9	Program site 10	Program site 11	Program site 12
Number of Offers 2022/23	65	28	34	45	40	48	69	37	10	15	58	8	16
Proportion of referrals receiving an Offer 22/23	69%	85%	76%	57%	100%	100%	83%	80%	59%	65%	77%	50%	89%
Program duration (2009-2021/22)	950	509	594	559	247	228	396	181	80	86	217	104	111
Program duration (2009-2022/23)	1015	537	628	604	287	276	465	218	90	101	275	112	127

2.1.9 Table 2.6: number of Accepted* clients 2022-23, 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 site 7	Program site 8	Program site 9	Program site 9	Program site 10	Program site 11	Program site 12
Number of Accepted clients 2021-22	55	24	31	39	24	27	56	30	8	14	47	8	14

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Proportion of Offered who accepted	85%	86%	91%	87%	60%	56%	81%	81%	80%	93%	81%	100%	88%
Program duration (2020-21)	671	446	470	397	194	144	295	155	63	70	189	85	92
Program duration (2021-22)	726	470	501	436	218	171	351	185	71	84	236	93	106

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

- The proportion of program referrals receiving an offer in 2022-23 ranged from 50% to 100% across program sites (Table 2.5).
- The proportion of offers accepted ranged from 56% to 100% (Table 2.6).

2.3 CLIENT REFERRAL SOURCES

Table 2.7 shows the top five referral sources for the AFPP during 2022-23 which account for 89% (548/617) of referrals to the program.

- In 2022-23, as in previous years, the majority of AFPP clients were referred from a local primary health care organisation. The overall AFPP referral pattern is like the previous reporting period.

2.1.10 Table 2.7: Top five referral sources 2022-23, by program site

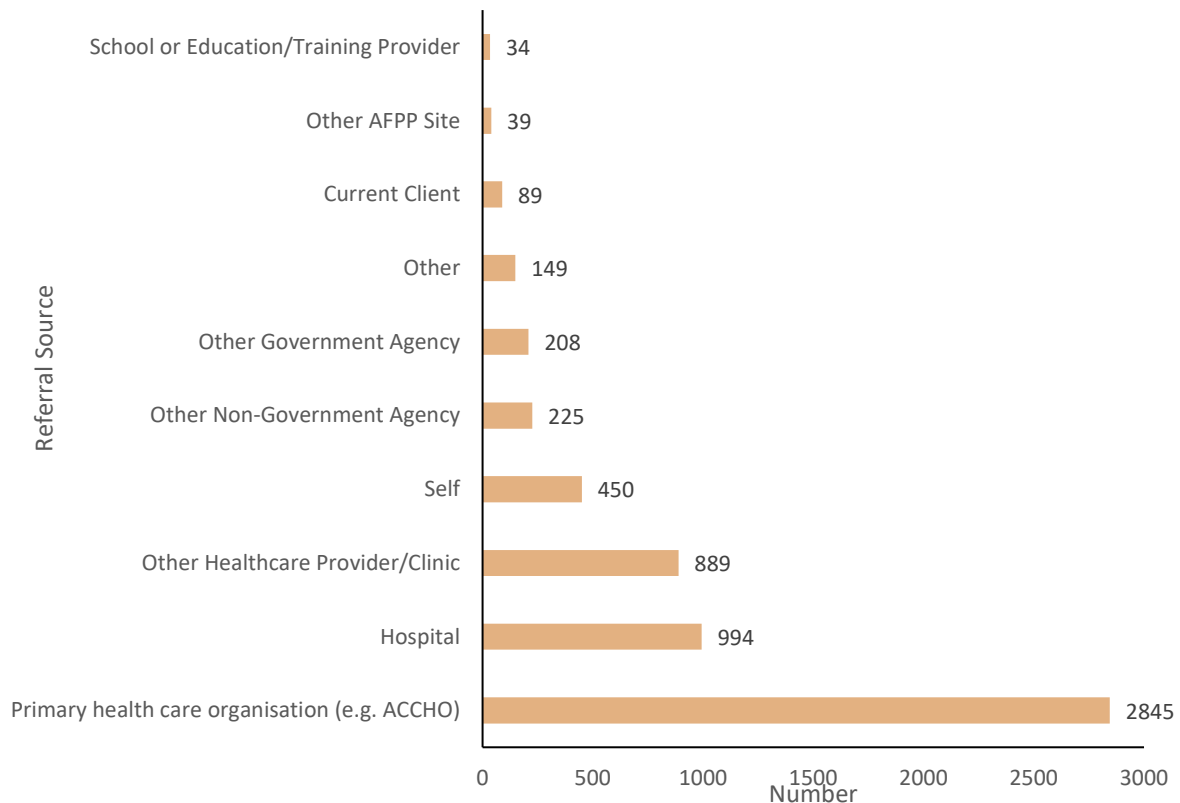
Program site	Primary health care organisation (e.g. ACCHO)	Hospital	Other healthcare provider/clinic	Self-Referral	Other government agency
Program site 1	62*	1	9	2	2
Program site 2	1	13*	1	6	1
Program site 3	21*	3	6	3	0

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Program site 4	17	42*	15	5	0
Program site 5	4	34*	0	0	0
Program site 6	34*	11	0	0	0
Program site 7	70*	5	5	3	0
Program site 8	14	0	20*	4	1
Program site 9	10*	1	5	0	1
Program site 10	10*	0	2	4	2
Program site 11	5	9	21*	17	15
Program site 12	12*	1	1	1	1
Program site 13	10*	4	0	1	0
Total (Referral Source)	270	124	85	46	23

* top referral source for each program site

2.1.11 *Figure 2.3: client referral sources for program duration*



- Primary health care organisations and hospitals have been the primary referral sources for the AFPP program sites for the program duration (Figure 2.3)

2.4 HOME VISITS ANALYSIS

Under CME 10, the AFPP 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 apportion time in visits across the AFPP 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.

2.1.12 Table 2.8: Time Apportioned Across Program Domains 2022-23, By Program Phase And Remoteness Area

Remoteness	Phase	My Child and Me	My Family & Friends	My Health	My Home	My Life
	Benchmark	23-25%	10-15%	35-40%	5-7%	10-15%
Major Cities	Pregnancy	20	15	40	10	15
Inner Regional	Pregnancy	20	15	20	20	20
Outer Regional	Pregnancy	20	17	32	14	12
Remote	Pregnancy	25	14	38	10	11
	Benchmark	45-50%	10-15%	14-20%	7-10%	10-15%
Major Cities	Infancy	40	15	20	10	15
Inner Regional	Infancy	35	15	20	12	16
Outer Regional	Infancy	30	17	25	12	15
Remote	Infancy	35	11	25	10	10
	Benchmark	40-45%	10-15%	10-15%	7-10%	18-20%
Major Cities	Toddlerhood	40	15	15	10	20
Inner Regional	Toddlerhood	30	10	20	20	20
Outer Regional	Toddlerhood	36	16	22	8	17
Remote	Toddlerhood	34	15	25	10	11

Key  Below range  Within range  Above range

Table 2.8 shows the estimated proportion of time spent in each program domain, by program phase. **IMPORTANT NOTE: In Table 2.8, the totals reported by AFPP 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%. Additionally, because the time reported represents an estimate, the time apportioned in Table 2.8 is a guide only.

2.1.13 Table 2.9: Visits In The Client's Home 2022-23, By Remoteness Area

Remoteness	Visits in the Client's Home	
	n*	%
Major Cities	2219/3221	69

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Inner Regional	256/446	57
Outer Regional	270/720	38
Remote	271/1373	20
Total	3016/5760	52

*Excluding video conferencing/telehealth visits

AFPP 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, since the start of the COVID-19 pandemic, program delivery via video or telehealth visits has increased. Phone and videoconferencing visits are excluded from Table 2.9.

- In 2022-23, 52% of the total AFPP home visits were recorded as taking place in the woman's home. This is higher than the 44% estimate recorded in 2021-22.
- Women who live in major cities are more likely than women who live in other remoteness areas to have their program visits recorded as taking place in their home (Table 2.9)

2.1.14 **TABLE 2.10: CLIENTS WHO HAD a FIRST HOME VISIT BEFORE 28 WEEKS 2022-23, BY REMOTENESS AREA**

Remoteness	First home visit before 28 completed weeks of pregnancy	
	n*	%
Major Cities	79/165	48
Inner Regional	7/22	32
Outer Regional	47/67	70
Remote	56/78	72
Total	189/332	57

*Denominator: Clients who had a first home visit completed in 2022-23 and had data on gestational age at First Home Visit

Under CME 4, women are enrolled in the program early in pregnancy and receive their first home visit no later than the 28th 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

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pregnancy and establishment of clinical antenatal care. Sometimes the timing of a pregnancy becoming known is bound by cultural or other personal considerations.

- In major city sites, about half of women who had a first home visit in 2022-23 were less than 28 completed weeks of gestation at the time of that visit (Table 2.10).
- Women in inner regional sites were less likely to have a first home visit by 28 weeks (32%).
- Women in remote and outer regional sites were more likely than women living in other remoteness areas to have a first home visit by 28 weeks (70% and 72% respectively).

2.5 HOME VISITS DOSAGE

In the AFPP, 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 AFPP 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 0-1st birthday – 28 visits; toddlerhood 12-24 months – 22 visits).

2.1.15 *TABLE 2.11: Home visits completed (range and median) 2022-23, by completed program phase*

	Pregnancy n = 194	Infancy n = 108	Toddlerhood n = 81	Entire Program n = 383*
Range; median	4(1-18)	12(1-37)	10(1-21)	6(1-37)

*Active clients who have not completed a program phase excluded

The clients included in Table 2.11 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 2022-23 was below the standard visit schedule in pregnancy, infancy, and toddlerhood (Table 2.11).
- The range number of visits was wide, especially in infancy, indicating that a proportion of the 2022-23 AFPP clients were complex or with a high level of program needs.

2.6 CLIENT ATTRITION ANALYSIS

Participation in the AFPP, 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 2022-23 reporting period totalled 274. This is less than the last reporting period when 282 clients left the program before graduation.

Table 2.12 shows the number of clients who left during 2022-23 for each program site as well as the cumulative total number that have left for the program duration to the end of the current (2022-23) and previous (2021-22) reporting periods.

2.1.16 *TABLE 2.12: NUMBER OF CLIENTS WHO LEFT the program 2022-23, 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 site 7	Program site 8	Program site 9	Program site 10	Program site 11	Program site 12	Program site 13	Total
2022-23	49	13	15	26	25	16	2	27	36	17	33	11	4	274
Program duration (2009-2021/22)	414	95	29	254	194	56	33	94	102	308	352	44	50	2,025
Program duration (2009-2022/23)	463	108	44	280	219	72	35	121	138	325	385	55	54	2,299

Tables 2.13 & 2.14 show the number and percentage of clients who left during pregnancy, infancy and toddlerhood, for 2022-23 and program duration respectively. The data is presented by remoteness area.

- In 2022-23, 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 comparatively fewer clients enrolled in the toddlerhood phase.

2.1.17 *TABLE 2.13: CLIENTS WHO LEFT IN EACH PROGRAM PHASE 2022-23, BY REMOTENESS AREA*

Remoteness	Pregnancy n (%)	Infancy n (%)	Toddlerhood n (%)	All Phases n (%)
Major Cities	42(37%)	50(44%)	22(19%)	114 (42%)
Inner Regional	4(24%)	10(59%)	3(18%)	17(6%)
Outer Regional	24(38%)	23(37%)	16(25%)	63(23%)
Remote	14(18%)	29(36%)	37(46%)	80(29%)

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Total	84(31%)	112(41%)	78(28%)	274
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2.1.18 TABLE 2.14: CLIENTS WHO LEFT in each program phase FOR PROGRAM DURATION, BY REMOTENESS AREA

Remoteness	Pregnancy n (%)	Infancy n (%)	Toddlerhood n (%)	All Phases n (%)
Major Cities	299(39%)	334(44%)	131(17%)	764 (33%)
Inner Regional	25(32%)	36(46%)	18(23%)	79 (3%)
Outer Regional	300(37%)	400(49%)	118(14%)	818(36%)
Remote	180(28%)	265(42%)	193(30%)	638(28%)
Total	804(35%)	1035(45%)	460(20%)	2,299

2.1.19 FIGURE 2.4: CLIENTS WHO LEFT in each PROGRAM PHASE FOR PROGRAM DURATION

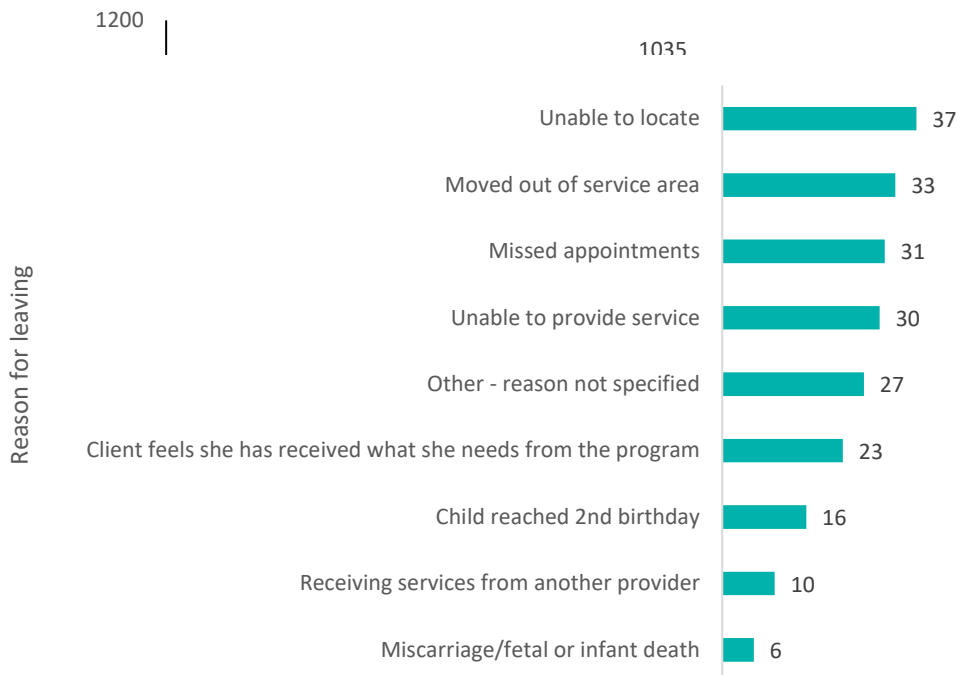


Figure 2.4 shows the number of clients who left the program in each phase for the duration of the program.

Home visiting teams report the primary reason for women leaving the program prior to graduation. Figure 2.5 shows the reasons (where provided) for leaving in 2022-23 and Figure 2.6 is for program duration.

- In 2022-23 (Figure 2.5), the most frequently reported reasons for leaving the program were the home visiting team being unable to locate the client (37) or she moved out of the service area (33).
- Overall, for program duration (Figure 2.6), the most frequently reported reason for leaving has been the woman moved out of the program service area.

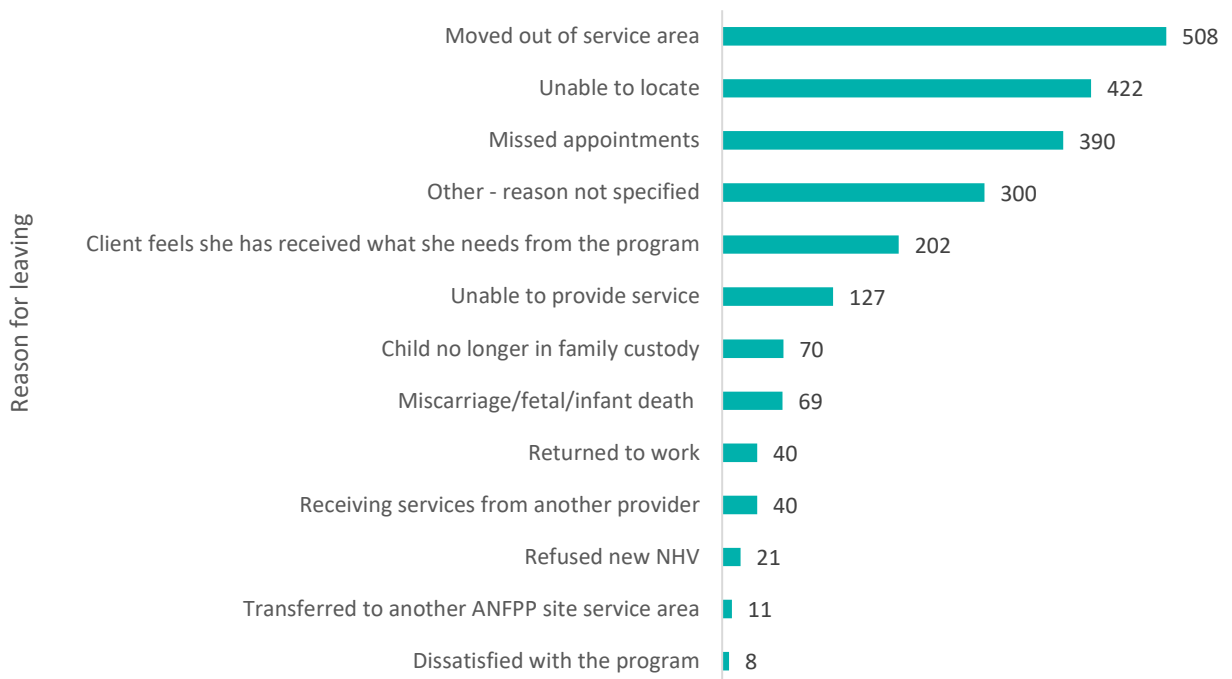
The category 'Other' as a reason for leaving the program is selected by home visiting teams at a site level and the specific reason is not provided.

2.1.20 FIGURE 2.5: RECORDED REASONS FOR LEAVING THE PROGRAM 2022-23

2.1.21 *FIGURE 2.6: RECORDED REASONS FOR LEAVING THE PROGRAM FOR PROGRAM DURATION*

Some of the recorded reasons for leaving the program occur infrequently. For privacy and confidentiality reasons, 'Reason for Leaving' with a count of less than 5 in Figures 2.5 and 2.6 are not shown in the graphs. This applies to the following recorded reasons: 'Moved to another AFPP site service area', 'Refused new NHV', 'Maternal death', 'Refused new FPW', 'Incarcerated or other out of home placement for mother', 'Pressure from family members' and 'Returned to education'.

During 2022-23, 23 women were recorded as leaving the program for because the 'Client felt she has received what she needs from the program' which may be regarded as a positive reason for exiting. In addition, very 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 not related to program client.



3 WORKFORCE

Family Partnership Workers, nurses and midwives that form the AFPP home visiting teams work within a defined model, in diverse settings to develop therapeutic relationships with families to achieve life-changing outcomes (AFPP, 2023). A home visiting team comprises: a Nurse Supervisor (NS), Family Partnership Workers (FPW) and Nurse Home Visitors (NHV).

This section of the report describes:

- AFPP workforce makeup by site on 30 June 2023 (Table 3.1)
- Proportion of Indigenous and non-Indigenous staff
- AFPP workforce retention

Workforce data for a new WA AFPP service established in 2023 are included chapter.

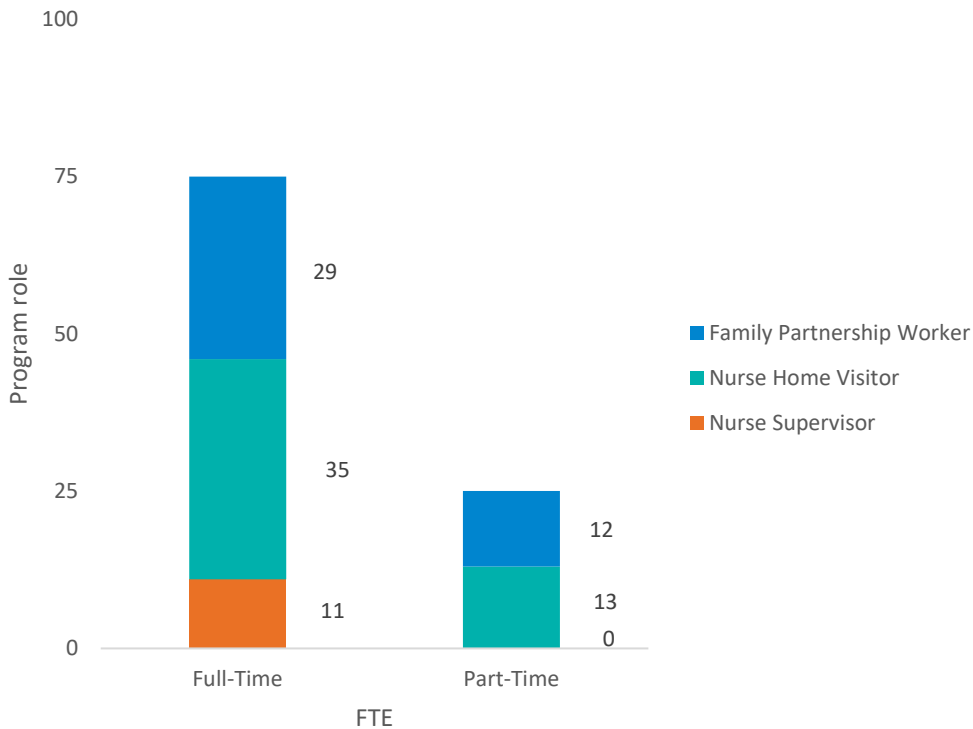
3.1.1 TABLE 3.1: HOME VISITING TEAMS 30 June 2023, by program role and site

Program Site	NS	NHV	FPW	Total
Program site 1	1	2(5*)	1(1*)	10
Program site 2	1	1(1*)	4	7
Program site 3	1	2	1	4
Program site 4	1	5	4	10
Program site 5		4(1*)	4	9
Program site 6	1	4(1*)	4	10
Program site 7	1	1*	1(2*)	5
Program site 8	1	5(1*)	5*	12
Program site 9	1	5	1	7
Program site 10	0	1*	1(1*)	3
Program site 11	0	1	1	2
Program site 12	1	2(1*)	2(1*)	7
Program site 13	1	1(1*)	2(2*)	7
Program site 14	1	3	3(1*)	8
Program site 15	No workforce data: AFPP in early establishment phase			
Total	11	48	42	101

*part-time FTE

Core Model Element 12 requires that each AFPP team has an assigned NS who leads and manages the team and provides regular clinical and reflective supervision. A NS should lead a team of no more than eight home visiting staff and a team administrator. Some teams may be larger than eight individuals due to the employment of staff in part-time positions. In Table 3.1, part-time positions appear in brackets, marked with a single asterisk).

3.1.2 FIGURE 3.1: HOME VISITING TEAMS 2022-23, BY FTE (FULL-TIME EQUIVALENCE)



The total AFPP workforce of NS, FPW and NHV on 30 June 2023 is 101 (Table 3.1). This is less than the total reported at the end of the previous reporting period (109), however, in the 4 weeks subsequent to 30 June 2023, an additional 9 AFPP staff commenced employment.

- The 2022-23 workforce included a total of 11 NS.
- There were 48 NHV and 42 FPW at the end of the reporting period.
- There were 26 part-time positions: 0 NS, 13 NHVs and 13 FPWs (Figure 3.1).

3.1.3 FIGURE 3.2: HOME VISITING TEAMS 2022-23, BY INDIGENOUS STATUS

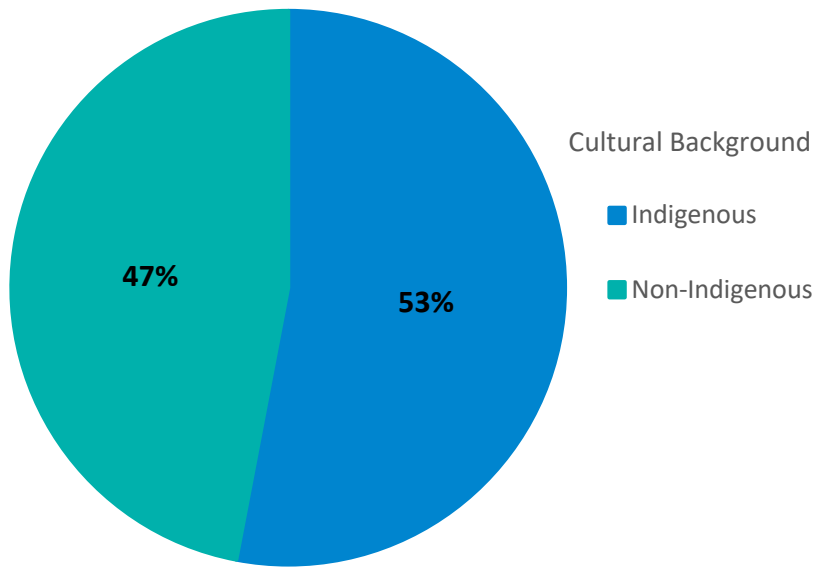


Figure 3.2 shows the proportion of Indigenous and non-Indigenous team members that made up the home visiting teams in 2022-23.

- Just over half of home visiting team members (53%) were Indigenous Australians.
- Five sites had FPW leads, and all (100%) were Indigenous Australians.

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3.1.4 TABLE 3.2: HOME VISITING TEAMS 2022-23, BY INDIGENOUS STATUS AND PROGRAM ROLE

Home visiting role	Indigenous	Non-Indigenous	Total (Indigenous %)
Family Partnership Worker Team Lead	5	0	5 (100%)
Family Partnership Worker	42	0	42 (100%)
Nurse Home Visitor	10	38	48 (21%)
Nurse Supervisor	2	9	11 (18%)
Total (N, %)	54	47	101 (53%)

3.1.5 FIGURE 3.3: HOME VISITING TEAMS 2021-22 AND 2022-23, BY INDIGENOUS STATUS AND PROGRAM ROLE

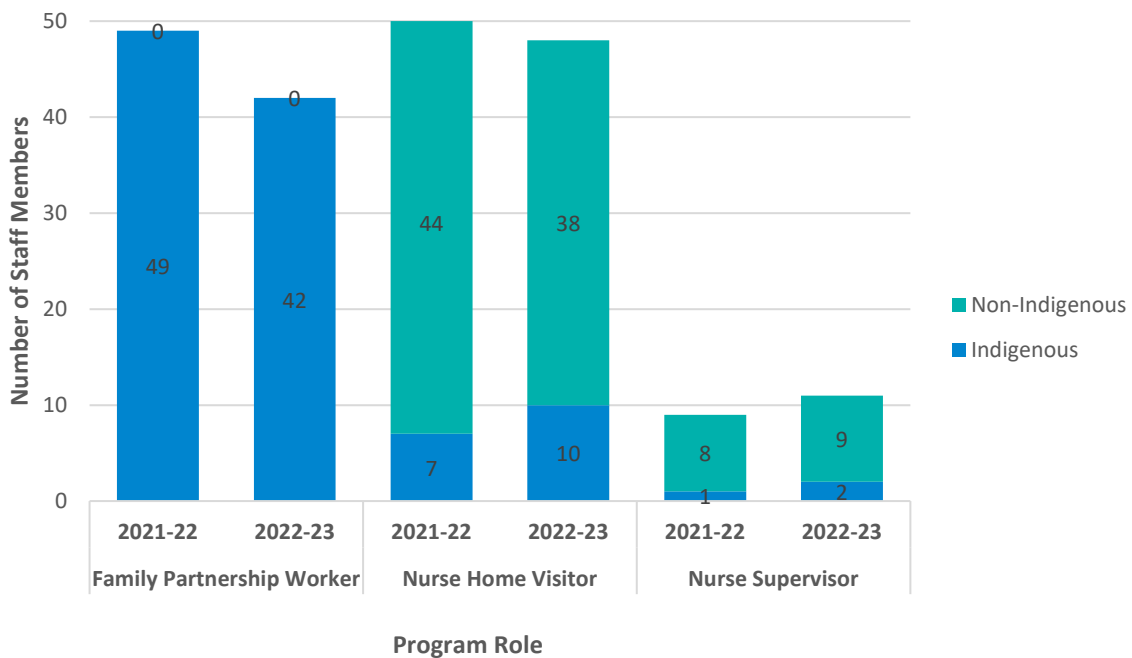


Table 3.2 and Figure 3.3 show the proportion of Indigenous and non-Indigenous team members according to program role.

- There were more First Nations NHV at 30 June, 2023 (21%) compared to 14% in the previous reporting period.

Staff recruitment and retention has been an ongoing challenge in the AFPP. Table 3.3 shows the number and proportion of staff who left that role in 2022-23 using total number of staff employed in each role during the reporting period as the denominator (n=147).

3.1.6 TABLE 3.3: STAFF TURNOVER 2022-23, BY PROGRAM ROLE

Program role	Total AFPP employees per role 1 Jul 22-30 Jun 2023	Total employed on 30 Jun 2023. n	Left the role 1 Jul 2022-30 Jun 2023 n (%)
Family Partnership Worker	67	42	25 (37%)
Nurse Home Visitor	69	48	21 (30%)
Nurse Supervisor	16	11	5 (31%)
Total	152	101	51 (34%)

Staff turnover in AFPP teams in 2022-23, and in the previous two years, has been reported as about one third of the workforce.

- Program sites reported 51 home visiting staff who left the program in 2022-23.
- The proportion of reported staff turnover was similar across program roles and ranged from 30% among NHV to 37% among FPWs (Table 3.3).

3.1.7 TABLE 3.4: STAFF TURNOVER 2022-23, BY REMOTENESS AREA

Remoteness area	Total AFPP employees per role 1 Jul 22-30 Jun 2023	Total employed on 30 Jun 2023. n	Left the role 1 July 2022-30 Jun 2023
Major cities	65	38	27 (41%)
Inner regional	13	9	4 (31%)
Outer regional	25	17	8 (32%)
Remote	49	37	12 (24%)
Total	152	101	51 (34%)

Table 3.4 shows AFPP staff turnover by remoteness area.

- Turnover in 2022/23 ranged from 24% in remote sites to 41% in major cities.

3.1.8 FIGURE 3.4: staff turnover 2022-23, BY PROGRAM ROLE & remoteness area

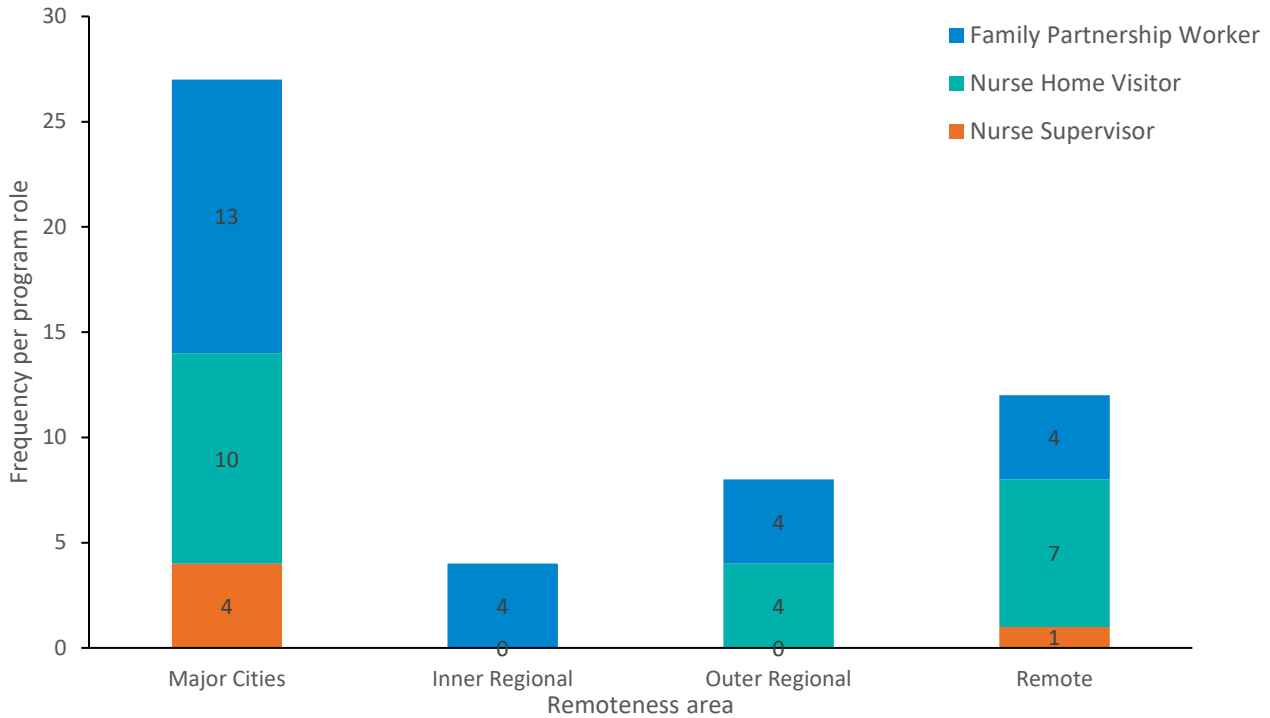


Figure 3.4 shows staff turnover in 2022-23 by program role and remoteness area

- In 2022-23, staff turnover as a proportion of the home visiting workforce was highest in major cities. This is a similar distribution of staff turnover to the previous reporting period.

4 CLIENT CHARACTERISTICS

Chapter 4 presents a description of selected characteristics of the mothers who enrolled in the AFPP during 2022-23 including maternal cultural background, parity, age, perinatal mental health screening and access to clinical antenatal care. In 2022-23, 377 clients were accepted (enrolled) in the AFPP (slightly less than 385 in 2021-22).

IMPORTANT NOTE: As stated in the introduction section of this report, as an interim reporting measure, the data presented in Sections 4 & 5 are from the ANKA system only representing 8/13 of the established program sites. Therefore, Section 4 reports on client characteristics of 254 (8 sites) of the 377 (total for 13 sites) accepted clients for the reporting period. The number of singleton babies born in 2022-23 at the 8 sites using ANKA data collection was 191.

4.1 CLIENT CULTURAL BACKGROUND AND PARENTING STATUS

CME2 defines program eligibility. Benchmark 1 states that 100% of enrolled clients are pregnant with an Aboriginal or Torres Strait Islander baby. Enrolments include non-Indigenous women in which the child's father is an Aboriginal or Torres Strait Islander person.

Benchmark 2 states that 90% of total clients enrolled identify as Aboriginal and, or Torres Strait Islander.

4.1.1 TABLE 4.1: INDIGENOUS STATUS OF ACCEPTED CLIENTS 2022-23

Remoteness area	Total Number	Percentage
Aboriginal	216	85.1
Torres Strait Islander	5	1.9
Non-Indigenous women having an Aboriginal or Torres Strait Islander baby	29	11.4
Aboriginal and Torres Strait Islander	4	1.6
Missing data	0	0
Total	254	100.0

Please Note: The above table is used to report data for 8 out of 13 sites.

Table 4.1 shows the cultural background of 254 women who were newly enrolled in the program during 2022-23.

- 89% of new clients enrolled in 2022-23 identified as Aboriginal and/ or Torres Strait Islander.

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- Most new clients identified as Aboriginal women (85.1%).
- Non-Indigenous women having an Aboriginal or Torres Strait Islander baby made up 11.4% of 2022-23 enrolments.
- The cultural background of clients in 2022-23 is similar to the previous reporting period.

Australia has an approved and accepted CME variation to include multiparous mothers on a case-by-case basis at the discretion of program sites.

AFPP CME 2 states that the client is a first-time mother, a multiparous mother having her first opportunity to parent, or a multiparous mother enrolled at the discretion of the program site.

4.1.2 TABLE 4.2: PARITY (PREVIOUS LIVE BIRTHS) OF ACCEPTED CLIENTS 2022-23

Parity Category (number Of children)	Total Number	Percentage
0	237	93.2
1	10	4.0
2	1	0.4
3	1	0.4
4+	5	2
Missing	0	0
Total	254	100.0

Table 4.2 shows that in 2022-23:

- Most AFPP enrolments were first time mothers (93.2%)
- Multiparous clients (6.8%) included mothers for whom it may have been their first opportunity to parent.

New enrolments in 2022-23 were similar to 2021-22 in terms of mother's parity, however, in 2022-23, the data shows no missing data about number of previous births.

4.2 CLIENT AGE

The age of a mother can be an important factor in how she experiences her pregnancy and birth. Most mothers, regardless of their age will have a healthy pregnancy and baby, but younger (under 20 years) and older mothers (over 40 years) generally have a higher risk of adverse pregnancy outcomes such as a preterm and/or low birthweight birth. However, the statistical relationship between age and birth outcomes, is population dependent and can be confounded by socio economic factors (Restrepo-Méndez, 2015).

The AFPP clients who may benefit most from the education and other support provided by their home visiting team are younger women. AFPP clients overall, most of whom are having their first baby, are a cohort of younger women.

4.1.3 TABLE 4.3: AGE (MEAN, MEDIAN, MIN, MAX) OF ACCEPTED CLIENTS IN 2022-23

Total Number of clients.	Mean(Average) age	Median age	Minimum age	Maximum age
254	23.35	22	14	40

Table 4.3 shows that:

- The average age of 254 new clients enrolled in the program in 2022-23 was 23.35 years. This is a little higher than the previous reporting period's average of 22 years.
- The age of new clients ranged from 14 to 40 years.

4.1.4 TABLE 4.4: AGE DISTRIBUTION OF ACCEPTED CLIENTS at intake 2022-23

Age category	Number	Percentage
Under 20	73	28%
20-24	103	40%
25-34	75	29%
35+	10	3%
Missing data	0	0
Total	254	100%

Table 4.4 shows that:

- In 2022-23, 28% of 254 new clients were aged under 20. This is around the same range as the previous 2021-22 reporting period, when the proportion aged under 20 years was 28.8%.

4.3 HOUSING AND LIVING ARRANGEMENTS

Data about housing and living arrangements is not included in the 2022-23 report due to data quality considerations.

As AFPP sites transition from ANKA data collection to Communicare, it is expected that data quality about housing and living arrangement of AFPP clients will improve.

Whether or not a household is crowded is not only related to the number of people who live there, but also to the size of the dwelling and number of bedrooms available.

To better understand housing and living arrangements of AFPP clients in the future, two new questions have been added to the new Communicare and MMEX data collections. They are:



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1. How stable do you feel your current accommodation is? Very unstable, Moderately unstable, Quite stable, Very stable.
2. How suitable do you feel your current accommodation is for you [and your baby]? Very unsuitable, moderately unsuitable, Quite suitable, Very suitable.

4.4 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.

In the AFPP, 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. For women who are referred and enrolled in the program later in their pregnancy, there may only be one practical opportunity for screening during the pregnancy. The recommended screening tools are the Edinburgh Postnatal Depression Scale (EPDS) or the Kimberley Mum's Mood Scale (KMMS).

In Table 4.5, the category 'Not screened or not reported' includes women who were offered but declined screening (Declined), women who were not offered screening (Not Offered), and missing data.

191 women in the AFPP who had a singleton baby in 2022-23 were eligible for mental health screening in pregnancy. By definition, ineligible women (2 for this reporting period) include those who have not had a singleton baby, i.e. have had more than one baby.

Table 4.5 shows:

- 22 women were screened at intake only, and 12 women at 36 weeks only.
- There were 43 or 22.5% (43/191) of women who had a baby in 2022-23, who had perinatal screening results recorded at both intake to the program and 36 weeks gestation.
- Overall, 77 women or 40% (77/191), had perinatal screening during pregnancy results recorded-either at intake, at 36 weeks of pregnancy, or both timepoints.
- 70/191 women were screened, but at a time that was not at pregnancy intake or 36 weeks gestation.
- There was no perinatal screening data for 44 women.

4.1.5 TABLE 4.5: PERINATAL MENTAL HEALTH SCREENING DURING PREGNANCY 2022-23, BY REMOTENESS AREA

Denominator: Clients who had a singleton baby in 2022-23 n=191

Screened, but not at intake or 36 wks pregnancy n=70; Not screened or not reported n =44

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)	Not screened or not reported	In the AFPP, perinatal mental health screening is usually
Major Cities	18	5	39	62(68%)	29(32%)	
Inner Regional	0	0	0	0(0%)	1(100%)	
Outer Regional	2	2	1	5(50%)	5(50%)	
Remote	2	5	3	10(53%)	9(47%)	
Total	22	12	43	77(64%)	44(36%)	

completed using the EPDS or the KMMS. Each scale contains 10 items that are each scored from 0-3, then added to obtain an overall score. Item Numbers 3,4 & 5 represent a subscale for assessing anxiety. The KMMS screening includes a Part 2 assessment of protective and risk factors the client may be experiencing in her life. Follow-up recommendations and client care after perinatal mental health screening use a combination of screening results and clinical judgement.

In Table 46, clients with possible depression symptoms are those who scored 13 or more: 13 - 14 (possible risk) and 15 or more (possible high risk).

4.1.6 TABLE 4.6: POSSIBLE DEPRESSIVE SYMPTOMS: SCORE OF 13 OR MORE DURING PREGNANCY 2022-23

	Screened at intake only (n=22)	Screened at 36 weeks only (n=12)	Screened at intake & 36 weeks (n=43)	Total women (screened at intake and/OR 36 weeks) (n=77)
Possible depression symptoms	3	2	7	12

Denominator: Clients who had a singleton baby in 2022-23 n=191

Screened, but not at intake or 36 wks pregnancy n=70; Not screened or not reported n =44

Table 4.6 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 77 women screened at pregnancy and/or 36 weeks, 15.5% (12) had a score of 13 or more reported.
- An additional 5 women scored from 10-12 – considered a low-risk result with a recommendation to review their existing supports and repeat screening in 2-4 weeks.

In Table 4.7, clients with possible anxiety symptoms are those who received a combined score of 6 or more for Items 3, 4 & 5.

4.1.7 *TABLE 4.7: POSSIBLE ANXIETY SYMPTOMS: SCORE 6 OR MORE (ITEMS 3,4 & 5) DURING PREGNANCY 2022-23*

	Screened at intake only (n=22)	Screened at 36 weeks only (n=12)	Screened at intake & 36 weeks (n=43)	Total women (screened at intake and/OR 36 weeks) (n=77)
Possible anxiety symptoms	6	2	7	15

Denominator: Clients who had a singleton baby in 2022-23 n=191

Screened, but not at intake or 36 wks pregnancy n=70; Not screened or not reported n =44

Table 4.7 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 77 women screened, 19.5% (15) had a score of 6 or more, indicating possible anxiety symptoms at intake and/or 36 weeks.

4.5 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 (Australian Institute of Health and Welfare, 2023a).

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.

AFPP home visiting teams record their client's stage of pregnancy when she attended her first clinical antenatal visit.

- Data about timing of first antenatal visit was available for 41% (104/254) of new clients who were enrolled in 2022-23 (Table 4.8).

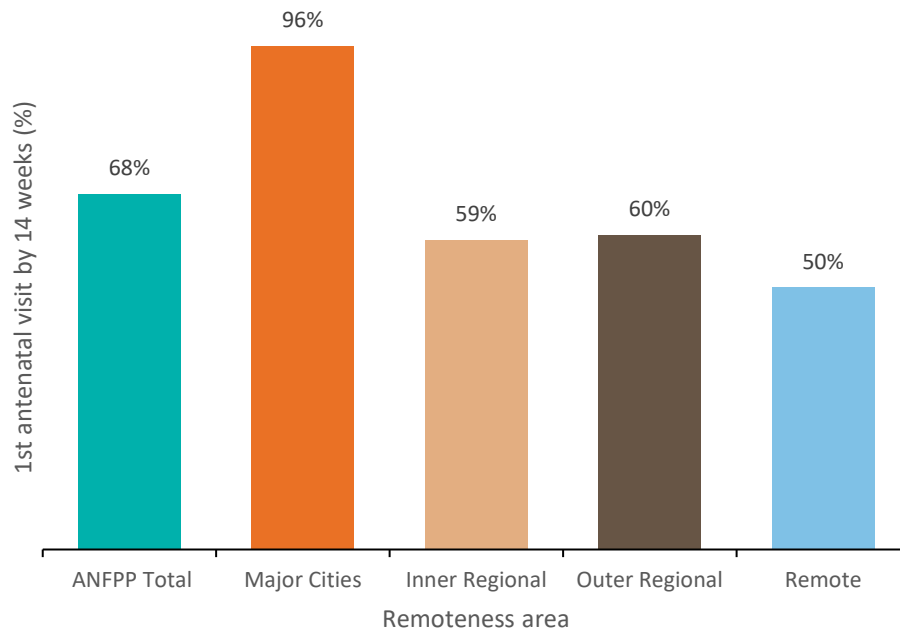
4.1.8 TABLE 4.8: First clinical antenatal visit before 14 weeks 2022-23, by remoteness area

Remoteness Area	First visit < 14 weeks	Percent
Major Cities	62/64	96%
Inner Regional	10/17	59%
Outer Regional	3/5	60%
Remote	9/18	50%
Total	71/104	68%
Missing	150/254	59%

Denominator: Clients who were enrolled/accepted in 2022-23 n = 254

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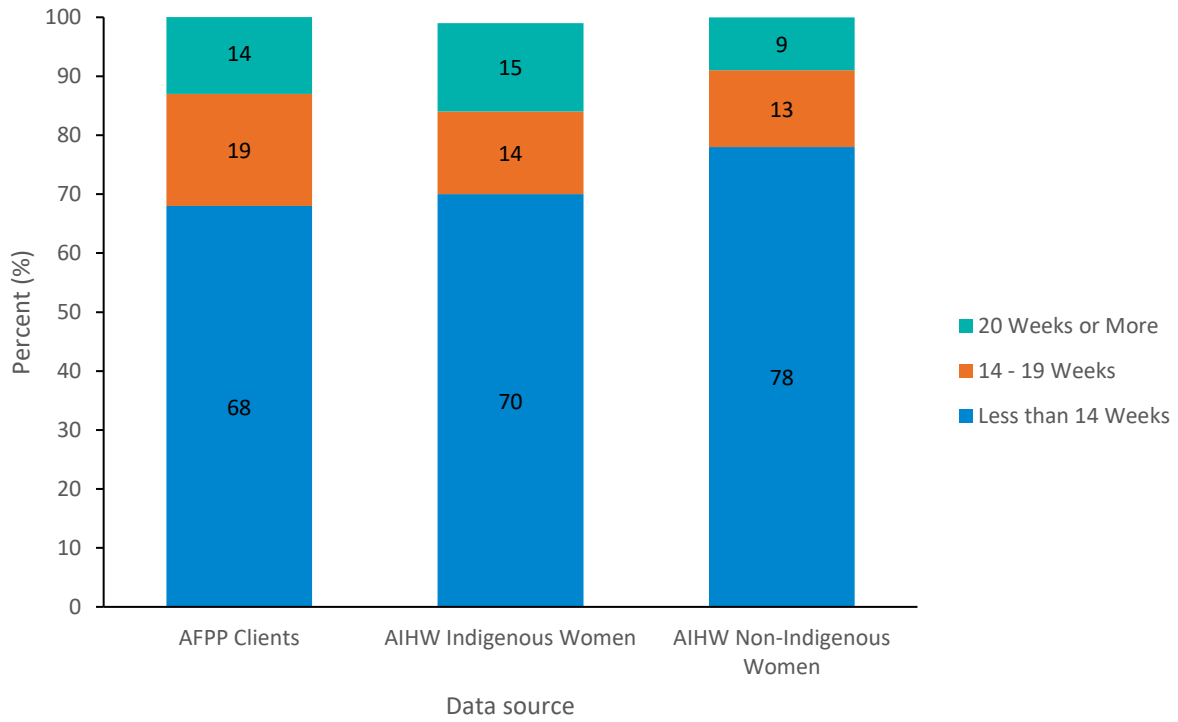
4.1.9 **FIGURE 4.3: FIRST CLINICAL ANTENATAL VISITS OCCURRING BEFORE 14 WEEKS OF PREGNANCY 2021-22, BY REMOTENESS AREA**



- Timing of first clinical antenatal visit is reported by women and recorded by their AFPP home visitor.
- 96% of women in major cities were recorded as having a first antenatal visit before 14 weeks of pregnancy (Table 4.8 & Figure 4.3).
- In the other remoteness areas, clients who reported a first antenatal visit before 14 weeks ranged from 50-60%.
- Overall, 68% of AFPP clients had their first clinical antenatal visit before 14 weeks (same as in the previous reporting period 2021-22).

4.1.10 FIGURE 4.4: DURATION OF PREGNANCY AT FIRST ANTENATAL VISIT AFPP CLIENTS 2022-23, AND AIHW 2021 Mothers and babies data collection

Figure 4.4 shows duration of pregnancy at first antenatal visit for 2022-23 AFPP 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 2023a).

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

- a similar proportion of 2022-23 AFPP clients (68%) accessed antenatal care before 14 weeks gestation when compared to other Aboriginal and Torres Islander women (70 %) nationally in 2022-23.
- Nationally, in data from 2021, more non-Indigenous Australian women (78%) accessed antenatal care before 14 weeks.

4.6 MULTIPAROUS MOTHERS

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

- Over the past four years from 2019-20 to 2021-22, the proportion of multiparous mothers who had a singleton baby in the AFPP ranged from 11%-17%. In 2022-23 the proportion of multiparous mothers enrolled at 8 ANKA sites was 9% (Table 4.9).
- In 2022-23, it was their first opportunity to parent for 15/17 enrolled mothers.

For 2022-23, also shown is the percentage of multiparous clients having their first opportunity to parent, as a proportion of singleton births (for available data). The new Communicare & MMEEX AFPP data collection forms have been updated to also capture this information.

4.1.11 *TABLE 4.9: BIRTHS TO MULTIPAROUS CLIENTS 2019-20 – 2022-23, AS A PROPORTION OF singleton BIRTHS*

Year	Total singleton births	Multiparous clients with all parenting experiences.	Percent of Multiparous clients with all parenting experiences	Multiparous clients first opportunity to parent	Percent of Multiparous clients first opportunity to parent
2019/20	314	54	17%	Not Available	Not Available
2020/21	281	40	14%	Not Available	Not Available
2021/22	298	34	11%	Not Available	Not Available
2022/23	191	17	9%	15	8%

NB: 2022-23 data only includes data from 8 ANKA sites. Previous years reported in the table include total program data from both ANKA and Communicare sites.

All program sites have at some time enrolled multiparous mothers. In 2022-23, at sites that use ANKA for data collection, most of these enrolments have been in major cities (Table 4.10).

4.1.12 *TABLE 4.10: BIRTHS TO MULTIPAROUS CLIENTS 2019-20 – 2022-23, BY REMOTENESS AREA*

Year	Major cities	Inner regional	Outer regional	Remote
2019/20 n=54	13	12	4	25
2020/21 n=40	24	3	6	7
2021/22 n=34	8	4	1	21
2022/23 n=17	12	1	2	2

NB: 2022-23 data only includes data from 8 ANKA sites. Previous years reported in the table include total program data from both ANKA and Communicare sites.

5 PROGRAM OUTCOMES

5.1 OVERVIEW

In this section, we report on program outcomes from the AFPP data collection.

IMPORTANT NOTE: As stated in the introduction section of this report, as an interim reporting measure, the data presented in Section 5 are from the ANKA system only representing 8/13 of the established program sites. Therefore, Section 4 reports on client characteristics of 254 (8 sites) of the 377 (total for 13 sites) accepted clients for the reporting period. The number of singleton babies born in 2022-23 at the 8 sites using ANKA data collection was 191.

Here we include reporting detail about the following key outcome areas:

- Immunisation
- Breastfeeding
- Birthweight and preterm births
- Smoking
- Child development

5.2 IMMUNISATION

The aim of the National Immunisation Strategy 2019-24 is to achieve herd immunity against vaccine-preventable diseases (Australian Government Department of Health, 2023). 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 a high immunisation coverage rate. Australia's national target is 95% coverage (Australian Government Department of Health, 2023).

The latest reporting from the Australian Immunisation Register provides data on childhood immunisation coverage up to June 2023 (Australian Government Department of Health, 2023). The percentage of Aboriginal and Torres Strait Islander children reported as fully immunised by 12 months of age is 90.83% and by 24 months is 88.57%.

5.1.1 **TABLE 5.1: PERCENTAGE OF AFPP CHILDREN FULLY IMMUNISED AT 12 AND 24 MONTHS 2019-20 to 2022-23**

Stage	AFPP immunisation coverage by period				National rate for Aboriginal and Torres Strait Islander Children**
	2019–20	2020–21	2021–22	2022–23	
12 months	98%	99%	97%	91%	90.83%
24 months	97%	98%	99%	97%	88.57%

*Data completeness 2022/23 at 12 months (86/157) 57%, at 24 months (86/120) 72%

**2022/23 national data sourced from DOH (Australian Government Department of Health 2023).

5.1.2 FIGURE 5.1: PERCENTAGE OF AFPP CHILDREN FULLY IMMUNISED AT 12 AND 24 MONTHS 2019-20 – 2022-23

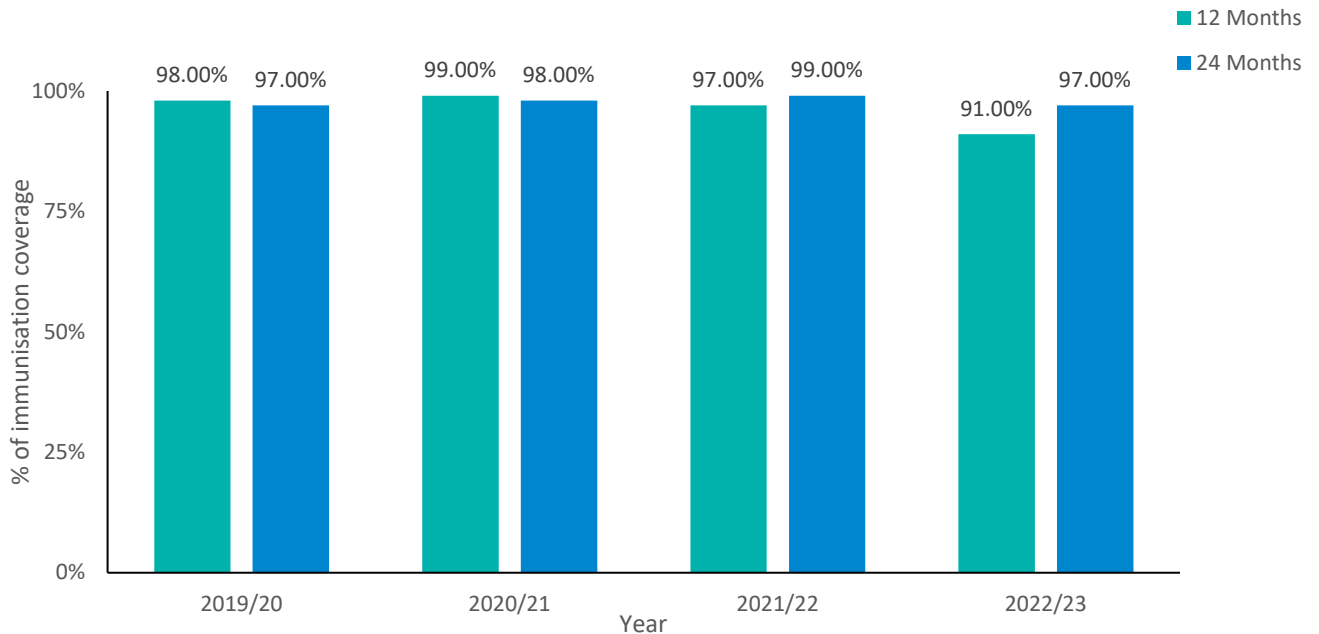


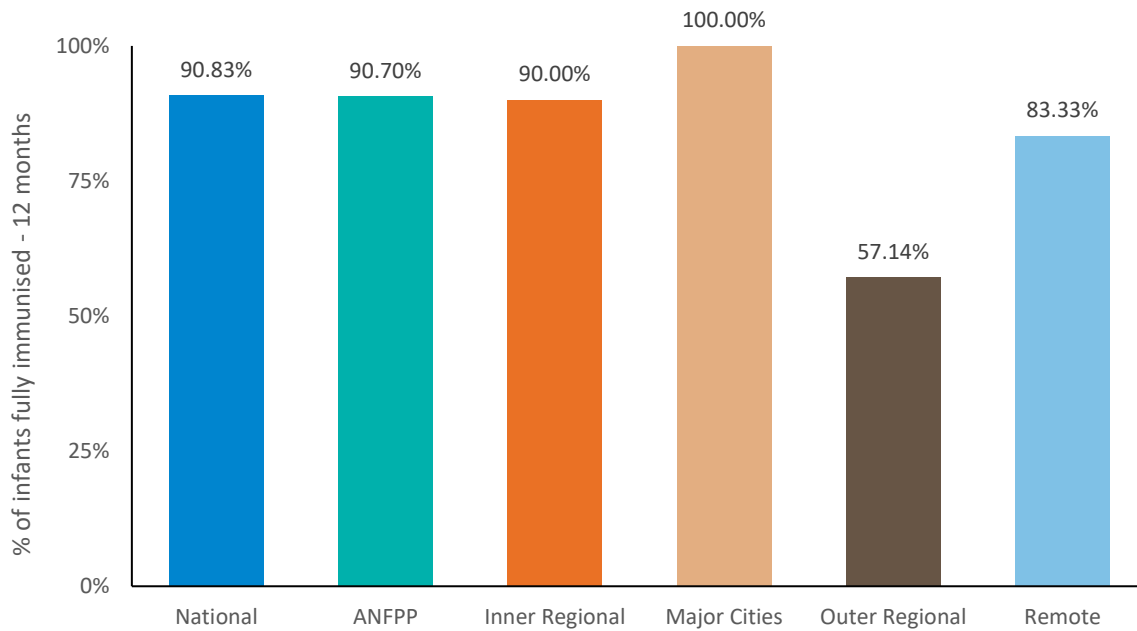
Table 5.1 and Figure 5.1 show the percentage of AFPP children reported as fully immunised from 2019-20 through to the current reporting period, 2022-23.

- Data completeness for reporting immunisation status in 2022-23 was 57% (86/157) for children aged 12 months, and 72% (86/120) for children aged 24 months (Table 5.1)
- Children eligible at 12 months & 24 months in Table 5.1 and Figure 5.1 are those children who were active in the AFPP program in the 2022-23 reporting period when they turned 12 months and 24 months of age, respectively.
- The 2022-23 immunisation coverage was high among children in the program with data available. Of children aged 12 months, 91% (78/86) were reported as fully immunised, 8% (7/86) were partially immunized and 1 not immunized.
- Of children aged 24 months, 97% (83/86) of children were fully immunised, 2% (2/86) were partially immunized and 1 not immunized.
- Immunisation coverage of children in the AFPP has stayed just below the national aspirational target of 95% in 2022-23 overall for toddlers aged 12 and has just about exceeded the national aspirational target of 95% for toddlers aged 24 months (Figures 5.2 and 5.3).



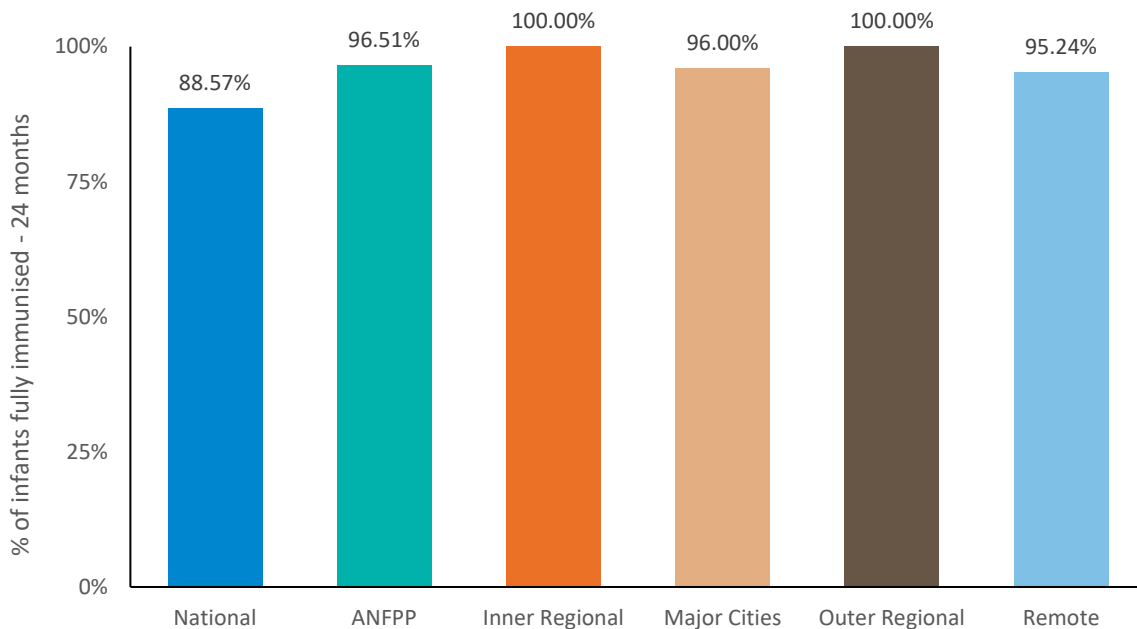
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5.1.3 FIGURE 5.2: PERCENTAGE OF CHILDREN FULLY IMMUNISED AGED 12 MONTHS 2022-23, BY REMOTENESS AREA



National Data: Sourced from Australian Government Department of Health 2023.

5.1.4 FIGURE 5.3: PERCENTAGE OF CHILDREN FULLY IMMUNISED AGED 24 MONTHS 2022-23, BY REMOTENESS AREA



National Data: Sourced from Australian Government Department of Health 2023.

5.3 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).

The Thompson Method of breastfeeding education was created by Australian midwife, Dr Robyn Thompson (Thompson, 2023). The Method promotes improving breastfeeding experiences of mothers through evidence based breastfeeding education and support. It aims to empower women with knowledge and increased confidence to feel they are in control of their breastfeeding experience.

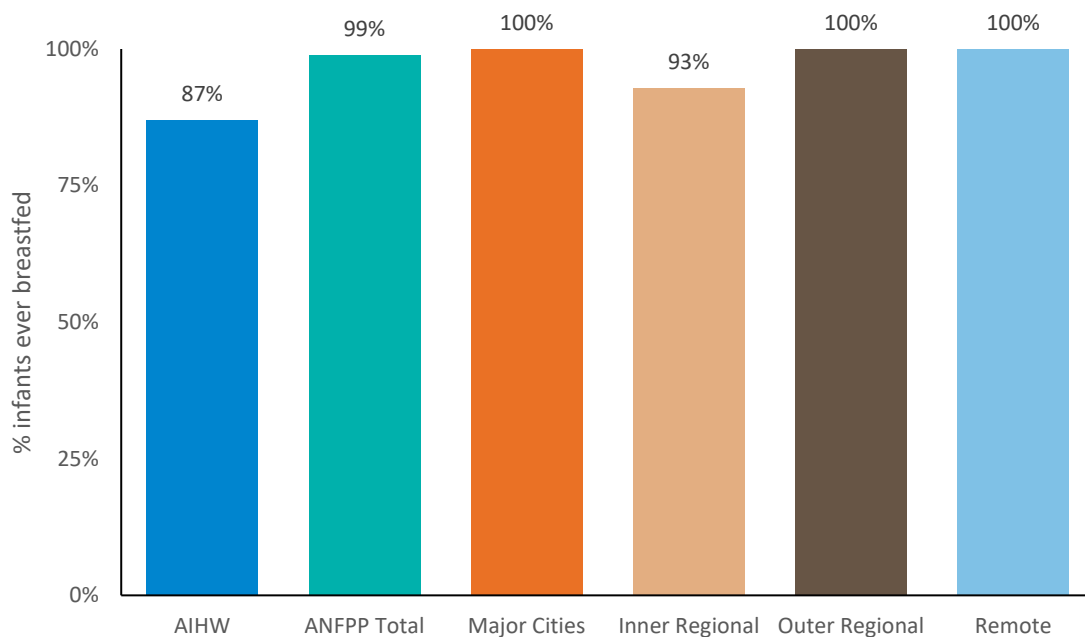
- **AFPP home visiting team members access the Thompson Method professional modules.**

These education modules provide Family Partnership Workers and Nurse Home Visitors with knowledge and skills to support all their clients, including women who do not choose breastfeeding.

Figure 5.4 shows the percentage of singleton infants in the program in 2022-23 who were recorded as ever breastfed, by remoteness area. This is self-reported information and includes infants who were breastfed or received expressed breast milk at least once.

- Reported 'ever breastfed' is high in all remoteness areas. This is consistent with the previous reporting period.

5.1.5 *FIGURE 5.4: PERCENTAGE OF INFANTS EVER BREASTFED 2022-23, BY REMOTENESS*



AREA

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AIHW Data: Tier 2 Determinants of health Breast feeding for 2018-19 period (Aust. Institute of Health and Welfare 2023)
AFPP Data: Denominator n=214. Missing data for 120.

Table 5.2 shows the ‘ever breastfed’ data for the years 2019-20 to 2022-23 by remoteness area.

- Reported ‘ever breastfeeding’, meaning an infant has received breast milk on at least one occasion since birth, is consistently high over time.

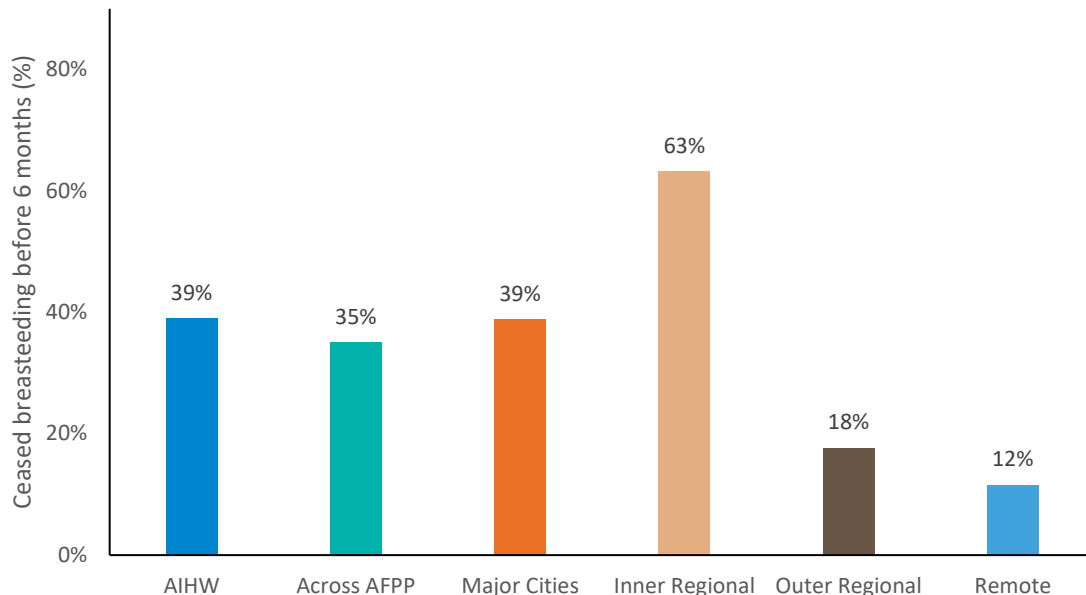
(Note: In order to ensure better accuracy of EverBreastFed data, the child is considered to be Everbreastfed if there has been at least one instance of “StillBreastFed” information or has been at least one instance of non-zero value of “StartedFormulaWhen” information).

5.1.6 TABLE 5.2: PERCENTAGE OF INFANTS EVER BREASTFED 2019-20 – 2022-23, BY REMOTENESS AREA

Remoteness Area	AFPP % Ever Breastfed Rates			
	2019-20	2020-21	2021-22	2022-23
Major Cities	89%	85%	100%	100%
Inner Regional	83%	80%	100%	90%
Outer Regional	89%	95%	97%	100%
Remote	99%	98%	97%	100%
AFPP Total	97%	90%	99%	99%

*Denominator: n=214. Missing=120

5.1.7 FIGURE 5.5: PERCENTAGE OF BREASTFEEDING CESSATION BEFORE SIX MONTHS 2022-23, BY REMOTENESS AREA



AIHW Data: Tier 2 Determinants of health Breast feeding practices. (Australian Institute of Health and Welfare 2023)

AFPP Data: Infants who have ceased breastfeeding before 6 months.

Total number of infants aged 1-6 months in 2022-23 = 268. Missing data for 102 infants.

Percentages provided for 160 infants who had data regarding Cessation of Breastfeeding.

Figure 5.5 and Table 5.3 present the same data for 2022-23 from two perspectives. Figure 5.5 shows breastfeeding cessation prior to six months and Table 5.3 shows continued breastfeeding at 6 months. Please note the data do not indicate Exclusive Breastfeeding – when their infant is around 6 months old, women are asked “Is the child still being breastfed?” (ANKA). A positive response includes infants who are partially breastfed at the milestone.

Australia’s National Health Survey of approximately 11 000 households for the 2021-22 financial year showed that at 6 months, almost three quarters of infants (73.8%) were still receiving breast milk (Australian Bureau of Statistics, 2022). However, the Australian Breastfeeding Association (ABA) has criticised the National Health Survey breastfeeding data as being weak and inconsistent with other infant feeding surveys (Australian Breastfeeding Association, 2023). The ABA does not accept reports that breastfeeding rates in Australia have increased, contending that data available in state jurisdictions reveal rates of exclusive breastfeeding to six months have not increased since 2003.

5.1.8 *Table 5.3: INFANTS STILL BREASTFEEDING AT 6 MONTHS (24 WEEKS), 2019-20 to 2022-23, BY REMOTENESS area*

Remoteness Area	AFPP % Still Breastfeeding at 6 months			
	2019–20	2020–21	2021-22	2022-23
Infants aged 6 months 2022-23	138	314	245	162
Major Cities	66% (28/44)	48% (52/109)	42% (31/74)	59% (36/61)
Inner Regional	- <5	43% (10/23)	17% (<5/12)	31% (4/13)
Outer Regional	42% (10/24)	47% (16/34)	31% (<5/13)	71% (5/7)
Remote	100% (30/30)	96% (67/70)	68% (45/67)	91% (10/11)
Missing	36	78	79	70
AFPP Total	69%	61%	49%	60%

5.4 INFANTS: BIRTHWEIGHTS AND PRETERM BIRTHS

LOW BIRTHWEIGHT BABIES

Birthweight is an important indicator of infant health. Babies who are born low birthweight (defined as <2500g) are at a higher risk of illness, disability and death than other babies (Australian Institute of Health and Welfare, 2023b). 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 alcohol consumption, and poor antenatal care (Australian

Institute of Health and Welfare, 2023b). Preterm birth is a principal determinant of low birthweight.

Table 5.4 shows the percentage of low birthweight babies in the AFPP from 2019-20 to 2022-23.

- There were 191 babies born in the program in 8 sites that used the ANKA data collection system in 2022-23.
- Birthweight was missing for 16 infants and a further 32 infants were not included because their birthweights were recorded as <500g (likely data recording errors).
- Low birthweight (<2500g) in the AFPP program in 2022-23 was 13% (25/191).

5.1.9 TABLE 5.4: LOW BIRTHWEIGHT SINGLETON BIRTHS 2019-20 – 2022-23

	Total Number of Singleton births	Low birthweight <2500g	
		Number	Percentage
2019-20	314	41	13%
2020-21	281	42	15%
2021-22	298	42	15%
2022-23	191	25	13%

**In 2022-23, birthweight data was missing for 19 infants. *In 2022-23, birthweight data was missing for 19 infants. 32 infants with birthweights less than 500 g were not included.*

For comparison, in national data about women who had a baby in 2021 (Australian Institute of Health and Welfare, 2023c):

- Of women who had an Indigenous baby in 2020, 10.8% (2,039/18,941) were born low birthweight.
- Of Indigenous women who had a baby in 2020, 11.8% (1,825/15,473) were born low birthweight.

PRETERM BIRTHS

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

Table 5.5 shows the number and percent of preterm births among singleton babies born in the AFPP from 2019-20 to 2022-23.

5.1.10 TABLE 5.5: PRETERM SINGLETON BIRTHS 2019-20 – 2022-23

	Total singleton births n	Preterm births <37 weeks	
		n	%
2019-20	314	26	8.3%
2020-21	281	35	12.5%
2021-22	298	39	13.4%

2022-23*	191	13	6.8%**
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*Gestational age at birth was missing/was of poor quality for 10 birth records not included the denominator in 2022-23

Among 191 AFPP clients who had a singleton baby in 2022-23

- Gestational age at birth was missing/was of poor quality for 10 clients.
- 7.2% (13/181) were born preterm.

**The percentage of AFPP pre-term births is lower than previous reporting periods. This is possibly to be related to interim reporting on data from 8 ANKA sites only.

For comparison, in national data about women who had a baby in Australia in 2021 (Australian Institute of Health and Welfare, 2023e).

- Of women who had an Indigenous baby in Australia in 2021, 12.6% (2,413/19,155) were born preterm.
- Of Indigenous women who had a baby in Australia in 2021, 14.1% (2,207/15,698) were born preterm.

5.5 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).

iSISTAQUIT TRAINING PACKAGES

iSISTAQUIT is a wrap-around support for pregnant Aboriginal and Torres Strait Islander women who are wanting to quit smoking (iSISTAQUIT, 2023). The iSISTAQUIT training has been co-developed with Aboriginal communities and with specialist Aboriginal advisors and is associated with the Tackling Indigenous Smoking program.

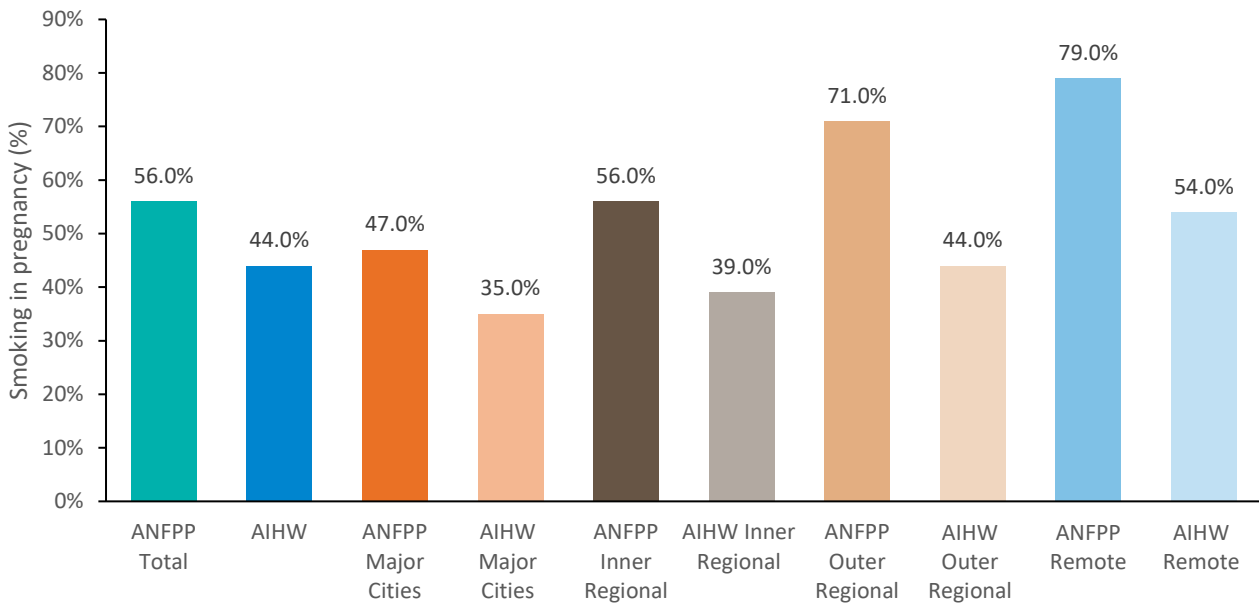
AFPP is partnered with iSISTAQUIT to ensure all AFPP home visiting team members have access to best practice training and resources to support women with smoking cessation. The education package includes 14 self-paced online modules and printed resources on smoking cessation care, including the iSISTAQUIT Treatment Manual and iSISTAQUIT Patient Flipchart for health professionals and an iSISTAQUIT 'My Journey' booklet for women. If you would like more information about the education and resources please email education@anfpp.com.au or visit <https://isistaquit.org.au/>

AFPP data shows that maternal smoking presents an ongoing challenge. Smoking data is self-reported by women and recorded by her home visitor.

Of 191 women who had a baby in 2022-23, 87 had data about smoking in pregnancy and 104 (54.45%) had no smoking data (includes missing responses and responses recorded as

blank, not answered and not asked). Of the available smoking data, 49 (56%) were recorded as smoking at some time (Figure 5.9).

5.1.11 FIGURE 5.9: CLIENTS WHO REPORTED SMOKING DURING PREGNANCY 2022-23, BY REMOTENESS AREA



AFPP Data: Clients who had a singleton baby in 2022-23 n=191; missing data = 104; reported as smoking=49
 AIHW Data: Aboriginal and Torres Strait Islander specific primary health care results: Smoking during pregnancy, by smoking status (current smoker) and remoteness June 2021. (Australian Institute of Health and Welfare, 2023f)

Figure 5.9 presents AFPP smoking data for 2022-23, compared with 2022 national Aboriginal and Torres Strait Islander primary health care data published by the Australian Institute of Health and Welfare. Figure 5.9 shows:

- Maternal smoking reported among women who had a baby in the AFPP ranged from 35% in major cities to 79% in remote areas.

In 2022-23, the data shows that smoking in pregnancy among AFPP mothers overall was more than 2022 national data for Aboriginal and Torres Strait Islander mothers.

5.6 CHILD DEVELOPMENT

In the AFPP, 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 identifies children who may need further evaluation, assessment or referral to an intervention service.

FUTURE MONITORING of CHILD DEVELOPMENT IN THE AFPP

The new AFPP Communicare data collection forms will differentiate between the ASQ and ASQ-TRAK. ASQ-TRAK is based on questionnaires from the ASQ and adapted to create a more culturally appropriate version of the tool for Aboriginal children. The ASQ-TRAK is an easy-to-use, family-centred tool which highlights a child's strengths as well as catching delays early (ASQ-TRAK, 2023).

The new Communicare and MMEX forms also include an opportunity to collect additional child development data using PLUM and HATS (PLUM & HATS, 2023). The PLUM (Parent-evaluated Listening & Understanding Measure) screens for hearing and listening problems in young children. The HATS (Hearing and Talking Scale) screens for communication problems. The National Acoustic Laboratories have worked with Aboriginal health and early childhood services from both urban and remote communities to develop these checklists. They use pictorial format to engage parents or carers to talk about their children's listening and talking activities in real-life situations. The checklists are validated for use with parents of Aboriginal and Torres Strait Islander children in urban, rural and remote communities.

ASQ SCREENING

In 2022-23, children in the AFPP were screened using the ASQ on four occasions, at or as close as practicable to the following timepoints:

- Infancy phase at 4 months (includes infants aged 3 and 5 months)
- Infancy phase at 10 months (includes infants aged 9 and 11 months)
- Toddlerhood phase at 14 months (includes infants aged 13 and 15 months)
- Toddlerhood phase at 20 months (includes infants aged 19 and 21 months)

Table 5.6 shows, for children who were in the Infancy phase of the AFPP during 2022-23 reporting period,

- 34% of (age) eligible infants had an ASQ assessment reported at 4 months and 30% at 10 months.

5.1.12 TABLE 5.6: summary of ASQ ASSESSMENTS 2022-23: INFANCY

ASQ	4 months category	10 months category
Number of infants with eligible for screening (aged 4 months and/ or 10 months in 2021-22)	218	206
Infants with ASQ data recorded (n/%)	76 (34%)	63 (30%)

For the children assessed as requiring further assessment/referral, Tables 5.7 & 5.8 (and 5.10 & 5.11) show assessments according to domains. In these tables, some individual children scored below the cut off score in more than one domain.

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- Tables 5.7, 5.8, 5.10 & 5.11 show that only a small number of the assessed children scored below the cut-off points for ASQ at 4 months, 10 months, 14 months & 20 months.

5.1.13 TABLE 5.7: AGES AND STAGES QUESTIONNAIRE 2022-23, INFANCY AT 4 MONTHS

PARAMETER	Total Number of Infants who were assessed.	Cut-off score	Below cut-off score n (%)
Communication	76	34.6	<5 (1.3%)
Fine motor	76	29.6	<5 (2.6%)
Gross motor	76	38.4	<5 (2.6%)
Personal/Social	76	33.2	<5 (3.9%)
Problem Solving	76	35.0	0

5.1.14 TABLE 5.8: Ages and Stages Questionnaire 2022-23, infancy at 10 months

Parameter	Total Number of Infants who were assessed.	Cut-off score	Below cut-off score n (%)
Communication	63	22.9	<5 (1.5%)
Fine Motor	63	38.0	<5 (4.8%)
Gross Motor	63	30.1	7 (11.1%)
Personal/Social	63	27.3	<5 (4.8%)
Problem-Solving	63	32.5	<5 (4.8%)

Table 5.9 shows for children who were in the toddlerhood phase.

- 33% of (age) eligible toddlers had an ASQ assessment reported at 14 months and 28% at 20 months.

5.1.15 TABLE 5.9: ASQ ASSESSMENTS 2022-23: TODDLERHOOD

ASQ	14 months category	20 months category
Number of toddlers eligible for screening (aged 14 months and/or 20 months in 2022-23)	195	165
Toddlers with ASQ data recorded -Number (%)	65 (33%)	47(28%)

5.1.16 Table 5.10: Ages and Stages Questionnaire 2022-23, toddlerhood at 14 months

Parameter	Total Number of Infants who were assessed.	Cut-off score	Below cut-off score n (%)
Communication	65	17.40	0
Fine Motor	65	23.06	0
Gross Motor	65	25.80	<5 (3%)
Personal/Social	65	23.18	0
Problem-Solving	65	22.56	<5 (1.5%)

*Numerical values <5 not presented. Some individual children scored below the cut-off in more than one domain.

5.1.17 Table 5.11: Ages and Stages Questionnaire 2022-23, toddlerhood at 20 months

Parameter	Total Number of Infants who were assessed.	Cut-off score	Below cut-off score n (%)
Communication	47	20.50	5 (10.6%)
Fine Motor	47	36.05	<5 (2.1%)
Gross Motor	47	39.89	<5 (2.1%)
Personal/Social	47	33.36	<5 (4.2%)
Problem-Solving	47	28.84	0

*numerical values <5 not presented. Some individual children scored below the cut-off in more than one domain.

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

Tables 5.12 shows, in 2022-23, 30% of eligible infants were screened at 6 months and 24% at 12 months, 31% at 18 months and 33% at 24 months.

5.1.18 TABLE 5.12: summary of ASQ-SE ASSESSMENTS 2022-23: INFANCY & toddlerhood

ASQ - SE	6 months	12 months	18 months	24 months
Number of children with eligible for screening (according to their age in 2022-23)	192	193	181	128
Children with ASQ-SE data recorded (n/%)	59 (30%)	47 (24%)	56 (31%)	42 (33%)

6 AFPP CORE MODEL ELEMENTS: 2023 REVIEW AND REVISIONS

In this section we provide an overview of the AFPP Core Model Elements review project completed in 2023. The section includes summaries of the project background and outcomes, and program data from 2009-2023 which informed recommendations.

6.1 PROJECT BACKGROUND

The AFPP home visiting teams implement the program at Australian sites with fidelity to the program model originally developed and tested in the United States (US) in work led by Professor David Olds (Nurse-Family Partnership 2023). The key features of the US program (both the clinical model and the organisational supporting arrangements) that need to be reproduced are identified as Core Model Elements (CMEs). In the Australian context of providing services for Aboriginal and Torres Strait Islander families, the AFPP adheres to a set of 15 CMEs.

Fidelity, or the extent to which Australian AFPP program sites achieve benchmarks associated with to the 15 CMEs, is reported to DoHAC 6-monthly in site-specific Fidelity Reports. The Fidelity Report template will be updated with the revised CMEs and benchmarks.

REASONS FOR 2023 AUSTRALIAN CME REVIEW

The 2023 CME review and revision project responds to recommendations outlined in the 2018 West Report. The report presents the ANFPP National Workforce Development Study - Informing the Way Ahead (West R, et. al. 2018). Additionally, AFPP home-visiting teams have observed and reported that some CME benchmarks are not achievable and therefore not appropriate in the Australian context and therefore consistently not met.

The 2023 CME review included an analysis of AFPP CME-related data from 2009-2022 described below to inform recommendations for CME and benchmark revisions for Australia.

PREVIOUS AUSTRALIAN CME REVISIONS

The AFPP Core Model Elements were previously altered to include important revisions for the Australian context.

CME 2: Client is a first-time mother. Benchmark: 100%

Australia has an approved and accepted CME variation to include multiparous mothers on a case-by-case basis at the discretion of program sites. For some multiparous mothers enrolled in the program, it may be their first opportunity to parent.

CME 15: ANFPP teams must employ Aboriginal and/or Torres Strait Islander Family Partnership Workers to support delivery of the program and who participate in reflective supervision. Benchmark: 100%

CME 15 was added to the Australian CMEs acknowledging the importance and value of First Nations leadership in the program and First Nations knowledges.

6.2 2023 CME REVIEW PROJECT OUTCOMES

Recommendations for 2023 CME and benchmark revisions were developed in collaboration with DoHAC and approved by the University of Colorado.

Table 6.1 provides a summary of the 2023 AFPP CME review project.

The table shows:

1. The 2023 (NEW) AFPP Core Model Elements: include agreed changes from the 2023 AFPP CME review.
2. The pre-2023 (previous) ANFPP Core Model Elements
3. Rationale, Evidence and Actions
4. Corresponding International NFP Core Model Elements.

TABLE 6.1: 2023 AFPP CORE MODEL ELEMENTS REVIEW

<p style="text-align: center;">NEW</p> <p style="text-align: center;">2023 Australian Family Partnership Program Core Model Elements (CMEs)</p>	<p style="text-align: center;">PREVIOUS</p> <p style="text-align: center;">Australian Nurse Family Partnership Program Core Model Elements (CMEs)</p>	<p style="text-align: center;">Rationale Evidence Actions</p>	<p style="text-align: center;">International Nurse-Family Partnership Core Model Elements (CMEs)</p>
<p>CME 1: Client participates voluntarily in the Australian Family Partnership Program (AFPP).</p> <p>Benchmark 1: 100% of clients participate voluntarily in the Australian Family Partnership Program (AFPP).</p>	<p>CME 1: Client participates voluntarily in the ANFPP.</p> <p>Benchmark: 100%</p>	<p>Noted that the benchmark is consistently met.</p>	<p>CME 1: Client participates voluntarily in the Nurse-Family Partnership (NFP) program.</p>
<p>CME2: Client is pregnant with an Aboriginal and/or Torres Strait Islander child. Client is a first-time mother, a multiparous mother having her first opportunity to parent, or a multiparous mother enrolled at the discretion of the program site.</p> <p>Benchmark 1: 100% of clients are pregnant with an Aboriginal and/or Torres Strait Islander child.</p> <p>Benchmark 2: 90% of clients identify as Aboriginal and/or Torres Strait Islander.</p>	<p>CME 2: Client is a first-time mother.</p> <p>Benchmark: 100%.</p> <p>Accepted variation: to include multiparous mothers on a case-by-case basis.</p>	<p>Original benchmark for CME3 has been moved to CME2 so that Aboriginality is not directly linked to socioeconomic vulnerability.</p> <p>High rates of First Nations clients are important to positively achieve outcomes, hence the new Benchmark 2.</p>	<p>CME: 2: Client is a first-time mother.</p>
<p>CME 3: Client meets socioeconomic disadvantage criteria at intake.</p> <p>Benchmark 1: 80% of clients meet socioeconomic disadvantage criteria.</p>	<p>CME 3: Client meets socioeconomic disadvantage criteria at intake.</p>	<p>Further work by NSS and DoHAC is needed to identify appropriate measure of vulnerability (e.g. Socio-Economic Indexes for Areas (SEIFA) score, income range and/or whether mothers self-identify their own level of vulnerability) before receiving a clinician assessment.</p>	<p>CME: 3: Client meets socioeconomic disadvantage criteria at intake.</p>

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<p>Note: Further work is needed to identify most appropriate measure of vulnerability</p>	<p>Benchmark: 100% of women are pregnant with an Aboriginal or Torres Strait Islander child.</p>		
<p>CME 4: Client is enrolled in the program early in her pregnancy and receives her first home visit no later than 28th week of pregnancy.</p> <p>Benchmark 1: 80% of clients receive their first home visit no later than their 28th week of pregnancy.</p> <p>Benchmark 2: 60% of pregnant women are enrolled by 20 weeks gestation or earlier.</p> <p>Benchmark 3: 75% of eligible referrals who are intended to be recruited to ANFPP are enrolled in the program.</p>	<p>CME 4: Client is enrolled in the program early in her pregnancy and receives her first home visit no later than 28th week of pregnancy.</p> <p>Benchmarks: 100% of clients receive their 1st home visit no later than 28th week of pregnancy.</p> <p>60% of pregnant women are enrolled by 16 weeks gestation or earlier.</p> <p>75% of eligible referrals who are intended to be recruited to ANFPP are enrolled in the program.</p>	<p>Data presented outlined that Benchmarks 1 and 2 are difficult to meet in Australia and it is unrealistic to continue asking sites to meet these benchmarks.</p> <p>The changes agreed reflect ANFPP visits over the last 3 years.</p>	<p>CME: 4: Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th weeks of pregnancy.</p>
<p>CME 5: Client is assigned an AFPP nurse or midwife who establishes a therapeutic relationship through AFPP home visits.</p> <p>Benchmark 1: 100% of clients are assigned an AFPP nurse or midwife.</p> <p>Benchmark 2 : 5% of clients are assigned an AFPP nurse or midwife who identifies as Aboriginal and/or Torres Strait Islander.</p>	<p>CME 5: Each client is assigned an identified ANFPP nurse who establishes a therapeutic relationship through ANFPP home visits.</p> <p>Benchmarks: 100% of clients are assigned an identified ANFPP nurse.</p> <p>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>Client Attrition/Retention: 1. Program attrition is 40% or less through to the child’s 2nd birthday. (60%</p>	<p>The word ‘identified’ is confusing for some staff as in the Australian context it can refer to Aboriginality.</p> <p>It was noted that ANFPP data shows 25% graduation rate. NSS recommended removing the benchmarks for retention as they are not achievable, and they are not required for national or international reporting.</p>	<p>CME 5: Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.</p>

	<p>retention) as an average across partner organisations</p> <ol style="list-style-type: none"> 2. 10% or less for pregnancy phase (≥ 90% retention) 3. 20% or less for infancy phase (≥ 80% retention) 4. 10% or less for toddler phase (≥ 90% retention) 		
<p>CME 6: Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the AFPP nurse, midwife, Family Partnership Worker (FPW) and client) when this is not possible.</p> <p>Benchmark 1: Client are visited in the client's home as a minimum of once every four visits across the standard visit schedule (this equates to a total of 16/64 visits in the standard visit schedule or 25% of completed visits).</p>	<p>CME 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>Benchmarks: All clients are visited in the client's home as a minimum of once every four visits across the standard visit schedule (this equates to a total of 16/64 visits over the life of client involvement in the program, or 25% of completed visits). 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>NSS noted the 25% benchmark is consistently met by sites.</p>	<p>CME 6: Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.</p>
<p>CME 7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard AFPP visit schedule or an alternative visit schedule agreed upon between the client, nurse/midwife and FPW.</p>	<p>CME 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>No change required. The NSS will continue monitoring and reporting on this CME.</p>	<p>CME 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>CME 8: ANFPP nurses, midwives and nurse supervisors are registered with the Nursing and Midwifery Board of Australia (NMBA) with a minimum of a bachelor's degree (or equivalent).</p>	<p>CME 8: ANFPP nurses and supervisors are registered nurses or midwives with a minimum of a baccalaureate/bachelor's degree.</p>	<p>There is increasing demand from sites for FPWs to deliver more content originally provided by nurses.</p> <ul style="list-style-type: none"> • Action: NSS to identify how an AHP in the NHV role can be monitored 	<p>CME 8: NFP nurses and supervisors are registered nurses or midwives with a minimum of a baccalaureate /bachelor's degree.</p>

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<p>Benchmark 1: 100% AFPP nurses, nurse supervisors and midwives are registered with the Nursing and Midwifery Board of Australia (NMBA) with a minimum of a bachelor's degree (or equivalent).</p>	<p>Benchmark: 100%</p>	<ul style="list-style-type: none"> Action: DoHAC to liaise with Professor of Workforce Innovation (Roianne West) to identify how an AHP (AQF 4-5) could be supported to work within the NHV role (AQF 7-8) safely. Action: NSS to undertake research on the impacts experienced by FPWs delivering NHV core content. 	
<p>CME 9: AFPP FPWs, nurses, midwives, nurse supervisors, and program managers complete the required ANFPP educational curriculum and participating in on-going learning activities.</p> <p>Benchmark 1 : 100% AFPP FPWs, nurses, midwives, nurse supervisors and program managers complete the required AFPP educational curricula and participate in ongoing learning activities</p>	<p>CME 9: ANFPP nurses, nurse supervisors develop the core ANFPP competencies by completing the required ANFPP educational curriculum and participating in on-going learning activities. Variation to include Family Partnership Workers (FPWs) has been accepted.</p> <p>Benchmark: 100% ANFPP nurses, and supervisors will complete the required ANFPP educational curricula and participate in on-going learning activities.</p>	<p>This CME is consistently achieved with the exception of Program Managers which would assist with program support and success.</p>	<p>CME 9: NFP nurses and supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities.</p>
<p>CME 10: AFPP FPWs, nurses and midwives using professional knowledge, judgement, 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.</p> <p>Benchmark 1: AFPP FPWs, nurses and midwives apply professional knowledge, cultural knowledge, judgement, and skill.</p>	<p>CME 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.</p>	<p>This CME is generally consistently met however NSS noted it is highly subjective.</p> <p>The inclusion of cultural knowledge is an important addition to this benchmark.</p>	<p>CME 10: NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths and risks of each family, and apportioning time appropriately across the six program domains.</p>
<p>CME 11: AFPP FPWs, nurses, midwives and nurse supervisors 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.</p>	<p>CME 11: ANFPP nurses, and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide</p>	<p>NSS outlined there are no measures currently reported that capture the applications of these important theories or the impact of those theories on clinical outcomes, particularly self-efficacy for mother and infant attachment for the infant.</p>	<p>CME 11: NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their</p>

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<p>Benchmark 1: AFPP FPWs, nurses, midwives and nurse supervisors apply the theoretical framework that underpins the program.</p> <p>Benchmark 2: 100% of clients complete the Growth and Empowerment Measurement Tool with their assigned FPW.</p>	<p>their clinical work and achievement of the three NFP goals.</p>	<p>The NSS is introducing the Growth Empowerment Measurement tool which should capture empowerment as a proxy measure for self-efficacy however measuring infant attachment is challenging in non-research environments.</p>	<p>clinical work and achievement of the three NFP goals.</p>
<p>CME 12: AFPP team has an assigned ANFPP supervisor who leads and manages the team and ensures all team members have access to regular clinical and reflective supervision. AFPP team has an assigned FPW Team Leader who leads the Cultural contextualising of the program to local community needs.</p> <p>Benchmark 1: A full time AFPP supervisor can lead a team of no more than eight ANFPP nurses and a team administrator.</p> <p>Benchmark 2: All AFPP team members have access to regular, high quality, Culturally safe Reflective Supervision.</p> <p>Benchmark 3 : 10% of AFPP Nurse Supervisors identify as Aboriginal and/or Torres Strait Islander.</p>	<p>CME 12: Each ANFPP team has an assigned ANFPP supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision.</p> <p>Benchmark: 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. The minimum team size is four ANFPP nurses with a half time supervisor.</p>	<p>Introduced new benchmark to promote First Nations leadership.</p>	<p>CME 12: Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular reflective supervision.</p>
<p>CME 13: AFPP 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.</p>	<p>CME 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.</p>	<p>A national minimum dataset is important.</p> <p>An international minimum dataset would also be useful.</p>	<p>CME 13: NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.</p>



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<p>Benchmark 1: Sites provide NSS with the agreed minimum data (with additional data provided on a case-by-case basis).</p> <p>Benchmark 2: AFPP team members have access to the bi-annual fidelity report to inform data collection, guide clinical practice, program delivery and CQI activities.</p>			
<p>CME 14: High quality AFPP implementation sustained through national and local support.</p> <p>Benchmark 1: Sites ensure the necessary infrastructure and resources for the team are made available, including office equipment, printed guideline materials and other resources, mobile phone, vehicles.</p> <p>Benchmark 2: Team members contribute to program sustainability through stakeholder and community engagement activities.</p>	<p>CME 14: High quality ANFPP implementation sustained through national & local support.</p>	<p>NSS to develop a guidance document on minimum resourcing and implementation activities.</p>	<p>CME 14: High quality NFP implementation is developed and sustained through national and local organized support.</p>
<p>CME 15: Client is assigned an FPW to ensure Cultural knowledge, expertise, skills and experiences of Aboriginal and Torres Strait Islander people are reflected in AFPP home visits</p> <p>Benchmark 1: 100% of clients are assigned a Family Partnership Worker (FPW).</p>	<p>CME 15: ANFPP teams must employ Aboriginal and/or Torres Strait Islander FPWs to support delivery of the program and who participate in reflective supervision.</p> <p>Benchmark: 100%</p>	<p>This CME is integral to the program and consistently met.</p> <p>FPW Team Leaders acknowledge the value of First Nations leadership in the program and First Nations knowledges.</p>	<p>Not applicable</p>

6.3 AFPP REVIEW OF CME-RELATED DATA

This section provides AFPP data used to inform 2023 revisions to CME2 & CME4.

CME 2

2023 CME & Benchmarks	Previous CME & Benchmarks
<p>CME 2: Client is pregnancy with an Aboriginal and/or Torres Strait Islander child. Client is a first-time mother, a multiparous mother having her first opportunity to parent, or a multiparous mother enrolled at the discretion of the program site.</p> <p>Benchmark 1: 100% of clients are pregnant with an Aboriginal and/or Torres Strait Islander child.</p> <p>Benchmark 2: 90% of clients identify as Aboriginal and/or Torres Strait Islander.</p>	<p>CME 2: Client is a first-time mother.</p> <p>Benchmark: 100%</p> <p>Accepted variation: to include multiparous mothers on a case-by-case basis.</p>

As above, Australia has an approved and accepted CME variation to include multiparous mothers on a case-by-case basis at the discretion of program sites. For some multiparous mothers enrolled in the program, it may be their first opportunity to parent.

AFPP data shows, between 2009-2022, 16% of mothers enrolled in the AFPP were multiparous. CME 2 has been changed to reflect the previously approved variation. Between 2019-2022, enrolment of multiparous mothers ranged from 11-17%. In the same time period, 87-88% of clients were Aboriginal or Torres Strait Islander mothers.

- The new CME Benchmarks 1 and 2 reflect the importance of high rates of First Nations clients to positively achieve outcomes.

6.1.1 *TABLE 6.2: proportion of multiparous & First nations mothers, 2019-2022*

YEAR	Proportion multiparous	Proportion First Nations mothers
2021-2022	11%	87%
2020-2021	14%	88%
2019-2020	17%	88%

CME 4

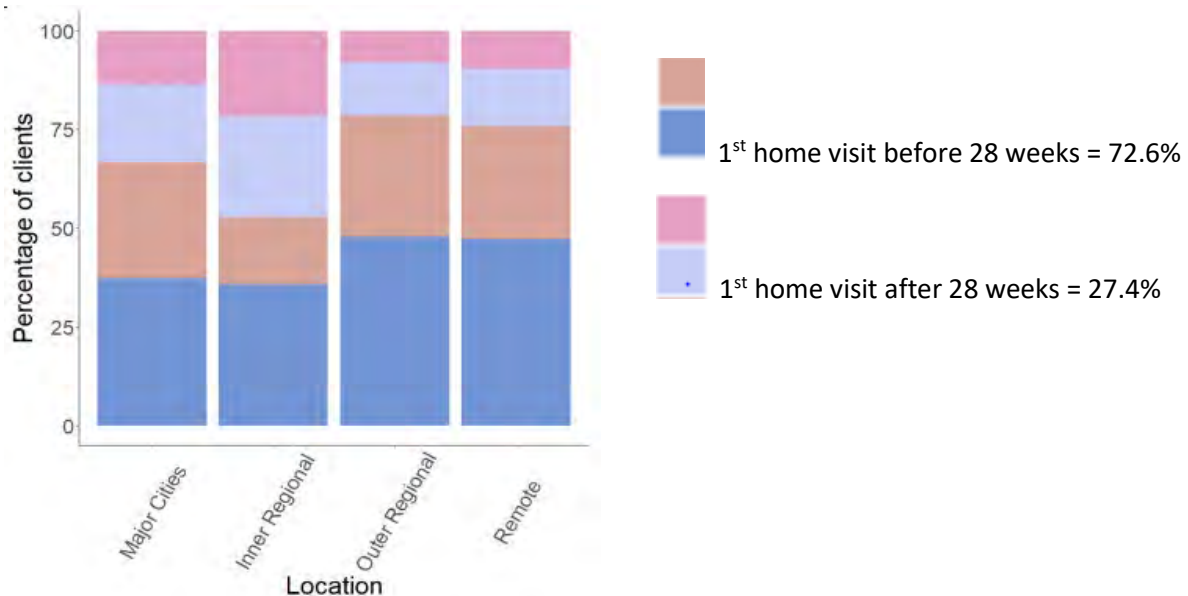
2023 CME & Benchmarks	Previous CME & Benchmarks
<p>CME 4: Client is enrolled in the program early in her pregnancy and receives her first home visit no later than 28th week of pregnancy.</p> <p>Benchmark 1: 80% of clients receive their first home visit no later than their 28th week of pregnancy.</p> <p>Benchmark 2: 60% of pregnant women are enrolled by 20 weeks gestation or earlier.</p> <p>Benchmark 3: 75% of eligible referrals who are intended to be recruited to ANFPP are enrolled in the program.</p>	<p>CME 4: Client is enrolled in the program early in her pregnancy and receives her first home visit no later than 28th week of pregnancy.</p> <p>Benchmarks: 100% of clients receive their 1st home visit no later than 28th week of pregnancy. 60% of pregnant women are enrolled by 16 weeks gestation or earlier. 75% of eligible referrals who are intended to be recruited to ANFPP are enrolled in the program.</p>

The previous CME 4 benchmark stated “100% of clients receive their 1st home visit no later than the 28th week of pregnancy”. AFPP program data from 2009-22 shows that in the Australian context, 72.6% of clients have received their first home visit by 28 weeks (Figure 6.1).

- The new Benchmark 1 for CME for has been set at “80% of clients receive their first home visit no later than the 28th week of pregnancy.

6.1.2 FIGURE 6.1: gestational age at 1st home visit 2009-2022

6.1.3



The previous CME 4 benchmark required that “60% of pregnant women are enrolled by 16 weeks gestation or earlier”. AFPP data shows, in the Australian context:

Between 2009-2022, 31% of women have been enrolled by 16 weeks gestation or earlier (Table 6.3). In the previous four years, between 2019-2022, 25% of women have been enrolled by 16 weeks (Table 6.4).

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Between 2009-2022, 64% of clients were enrolled by 24 weeks gestational age, and 80% were enrolled by 28 weeks (Table 6.5).

Between 2019-2022, 61% of clients were enrolled by 24 weeks gestational age, and 77% were enrolled by 28 weeks (Table 6.5).

- The new Benchmark 2 for CME 4 has been set at “60% of pregnant women are enrolled by 20 weeks or earlier”.

The final benchmark for CME 4 “75% of eligible referrals who are intended to be recruited to ANFPP are enrolled in the program” has been consistently achieved in the Australian context and remains unchanged.

6.1.4 TABLE 6.3: gestational age at enrolment, by geographical location, 2009-2022

Gestational age at enrolment	Major cities	Inner regional	Outer regional	Remote	Total
Enrolled by 16w	293 (24%)	42 (29%)	374 (35%)	333 (34%)	1042 (31%)
Enrolled by 20w	204 (17%)	16 (11%)	194 (18%)	162 (16%)	576 (17%)
Enrolled by 24w	218 (18%)	14 (9.5%)	175 (17%)	172 (18%)	579 (17%)
Enrolled by 28w	194 (16%)	26 (18%)	159 (15%)	156 (16%)	535 (16%)
Enrolled by birth	230 (19%)	37 (25%)	135 (13%)	125 (13%)	527 (16%)
Enrolled post-partum	62 (5.2%)	12 (8.2%)	19 (1.8%)	34 (3.5%)	127 (3.8%)
Total	1201 (100%)	147 (100%)	1056 (100%)	982 (100%)	3386 (100%)

6.1.5 TABLE 6.4: gestational age at enrolment, by year, 2019-2022

Gestational age at enrolment	2019-20	2020-21	2021-22	Total
Enrolled by 16w	116 (25%)	117 (26%)	96 (23%)	329 (25%)
Enrolled by 20w	70 (15%)	86 (19%)	76 (18%)	232 (18%)
Enrolled by 24w	84 (18%)	83 (19%)	69 (17%)	236 (18%)
Enrolled by 28w	78 (17%)	61 (14%)	75 (18%)	214 (16%)
Enrolled by birth	85 (18%)	79 (18%)	77 (19%)	241 (18%)
Enrolled post-partum	30 (6.5%)	22 (4.9%)	18 (4.4%)	70 (5.3%)

Total	463 (100%)	448 (100%)	411 (100%)	1322 (100%)
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6.1.6 TABLE 6.5: Average AFPP Enrolment by 16, 24 & 28 weeks, 2009-22 & 2019-22

Gestational age at enrolment	2009-2022 average	2019-2022 average
Enrolled by 16w	31%	25%
Enrolled by 24w	64%	61%
Enrolled by 28w	80%	77%

6.4 NEXT STEPS IN THE AFPP CME PROJECT

The revised set of Leadership Group endorsed AFPP CMEs and benchmarks will be adjusted to better suit the Australian program context so that they are both aspirational and achievable. The updated CME format described above at Table 6.1 will be included to guide future AFPP Fidelity reporting.

7 CONCLUSIONS AND DIRECTIONS FOR 2023-24

The NSS vision for the AFPP National Data Report is to be completed in accordance with the new Charles Darwin University, Molly Wardaguga Research Centre Indigenous Data Sovereignty Principles inclusive of Indigenous Data Agreements with each partner site. to more strongly align the values and aspirations of the Indigenous Australian Healthcare Context through the application of recognised frameworks as identified in the Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health, the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 through an approach that heightens and values Indigenous leadership and a partnership approach between the ANFPP and the IAH context.

This also includes building and maintaining a high-quality dataset that fulfils end-user (Partner 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 all AFPP program sites collected in multiple data systems. 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.

As per previous ADR there are continuing challenges related to having multiple information systems. Combining the data from these systems, known as 'data aggregation' is an important step in presenting the AFPP data at the national level, and in enabling comparisons. Some program variables are different between the multiple 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 AFPP data collection.

In working towards maintaining a high-quality AFPP dataset that fulfils end-user needs, the NSS is focusing on the following areas in 2023-24:

- Regular distribution of Data Quality and Completeness reports to continue the downward trend in missing data and data errors.
- Embedding education regarding data across all three units in the AFPP curriculum.
- In collaboration with program sites and Telstra Health, review and update Communicare data collection forms.
- In collaboration with program sites and Isa Healthcare, review and update MMEX data collection forms.
- 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
- 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



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- Assessment of Naturalistic Caregiver-child Experiences capture and reporting of STAR, the Strengths and Risks framework to characterise and organise client strengths and risks.
- Improve engagement and communications regarding data activities between the NSS and the AFPP program sites with regular meetings of the Data User Group, the AFPP Leadership & Program Managers Groups, and the AFPP Communities of Practice.

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