



IECD

EVALUATION OF THE NATIONAL PARTNERSHIP AGREEMENT ON INDIGENOUS EARLY CHILDHOOD DEVELOPMENT

Final report

July 2014

urbis

URBIS STAFF RESPONSIBLE FOR THIS REPORT WERE:

Project Directors	Claire Grealy, Susan Rudland
Independent Aboriginal Consultants	Kerry Reed-Gilbert, Karen Milward
Lead author	Julian Thomas
Consultants	Lee Holloway, Leila Collins, Ash Moore, Paul Fleckney, Bridie Allanadale, Geua Montana, Sara Hudson, Renee Best
Group Support	Kim Garrett, Christina Griffiths
Report Number	Final report



Urbis's Public Policy team has received ISO 20252 Certification for the provision of public policy research and evaluation, social planning, community consultation, market research and communications research

You must read the important disclaimer appearing within the body of this report.

Table of contents

Table of contents	i
Acronyms	iv
Acknowledgements	viii
Executive summary	ix
Summary of recommendations	xv
PART I: Preliminaries	1
1 Introduction	1
1.1 Background and policy context	1
1.2 Purpose of the evaluation	5
1.3 Evaluation governance	6
1.4 Previous reports	6
1.5 This report	6
1.6 A note on terminology	7
2 Methodology	8
2.1 Evaluation approach	8
2.2 Evaluation framework	8
2.3 Ethics coverage	8
2.4 Evaluation timeline	9
2.5 Evaluation field visits	10
2.6 Key data sources and analytical methods (Element 1)	11
2.7 Key data sources and analytical methods (Elements 2 and 3)	14
2.8 Attribution of NPA IECD results and outcomes	17
PART II: The national picture	20
3 Australia's progress under NPA IECD	21
3.1 National report card	21
3.2 Data and reporting	38
3.3 Long term trajectory	39
PART III: Jurisdictional achievements	42
4 Australian Government (New Directions)	43
4.1 Summary of achievements	43
4.2 Implementation Progress	43
4.3 Outcomes and program achievements	45
5 New South Wales	50
5.1 Summary of achievements	50
5.2 Progress on IECD Elements	50
5.3 Progress against performance indicators	50
6 Victoria	62
6.1 Summary of achievements	62

6.2	Progress on IECD Elements.....	62
6.3	Progress against performance indicators	62
7	Queensland	74
7.1	Summary of achievements	74
7.2	Progress on NPA IECD Elements	74
7.3	Progress against performance indicators	74
8	Western Australia	87
8.1	Summary of achievements	87
8.2	Progress on NPA IECD Elements	87
8.3	Progress against performance indicators	87
9	South Australia	98
9.1	Summary of achievements	98
9.2	Progress on IECD Elements.....	98
9.3	Progress against performance indicators	98
10	Tasmania	109
10.1	Summary of achievements	109
10.2	Progress on NPA IECD Elements	109
10.3	Progress against performance indicators	109
11	Australian Capital Territory	121
11.1	Summary of achievements	121
11.2	Progress on NPA IECD Elements	121
11.3	Progress against performance indicators	121
12	Northern Territory.....	131
12.1	Summary of achievements	131
12.2	Progress on NPA IECD Elements	131
12.3	Progress against performance indicators	131
	Bibliography.....	142
	Appendix A Evaluation framework and program logic	147
	Appendix B 2014 CFC leaders survey highlights report.....	155
	Appendix C Children and Family Centres	163

TABLES:

Table 1 – Summary of NPA IECD investment commitments (\$ million)	4
Table 2 – NPA IECD performance indicators.....	5
Table 3 – Evaluation timeline and key activities.....	9
Table 4 – Summary of Element 1 (CFC) field visits	10
Table 5 – Summary of Element 2 and 3 field visits	11
Table 6 – National progress report card	23
Table 7 – Types of services available at or through CFCs.....	27
Table 8 – Services areas offered by CFCs	28
Table 9 – CFC governance and management arrangements.....	36

Table 10 – Proportion of AEDI survey population rated as vulnerable in 2012, and change from 2009	41
Table 11 – 2012-13 New Directions funded services (by state and remoteness).....	44
Table 12 – Most frequently funded NDMB roles (ranked by proportion of total funded FTE).....	48
Table 13 – NSW progress report card.....	51
Table 14 – Victoria progress report card.....	63
Table 15 – Queensland progress report card	75
Table 16 – WA progress report card	88
Table 17 – SA progress report card	99
Table 18 – Tasmania progress report card	110
Table 19 – ACT progress report card.....	122
Table 20 – NT progress report card	132
Table 21 – CFC Integration continuum (and scoring key).....	158
Table 22 – CFC maturity and mean integration score	158
Table 23 – CFC models of integration (service areas).....	159
Table 24 – Children and Family Centres – Aboriginal and Torres Strait Islander names.....	164

FIGURES:

Figure 1 – Closing the Gap in Indigenous Disadvantage – Pathway Diagram	2
Figure 2 – Children and Family Centre locations at June 2013	31
Figure 3 – CFC service models	31
Figure 4 – Location of New Directions funded services	44
Figure 5 – NPA IECD Evaluation Framework	148
Figure 6 – NPA IECD program logic	153
Figure 7 – CFC self-reported organisational maturity	157
Figure 8 – CFC self-reported use of data to plan, inform and improve systems.....	160
Figure 9 – CFC self-reported confidence in governance arrangements	161
Figure 10 – CFC self-reported confidence in organisational sustainability	161

Acronyms

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACCO	Aboriginal Community Controlled Organisation
ACDW	Aboriginal Community Development Worker
ACT	Australian Capital Territory
AEDI	Australian Early Development Index
AEO	Aboriginal Education Officers
AEW	Aboriginal Education Workers
AFBP	Aboriginal Family Birthing Program
AFSP	Aboriginal Focus Schools Program (SA)
AHASI	Aboriginal Housing and Accommodation Support Initiative
AHC	Aboriginal Health Council (NSW)
AHCSA	Aboriginal Health Council of South Australia
AHCWA	Aboriginal Health Council of Western Australia
AHF	Aboriginal Health Forum
AHIU	Aboriginal Health Improvement Unit (Western Australia)
AHMRC	Aboriginal Health and Medical Research Council
AHS	Aboriginal Health Service
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
AMAP	Aboriginal Midwifery Access Program
AMIC	Aboriginal Maternal and Infant Care
AMIHS	Aboriginal Maternal and Infant Health Services
AMOP	Aboriginal Midwifery Outreach Project
AMS	Aboriginal Medical Services
AMSSU	Aboriginal Maternity Support Service Unit
ANAO	Australian National Audit Office
APTSTRH	Antenatal Care, Pre-pregnancy and Teenage Sexual and Reproductive Health Project
APY	Anangu Pitjantjatjara Yankunytjatjara
ARIA	Accessibility/Remoteness Index of Australia
ASEP	Adolescent Sexuality Education Project
ASH	Adolescent Sexual Health
ASHE	Academy of Sport and Education (Shepparton)
ASHHAC	Aboriginal STI, HIV and Hepatitis Advisory Committee (New South Wales)
ASHPAG	Aboriginal Sexual Health Project Advisory Group
ATSIHU	Aboriginal and Torres Strait Islander Health Unit (Australian Capital Territory)
BBV	Blood Borne Virus
BSF	Building Strong Foundations (New South Wales)
C4C	Communities for Children
CAAC	Central Australian Aboriginal Congress

CACH	Child and Adolescent Community Health
CASA	Centre Against Sexual Assault
CCB	Child Care Benefit
CCR	Child Care Rebate
CFC	Children and Family Centre
CHAPS	Child Health and Parenting Services (Tasmania)
COAG	Council of Australian Governments
COL	Core of Life Program
CSHC	Canberra Sexual Health Centre
DECD	Department for Education and Child Development (South Australia)
DEECD	Department of Education and Early Childhood Development (Victoria)
DEEWR	Department of Education, Employment and Workplace Relations
DET	Department of Education and Training (Northern Territory)
DETE	Department of Education, Training and Employment (Queensland)
DHHS	Department of Health and Human Services (Tasmania)
DOHA	Department of Health and Ageing
DOHA DEC	Department of Health and Ageing Departmental Ethics Committee
EACHS	Enhanced Aboriginal Child Health Schedule
EFT	Equivalent Full Time
FAFT	Families as First Teachers
FASD	Foetal Alcohol Spectrum Disorder
FHV	Family Home Visiting
FPT	Family Planning Tasmania
FTE	Full-Time Equivalent
GEGAC	Gippsland and East Gippsland Aboriginal Cooperative
GP	General Practitioner
GRAMS	Geraldton Regional Aboriginal Medical Service
HDT	Health Development Teams
HEALTH	Department of Health
HHS	Hospital and Health Services
HMHB	Healthy Mothers, Healthy Babies
HPF	Health Performance Framework
HREC	Human Research Ethics Committee
IAYP	Investing in Aboriginal Youth Program (SA)
IFSS	Integrated Family Support Services
IRIS	Indigenous Risk Impact Screening
IUSTI	International Union Against Sexually Transmitted Infections
IWHW	Indigenous Women's Health Workers
JET	Jobs, Education and Training
KBC	Kristine Battye Consulting
KESO	Koori Education Support Officers
KMS	Koori Maternity Services (Victoria)
LADS	Learning and Development Strategy

LEG	Local Enabling Group
LHD	Local Health District
LIL	Launching into Learning
LINC	Learning and Information Network Centre
LRG	Local Reference Group
MACH	Maternal and Child Health Services
MAFBP	Metropolitan Aboriginal Family Birthing Program
MGP	Midwifery Group Practice
MHDAS	Mental Health Drug and Alcohol Services
MOU	Memorandum of Understanding
MSEP	Maternity Services Education Program
MSHC	Melbourne Sexual Health Centre
MWH	Mobile Women's Health Nurses
MWRC	Marninwarntikura Fitzroy Women's Resource Centre Aboriginal Corporation
NAIDOC	National Aborigines and Islanders Day Observance Committee
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSIHWA	The National Aboriginal and Torres Strait Islander Health Worker Association
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCATSIS	National Centre for Aboriginal and Torres Strait Islander Statistics
NDMBS	New Directions: Mothers and Babies Services Program
NECDS	National Early Childhood Development Strategy
NECEC	National Early Childhood Education and Care Collection
NGO	Non-Government Organisation
NIR	National Immunisation Register
NMML	Northern Melbourne Medicate Local
NP ECE	National Partnership Agreement on Early Childhood Education
NPA IECD	National Partnership Agreement on Indigenous Early Childhood Development
NPY	Ngaanyatjarra Pitjantjatjara Yankunytjatjara
NSW	New South Wales
NT	Northern Territory
NTP	Ngunytju Tjitji Pirni
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OCHRE	Online Community Health Reporting Environment
OSR	Online Services Reporting
OVAHS	Ord Valley Aboriginal Health Service
PACE	Parental and Community Engagement program
PEDS	Parent Evaluation of Developmental Status
PI	Performance Indicator
PYEC	Pitjantjatjara Yankunytjatjara Education Committee
QH	Queensland Health
RASH	Relationships and Sexual Health
RWH	Royal Women's Hospital (Melbourne)
S&RH	Sexual and Reproductive Health

SA	South Australia
SCYCN	State-wide Child and Youth Clinical Network
SETAC	South East Tasmanian Aboriginal Corporation
SFA	Service Funding Agreement
SHADE	Sexual Health and Diversity Enterprise
SHFPACT	Sexual Health and Family Planning ACT
SHINE SA	Sexual Health Information Networking & Education SA Inc.
SNAICC	Secretariat of National Aboriginal and Islander Child Care
SSSF–FASD	Strong Spirit Strong Future Foetal Alcohol Spectrum Disorder Project
SSSM	Strong Spirit Strong Mind
STI	Sexually Transmissible Infection
STO	State and Territory Offices
SWC	Strong Women Coordinators
SWSBSC	Strong Women, Strong Babies, Strong Culture
SWW	Strong Women Workshops
TAC	Tasmanian Aboriginal Centre
TAS	Tasmania
TBC	To Be Confirmed
TEYF	Tasmanian Early Years Foundation
TSU	Training and Support Unit for Aboriginal Mothers, Babies and Children (New South Wales)
TYP SHO	Teenage and Young People's Sexual Health Outreach project (ACT)
UNESCO	United Nations Educational, Scientific and Cultural Organisation
VACCHO	Victorian Aboriginal Controlled Community Health Organisation
VAHS	Victorian Aboriginal Health Service
VET	Vocational Education and Training
WA	Western Australia
WACHS	Western Australia Country Health Service
WAG	Wayraparattee Advisory Group (Tasmania)
WBCFC	West Belconnen Children and Family Centre
WHS	ACT Women's Health Service
YFER	Youth and Family Education Resource

Acknowledgements

Urbis wishes to acknowledge the many communities and individuals at the Commonwealth, state and territory and local levels who gave their time and expertise to contribute to this evaluation.

In particular, we were made to feel welcome in communities across Australia during extensive fieldwork conducted during 2012 and 2013, including communities in and around Nowra, Mt Druitt, Shellharbour in NSW, Whittlesea and Bairnsdale in Victoria, Mornington Island, Palm Island, Ipswich, Redcliffe and Caboolture in Queensland, Halls Creek and Kununurra in WA, Port Augusta, Christies Beach and Whyalla in SA, Geeveston in Tasmania, West Belconnen in the ACT, as well as Yuendumu and Wadeye in the NT.

We also express our appreciation for the support and assistance provided by officers of state and territory departments, who have provided access to data and materials, participated in interviews, supported the conduct of field work, and contributed insightful comments and feedback on draft analysis and reporting.

We thank the NPA IECD Steering Committee members and those of the Evaluation Working Group, including representatives of Secretariat of Aboriginal and Islander Child Care and the National Aboriginal Community Controlled Health Organisation, for their support and guidance on the conduct of the evaluation; and to the secretariat led by Susan Mitchell and Mark Kettle at the Department of the Prime Minister and Cabinet, and previously by Glen Watson and Dallas Brabander at the Department of Education, Employment and Workplace Relations. We also acknowledge and thank the substantial support provided by Dr Annie Dullow and Rose Ledinic at the Department of Health over the course of the evaluation.

Finally, we also acknowledge the range of individuals who have worked on and contributed to this evaluation over its duration, beginning with Kerry Reed-Gilbert and Karen Milward, independent Aboriginal consultants, Associate Directors Julian Thomas, Sally Lai, Lee Holloway, Leila Collins and Ashley Moore, and Senior Consultants Paul Fleckney, Bridie Allanadale, Geua Montana and Sara Hudson.

Claire Grealy and Susan Rudland

NPA IECD Evaluation Project Directors

Executive summary

INTRODUCTION

The National Partnership Agreement on Indigenous Early Childhood Development (NPA IECD) is one of a range of measures agreed to by the Council of Australian Governments (COAG) in support of achievement of the Closing the Gap targets for Aboriginal and Torres Strait Islander people. It was introduced in July 2008 to specifically address the needs of Aboriginal and Torres Strait Islander children in their early years.

Under the NPA IECD the Australian Government and state and territory governments committed \$564 million over six years for a range of Indigenous early childhood initiatives.

The NPA IECD comprises three interrelated Elements:

- Element 1: Integration of early childhood services through the establishment of Children and Family Centres (CFCs)
- Element 2: Increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health
- Element 3: Increased access to and use of maternal and child health services by Indigenous families.

Urbis was engaged by the Australian Government to undertake the comprehensive evaluation of the NPA IECD from 2012 to 2013-14.

THIS DOCUMENT

This is the Final Report of the evaluation of the NPA IECD, and draws on a range of sources including state and territory annual and progress reports, two rounds of field visits to every state and territory encompassing funded services and programs under all three Elements, in-depth case studies of three CFCs, surveys of operating CFCs, structured discussions and telephone interviews with state and territory and Australian Government officers responsible for each Element.

The evaluation also accessed a range of other documentary sources, including the Australian Institute of Health and Welfare (AIHW) data reports on the NPA IECD health performance indicators (5-10) (AIHW 2012; AIHW 2013a),¹ the Descriptive Analysis of New Directions, Australian National Audit Office (ANAO) reports on implementation of Element 1 and New Directions, and other data sources where available and appropriate.

EVALUATION APPROACH

The evaluation framework was developed using a program logic and hierarchy of outcomes approach, the combination of which facilitates assessment of a range of results and outcomes in line with the goals of the NPA IECD. Some of these outcomes (for example, long-term outcomes) are beyond the timeframe of this evaluation.

The evaluation framework was designed to facilitate both a formative and summative evaluation. It looked to define not only the outcomes and impacts of the NPA IECD, but also to identify the key lessons learned about how to design, manage and implement large-scale, complex interrelated initiatives across multiple settings and sectors. It has taken account of the timing of the roll out of the various NPA IECD Elements, although aspects of some elements have been delayed. It has also incorporated the key evaluation questions that have been identified for the evaluation project and the performance indicators (PIs) specified for the NPA IECD.

¹ Un-published Report which has been endorsed by NPA IECD Steering Committee - February 2014, however AHMAC endorsement yet to be provided.

PROGRESS AGAINST PERFORMANCE INDICATORS

Progress against the ten longer term performance indicators for the NPA IECD was not expected to be evident at this stage of investment, although there are encouraging signs on some indicators. It should also be noted that high level outcomes are influenced by a range of factors beyond this set of initiatives. For indicators 1, 2 and 4, there is no nationally aggregated data against which to assess overall performance, although data is available at state and territory level in some cases.

Aboriginal and Torres Strait Islander children continue to be underrepresented in preschool enrolments and attendances (PI 2), although it is not expected that CFCs alone will significantly impact these data at the national level.

Some gains are evident in the proportion of pregnant Aboriginal and Torres Strait Islander women with an antenatal contact in the first trimester of pregnancy, with a rise from 60 to 66 per cent between 2007 and 2010 across the three jurisdictions for whom data were available (PI 5) (AIHW 2013a).

There are no direct measures for PI 6 and proxy measures are utilised. Between 2008 and 2012, there were no significant changes detected in the notification rates for chlamydia, gonorrhoea, syphilis, hepatitis C or hepatitis B among Aboriginal and Torres Strait Islander and other teenagers aged 15-19 (PI 6) (AIHW 2013a). Given the small numbers involved, significant change would not be expected over five years. This is the context of longer term trends since 1994-96 which showed a tripling of rates for chlamydia and a doubling for gonorrhoea, and a decline for syphilis.²

Over the period 2000 to 2010, in NSW, Victoria, Queensland, WA, SA and the NT combined, there was a significant decline in the proportion of low birth weight babies born to Aboriginal and Torres Strait Islander mothers (from 12% to 11% of liveborn singleton babies), and a significant narrowing of the gap between low birth weight babies born to Aboriginal and Torres Strait Islander and non-Indigenous mothers (PI 7). At the jurisdictional level, significant change was evident only in NSW and SA (AIHW 2013a).

Between 2008 and 2011, there was no significant change observed in the Aboriginal and Torres Strait Islander infant mortality rate or the gap. Over the period 2001 to 2011, in NSW, Queensland, WA, SA and the NT combined, there was a 55 per cent decline in the infant mortality rate for Aboriginal and Torres Strait Islander infants (PI 8) (AIHW 2013a).

No significant changes in rates of smoking by Aboriginal and Torres Strait Islander mothers during pregnancy were observed between 2007 and 2010, except in NSW where there was a significant fall on this indicator (PI 9) (AIHW 2013a).

Hospitalisation rates for Indigenous 0-4 year olds significantly increased (by 12.5%) between 2004-05 and 2010-11 in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined (PI 10). It should be noted that changes in hospitalisation rates may be reflective of a number of different factors, including changes in access to, and demand for, hospital treatment. Improvements in the recording of Indigenous status in hospital records may also affect hospitalisation rates reported for Indigenous children over time (AIHW 2013a).

STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

In addition to the documented gains on rates of antenatal contact and decreases in low birth weight babies noted above, there is evidence that a range of outcomes are being achieved for individuals, although the breadth and consistency of these is highly variable, and many are only anecdotally documented. Outcomes reported include:

² Between 1994-96 and 2010-12, in WA, SA and the NT combined, notification rates for chlamydia significantly increased among Aboriginal and Torres Strait Islander and other teenagers aged 15-19. Over the same period, notification rates for gonorrhoea increased by over 70 per cent and notification rates for syphilis decreased by over 90 per cent for Aboriginal and Torres Strait Islander teenagers, but not for other teenagers. Between 1997-98 and 2010-12, in WA, SA and the NT combined, notification rates for hepatitis C declined significantly among Aboriginal and Torres Strait Islander and other teenagers (from 171 to 70 and from 56 to 13 notifications per 100,000 population, respectively). Over the same period, in WA, SA and the NT combined, notification rates for hepatitis B declined significantly among Aboriginal and Torres Strait Islander teenagers (from 119 to 51 notifications per 100,000 population), but did not significantly change among other teenagers.

- consistent reports of increased client and parent engagement with a range of support services and programs (particularly where NPA IECD funded services have opened up referral pathways and networks to other services), a particularly important intermediate outcome for the often complex client group
- increases in knowledge and skills (parenting, nutrition, sexual reproductive health), some attitudinal change (substance use during pregnancy)
- local evidence for positive changes in some health behaviours, including reduced smoking during pregnancy, increased rates of breastfeeding, increased access to sexual and reproductive health services, increases in STI testing, reported improvement in safe sexual practices
- local reports of improvement on some clinical indicators including declines in hypertension and diabetes during pregnancy and decreased rates of anaemia in children and increased rates of immunisation
- personal growth and development (particularly through opportunities afforded by some CFC and other child and maternal health programs and services)
- anecdotal evidence that early learning activities in CFCs are leading to children being better prepared for school
- anecdotal reports of reductions in teenage pregnancies, and increased fertility planning.

These outcomes have not been observed consistently in all jurisdictions and many instances not sufficiently to have impacted on population level measures and indicators at this point in time, but they are illustrative of positive impacts at the local level.

INCREASING SERVICE ACCESS AND UTILISATION

Children and Family Centres are generally offering a broad range of services, with three quarters reporting that they offer at least 7 different types of services (Table 8, p 28). Parenting and family support and child support activities were offered in all CFCs, along with community events. Child health services, health promotion and early learning activities are also frequently offered, while approximately two thirds of CFCs offer each of childcare, formal early childhood education, child support services and maternal health services.

Data on service utilisation at CFCs is limited, but was collected nationally for the first time in 2013. Differences in the way states and territories have interpreted and reported data mean aggregation at the national level is not possible, but it is clear that services are being utilised by Aboriginal and Torres Strait Islander families.

Reliable data on access to an utilisation of sexual and reproductive health services is not often available, however there are localised instances which indicate that implementation of Element 2 funded programs and services have correlated with increases in attendance at sexual and reproductive health services and in uptake of screening measures for sexually transmissible infections.

There are indications of increasing access to maternal and child health services (the focus of Element 3 activity), with a rise from 60 to 66 per cent in the rate of access to antenatal care by Aboriginal and Torres Strait Islander women in the first trimester of pregnancy. New Directions funding has enabled services to increase total service capacity and capability and many of these organisations continue to report difficulty meeting demand, suggestive of high rates of utilisation even with increased capacity (DH 2013, p 41). State and territory funded activity under Element 3 is also reported to be having a substantial impact and increased access to and uptake of maternal health programs is explicitly reported by NSW, Victoria, in parts of Queensland, SA, Tasmania and the NT.

Many of the strategies adopted by state and territory and New Directions funded maternal and child health initiatives are focused on reducing barriers to access, and in particular through home visiting or outreach programs, and transport arrangements.

PROVIDING CULTURALLY ACCESSIBLE SERVICES

Cultural safety is a consumer-assessed and subjective phenomenon, but is central to providing services that are culturally accessible for Aboriginal and Torres Strait Islander people. Provision of services in environments that support cultural safety is a common strategy for NPA IECD services. Three quarters of New Directions funded services are ACCHOs, while CFCs in most cases report having been highly successful in creating a service and operating environment that is highly conducive to perceptions of cultural safety in those who use the services.

Most evidence collected through the course of the evaluation has been focused on documentation of fidelity to processes and implementation strategies that are expected to lead to culturally safe service models, in turn enhancing accessibility. These have included:

- design of physical service delivery environment (including CFC buildings) with community input to creating a welcoming space
- services engaging with community through provision of shared-use facilities (e.g. meeting space)
- outreach or outplacement strategies which situate service delivery in contexts that are familiar to and comfortable for potential users
- engagement of Aboriginal and Torres Strait Islander staff
- offering entry-level or training pathways and opportunities for Aboriginal and Torres Strait Islander people, including through pathways for clients to become involved in service operation and delivery through volunteer roles, and in some on to training and employment
- developing relationships between Aboriginal and Torres Strait Islander organisations and mainstream services
- broadening the capacity of existing organisations which have 'cultural capital' with their communities.

These strategies are representative of those engaged within NPA IECD implementation. Service users who participated in the evaluation were uniformly positive about the cultural safety of services offered to them, although those interviewed were generally 'engaged' and intrinsically more likely to hold positive views about services.

BUILDING AND STRENGTHENING CAPACITY

Thirty-five of the planned 38 CFCs were providing services to their local communities to June 2013. CFCs are all working towards an integrated model of service delivery, although how this is conceptualised varies between services. At April 2014, when operating CFCs were surveyed for the evaluation, 62 per cent reported that they were at consolidating stage, while 19 per cent indicated that they had achieved a level of organisational maturity where their focus was on optimising their operations. There was an apparent correlation between a CFC's level of organisational maturity and the extent to which their services were delivered in a more integrated way with other organisations, an observation consistent with qualitatively reported developmental trajectory of CFCs.

The extent to which the NPA IECD has contributed to increased systemic capacity to provide effective sexual and reproductive health services to Aboriginal and Torres Strait Islander young people is not able to be directly quantified. However, the focus of NPA IECD investment on workforce development and the adaptation, production and dissemination of a range of health educational resources, informational materials and professional training packages suggests that the NPA IECD is likely to have made a contribution to the longer term capacity of the health system to provide sexual and reproductive health services for Aboriginal and Torres Strait Islander people.

The New Directions program currently funds 85 services for provision of enhanced maternal and child health services, and a range of state and territory based initiatives have also been successfully implemented. Intra and inter-sector engagement and collaboration have also been a focus of efforts in many jurisdictions, and there is evidence that NPA IECD-funded efforts have created new referral pathways, as well as strengthened existing ones.

Training and workforce development efforts have also sought to provide another avenue to strengthen capacity within organisations and the workforce delivering maternal and child health services in most jurisdictions. Flexible models of service delivery, including home visiting programs and outreach programs have also been implemented to improve the capacity of some services to reach key target communities.

COMMUNITY ENGAGEMENT AND PARTICIPATION

Strategies for consultation with Aboriginal and Torres Strait Islander communities have varied across elements and between jurisdictions, but the prominence given to consultation and engagement within the NPA IECD itself is also evident in jurisdictional implementation plans and subsequent reporting. The extent to which consultation with communities has been effective in securing community engagement is not able to be directly measured in most instances, with the fact of consultation generally reported rather than the specific outcome.

Intensive local consultation is documented as a feature of CFC development, and community engagement was a key part of CFC planning and operation in all instances. Broad stakeholder groups were consistently identified as a priority for engagement: local Aboriginal and Torres Strait Islander community members and organisations, and service providers providing services either in-scope for CFC integration or via a referral pathway. Most CFC governance arrangements incorporated reference groups or advisory committees, and effective use of these groups is likely to support services that better meet the needs of the community, as well as engage community members both in the design of services and use of services.

Consultation and engagement with Aboriginal and Torres Strait Islander people has taken place through Element 2 funded programs in a range of ways, and at a number of levels (generally state-wide, regional and local). These have included engagement of state-level or regional forums, time-limited, specific purpose consultation projects, including, for example, local focus groups with Aboriginal and Torres Strait Islander communities). Ongoing engagement and participation in program planning and decision making has also in some cases been supported through partnerships in delivery with community organisations.

Community engagement and participation through New Directions services has been strongly supported by the focus on funding ACCHOs. Service delivery by or in partnership with Aboriginal and Torres Strait Islander organisations is also a common approach to support engagement with community for state and territory initiatives.

Workforce issues have presented challenges to community engagement in some jurisdictions, where it has been difficult to recruit and retain local staff with community networks and relationships and who have the required skillset to support maternal and child health services.

DATA COLLECTION AND UTILISATION

A key challenge for evaluation of the NPA IECD implementation has been the limitations in the available data. These limitations have a range of origins, but are related to the practical challenges of coordinating national data collection across a significant number of related initiatives and jurisdictions, but also the intrinsic difficulty in developing robust outcome indicators associated with efforts to tackle highly complex social issues.

In order to collect data, in a consistent manner across all jurisdictions, states and territories agreed to a set of performance indicators designed to measure progress towards the achievement of each of the three elements in the Agreement.

While the health performance indicators (5-10) were finalised relatively quickly, the education indicators (1-4) required additional time to finalise collection strategies for indicators related to Children and Family Centres. In 2012, the AIHW was commissioned by Department of Health to produce three annual data reports on the NPA IECD health performance indicators (5-10). Tracking the progress (and ultimately the outcomes) being achieved by some investment elements, particularly CFCs, was hampered by inconsistent data collection, and the absence of a clear framework for expected performance. Bi-lateral reporting frameworks have been focused largely on output delivery, and provided limited information about early outcomes. This has limited their usefulness as a tool to enable the investment performance to be evaluated.

THE LONG TERM TRAJECTORY

There is insufficient evidence at this stage to state with certainty that the longer term goals and outcomes will be achieved, although this evaluation has found that there are encouraging signs in the anecdotal evidence and earlier progress markers to suggest that there is a trajectory of improvement that will become clearer over time. Continuing development of consistent national and state-level data to inform ongoing monitoring and evaluation of reform outcomes is likely to be central to enabling questions about the ultimate success or otherwise of the NPA IECD to be answered.

THIS DOCUMENT

This document is structured into three parts.

Part I provides an introduction to the NPA IECD and context for the evaluation, and sets out the overarching methodology, including examination of the key sources of data and challenges associated with their collection and use.

Part II provides a national overview of the NPA IECD's achievements, focusing on the ten performance indicators, but also exploring key outcome areas of strengthening outcomes for individual and families, increasing service access and utilisation, providing culturally accessible services, building and strengthening capacity, community engagement and participation. Part II also briefly addresses the longer term trajectory of change, drawing on available Australian Early Development Index (AEDI) data.

Part III provides a summary of achievements and implementation progress for each jurisdiction, including the New Directions program and all states and territory. Analysis is provided for each NPA IECD Element, structured around the same outcome areas explored in the national narrative.

This report makes eleven high level recommendations for consideration by governments. These are summarised in the following section.

Summary of recommendations

KEY FINDINGS	RECOMMENDATIONS
<p>Investment performance</p> <p>The longer term outcomes sought by NPA IECD investments were not expected to show change in the period of the evaluation. However, there is strong evidence that investment in early childhood development pays significant dividends later in life. While definitive client outcomes data for NPA IECD investments is limited, stakeholders have consistently reported visible gains are being made that are attributable to NPA IECD efforts. It is highly likely that the investments are making a positive difference to the lives of Aboriginal and Torres Strait Islander children, families and communities.</p>	<ol style="list-style-type: none"> 1. Investment in early childhood development as a key investment in longer-term health, development and well-being' outcomes should retain prominence within ongoing strategies to 'close the gap' in health, social and economic outcomes for Aboriginal and Torres Strait Islanders and other Australians.
<p>Coordination and integration</p> <p>The extent of coordination and integration across NPA IECD elements varied between jurisdictions. In jurisdictions with a higher level of coordination, this was reported to have a positive benefit for clients, particularly those with complex presenting issues. There was also anecdotal evidence for positive local outcomes where services were moving toward integration.</p>	<ol style="list-style-type: none"> 2. Cross-portfolio investments in early childhood and family services, maternal and child health and sexual and reproductive health should maximise service pathways for families across the life course. Where appropriate, place-based integrated service delivery models should be pursued and linked to measurable early years' outcomes including school readiness and school attendance. 3. Investments focused on closing system gaps should be supported by vertical integration, with integrated and coordinated effort evident at the service provider level, the funding agency level and among the state/territory and Commonwealth government stakeholders in the desired outcome. A measure of this would be evidence of effective partnering, resolution of barriers, and effective leveraging of opportunities to better achieve outcomes.
<p>Monitoring investment performance</p> <p>Tracking the progress (and ultimately the outcomes) being achieved by some investment elements, particularly CFCs, was hampered by inconsistent data collection, and the absence of a clear framework for expected performance.</p> <p>Bi-lateral reporting frameworks have been focused largely on output delivery, and provided limited information about early outcomes. This has limited their usefulness as a tool to enable the investment performance to be evaluated.</p>	<ol style="list-style-type: none"> 4. Multi-year, complex investments should commit significant early effort and resources to establish an agreed outcomes and performance framework, supported by a well-resourced data development and collection strategy that is responsive to the implementation context. 5. Bi-lateral reporting frameworks should be linked to an agreed outcomes and performance framework beyond output delivery.

KEY FINDINGS	RECOMMENDATIONS
<p>Sustainability</p> <p>While some activities funded through NPA IECD were inherently time-limited investments (e.g. resource development; training programs; capital expenditure), other investments have directly funded service delivery. There is significant variation in the extent to which NPA IECD-funded services have been able to develop and transition to a sustainable operating and business model.</p> <p>Sustainability has different meanings in different contexts. The diversity of operating environments in which some services are established means they are very unlikely to achieve full independence from special-purpose funding.</p> <p>Delayed construction and establishment of many CFCs has significantly impacted on the level of organisational maturity and operational sustainability that CFCs have been able to achieve to this point in the life of the NPA IECD. It is not clear to what extent CFCs have established business plans.</p>	<ol style="list-style-type: none"> 6. Where time-limited funding is intended to lead to a 'sustainable' output, service or outcome, the meaning of sustainability should be defined. The definition should recognise that sustainability is place-based, with specific acknowledgement of the intensity and duration of work often required to achieve positive outcomes with clients. The costs associated with providing programs in remote areas, and the particular challenges in attracting and retaining staff, should also be acknowledged in attaining a sustainable status. 7. While the operating context for CFCs varies significantly, consideration should be given to the development of guidelines and resources to facilitate consistent understanding and the development of sustainable business models. 8. Parallel to service delivery investment, workforce development should be prioritised. Professional development focused on cultural competence in mainstream services increases access and effectiveness of services; while the training of Aboriginal staff increases service effectiveness, contributes to community stability, provides role models and increases economic participation. Evidence of effective workforce investment would be documented results of workforce activity, and metrics about participants that can be collated and analysed.
<p>Knowledge sharing and evidence development</p> <p>Stakeholders reported placing significant value on state-wide and national forums for CFC service leaders to come together as opportunities for informal benchmarking, knowledge transfer and professional networking. The extent to which service leaders implementing other NPA IECD investments were able to benefit from these kinds of activities varied.</p> <p>The concurrent implementation of related investments across different jurisdictions under the NPA IECD provided a unique opportunity to deepen the evidence base. While some research or evaluative activity was evident in many jurisdictions, it was not consistently reported for all NPA IECD elements. In some cases, jurisdictions reported reliance on the national evaluation and did not conduct program specific evaluations. Where evaluative activity has taken place, there were limited mechanisms for dissemination of new knowledge, both in terms of practices as well as resources developed.</p>	<ol style="list-style-type: none"> 9. Capacity building investments would complement program implementation. Further consideration should be given to committing resources to professional networking activities, bringing together service leaders at the state and national level, at key points in the implementation and operationalisation of the investment. 10. Where there is concurrent, coordinated investment in similar programs across all jurisdictions, consideration should be given to improving national coordination of evaluative efforts and implementing knowledge sharing strategies. This would require a mechanism for sharing and collating information, resources and evaluation findings in a timely way to benefit implementation that follows early efforts.
<p>Evidence-based practice</p> <p>There is a significant body of evidence for what works in Aboriginal and Torres Strait Islander early childhood development, maternal and child health, and sexual and reproductive health. While there were many examples of program planning and implementation informed by reference to the existing evidence base, this was not reported or documented in all cases.</p>	<ol style="list-style-type: none"> 11. While innovative practices should continue to be encouraged, consideration should be given to increasing the emphasis on funding evidence-based interventions, and to monitoring implementation for alignment with best practice program implementation. A measure of this would be evidence of continuous quality improvement processes influencing practitioner behaviour.

PART I: Preliminaries

1 Introduction

This is the final report of the evaluation of the National Partnership Agreement for Indigenous Early Childhood Development (NPA IECD).

1.1 BACKGROUND AND POLICY CONTEXT

In December 2007 the Council of Australian Governments (COAG) agreed to sustained engagement and effort by all governments over the next decade and beyond to achieve the Closing the Gap targets for Indigenous people (COAG, 2007, pp2-3). As a first step, COAG agreed in principle to a National Partnership with joint funding of around \$547.2 million over six years to address the needs of Indigenous children in their early years. (COAG, 2006, p11). This funding builds on the \$16.8 million previously committed over five years for the Indigenous Child Care Hubs, which takes the total amount of funding under the NPA IECD to \$564 million over six years.

In July 2008 COAG introduced the NPA IECD to specifically address the needs of Indigenous children in their early years. Funding was provided for better access to antenatal care, teenage reproductive health, maternal and child health (MACH) services, as well as integrated children's and family services (COAG, 2008a, p7). Signed in October 2008 the NPA IECD also included bilateral plans for implementing reforms signed between each jurisdiction and the Commonwealth (COAG, 2008b, p4).

The NPA IECD was one of a number of national agreements executed under the umbrella of the National Indigenous Reform Agreement (NIRA) and form part of a broader strategy for change being driven by COAG. This is set out in the Intergovernmental Agreement (IGA) on Federal Financial Relations, which came into effect in January 2009.

1.1.1 THE INTERGOVERNMENTAL AGREEMENT

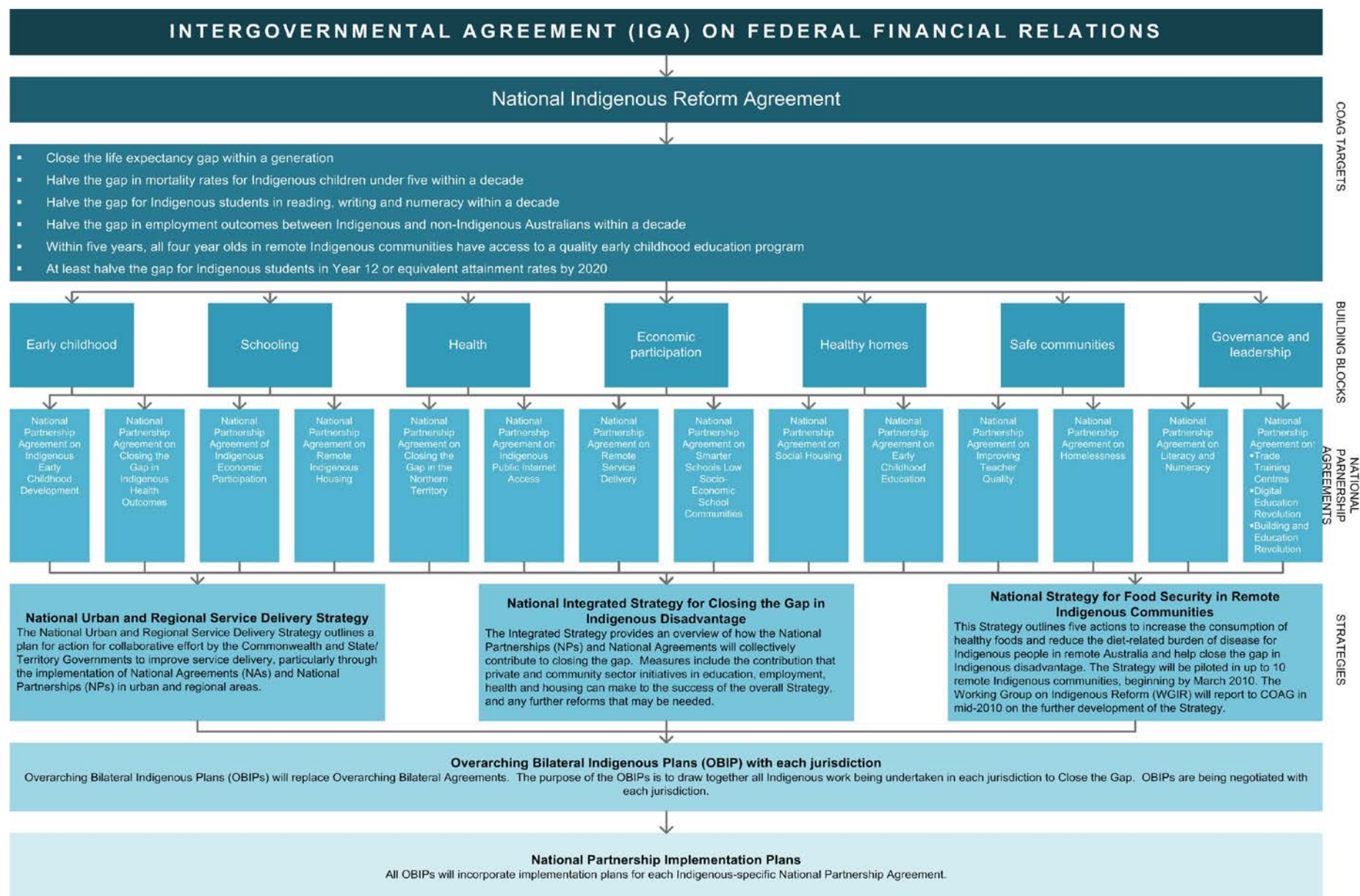
The IGA outlines the roles and responsibilities for national, and state and territory governments in delivering more collaborative, accountable, effective and flexible services. It also provides the foundation for collaboration on policy development and aims to facilitate the implementation of economic and social reforms in areas of national importance, with the key objective being the wellbeing of all Australians (COAG, 2009a, p6).

Sitting under the IGA is a range of other agreements and partnerships, that guide the delivery of reform in key areas which include health, education, skills and workforce development, disability, housing and Indigenous disadvantage (see Figure 1) (COAG, 2011a). The broad range of agreements and partnerships are associated with the provision of funding to states and territories to improve the services for all Australians, including Indigenous Australians (COAG, 2008, A-26). In addition to containing funding provisions, the agreements and partnerships are guided by the overarching principle of "Social Inclusion". The now-defunct Social Inclusion Board stated that to be socially included, people must be given the opportunity to secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voice heard (Australian Social Inclusion Board 2008).

Addressing social exclusion is a key theme in the preliminaries across all national partnership agreements. It reflects a key policy objective of the Australian, state and territory governments under which all parties aim for a 'socially inclusive society in which all Australians feel valued and have the opportunity to participate fully in the life of our society (Commonwealth, 2011a).'

Closing the Gap for Indigenous Australians is the central concept of the NIRA, embedded as Schedule F to the IGA.

FIGURE 1 – CLOSING THE GAP IN INDIGENOUS DISADVANTAGE – PATHWAY DIAGRAM



1.1.2 THE NATIONAL PARTNERSHIP AGREEMENT FOR INDIGENOUS EARLY CHILDHOOD DEVELOPMENT

Under the NPA IECD the Commonwealth, states and territories agreed to collaborate to reduce the high levels of disadvantage that Indigenous children experience, and to promote the best start in life (COAG, 2009f, p3).

The **aims of the NPA IECD** are to:

- improve developmental outcomes for Indigenous children and achieve key targets as agreed by COAG
- achieve sustained improvements in pregnancy and birth outcomes for Indigenous women and infants
- improve Indigenous families' use of the early childhood development services available to optimise the development of their children
- implement the NPA IECD in a way that also contributes to COAG's social inclusion, early childhood development, education, health, housing, and safety agendas, by identifying reforms and models of service delivery that will improve outcomes for Indigenous children (COAG, 2009f, p5).

To support these aims the NPA IECD frames actions against a series of **overarching outcomes**:

- Indigenous children are born and remain healthy
- Indigenous children have the same health outcomes as non-Indigenous children
- Indigenous children acquire the basic skills for life and learning
- Indigenous families have ready access to suitable and culturally inclusive early childhood and family support services (COAG, 2009f, p5).

The NPA IECD documents funding commitments totalling \$564 million, including \$489 million in Australian Government funding and \$75 million in contribution from state and territory governments. Table 1 provides a high level summary of investments committed under the NPA IECD across three elements:

- Element 1: integration of early childhood services through the development of Children and Family Centres
- Element 2: increased access to antenatal care, pre-pregnancy, and teenage sexual and reproductive health
- Element 3: increased access to and use of Maternal and Child Health (MACH) Services by Indigenous Families.

TABLE 1 – SUMMARY OF NPA IECD INVESTMENT COMMITMENTS (\$ MILLION)

	ELEMENT 1	ELEMENT 2	ELEMENT 3		
Jurisdiction	Australian Government funding to state and territory governments		Australian Government own purpose funding	State and territory own purpose funding	All sources ¹
NSW	74.70	26.75	20.00	21.50	142.95
Victoria	16.65	5.35	4.00	4.50	30.5
Queensland	75.18	29.96	25.50	21.25	151.89
WA	42.35	17.12	15.00	11.25	85.72
SA	25.22	5.35	4.00	3.75	38.32
Tasmania	8.09	3.21	3.00	2.50	16.8
ACT	8.09	1.07	0.50	0.50	10.16
NT	42.35	18.19	18.00	9.75	88.29
Total investment	292.62	107.00	90.30	75.00	564.62

¹ The distribution between jurisdictions of Australian Government own-purpose funding under Element 3 is indicative only.

1.1.2.1 ELEMENT 1 - INTEGRATION OF EARLY CHILDHOOD SERVICES THROUGH THE DEVELOPMENT OF CHILDREN AND FAMILY CENTRES

Overseen by the Department of the Prime Minister and Cabinet (and previously by the Department of Education, Employment and Workplace Relations (DEEWR) until 2013) the \$293 million in funding distributed to states and territories under this element sought to establish 38 Children and Family Centres (CFCs) in a mix of remote, regional and urban locations. The CFCs were to be located in areas of demonstrated high need such as areas with high disadvantage, and a high proportion of Indigenous children under five years of age.

The NPA IECD notes it is important that action in this area must include the provision of parent and family support services, because evidence shows parents' active involvement in the development of their child leads to more effective early childhood programs.

1.1.2.2 ELEMENT 2: INCREASED ACCESS TO ANTENATAL CARE, PRE-PREGNANCY, AND TEENAGE SEXUAL AND REPRODUCTIVE HEALTH

Element 2 is managed by the Department of Health (formerly the Department of Health and Ageing until 2013), with \$107 million in funding distributed to states which is aimed at improving access to, and use of antenatal care by young Indigenous mothers. Funding was also directed to assist programs which support young Indigenous people to make informed decisions about their sexual and reproductive health, particularly in areas with high numbers of young Indigenous people and high numbers of births to teenagers.

Under initiatives contributing to the second element, states and territories have focused particularly on young Indigenous women with the aim of increasing first trimester antenatal visits and reducing pregnancy risk factors including smoking.

Additionally, states and territories were to deliver sexual and reproductive health programs for Indigenous teenagers, implement strategies to reduce the high rate of early pregnancy in the Indigenous population and to educate young people on sexual and reproductive health issues.

1.1.2.3 ELEMENT 3: INCREASED ACCESS TO AND USE OF MATERNAL AND CHILD HEALTH SERVICES BY INDIGENOUS FAMILIES:

The Department of Health also manages Element 3, under which \$90 million in funding was initially committed to supporting the New Directions Mothers and Babies Services program (New Directions) provided through primary health services. The Australian Government's initial commitment was extended in the 2011-12 Budget and New Directions is now an ongoing program, separate to the life of the NPA IECD. Access to the New Directions program is expected to lead to improved outcomes including access to antenatal care in the first trimester, a reduced rate of low birth weight babies being born, as well as a decrease in the number of women smoking during pregnancy.

Under Element 3, states and territories are also investing \$75 Million to deliver antenatal, postnatal, child and maternal health services to Indigenous families.

1.1.3 NPA IECD PERFORMANCE INDICATORS

As reporting has become available, the evaluation has assessed the performance of the NPA IECD against the ten performance indicators (PIs) mandated by the NPA IECD. These indicators are set out in Table 2.

TABLE 2 – NPA IECD PERFORMANCE INDICATORS

PERFORMANCE INDICATOR	
PI 1:	Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations
PI 2:	Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development, and child care services
PI 3:	Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly
PI 4:	Increased proportion of Indigenous children and families accessing a range of services (e.g. childcare and parent and family support services) offered at or through CFCs
PI 5:	Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year
PI 6:	Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services
PI 7:	Reduced proportion of Indigenous babies born with low birth weight each year
PI 8:	Reduced mortality rate of Indigenous infants each year
PI 9:	Reduced proportion of Indigenous women who use substances such as tobacco and alcohol during pregnancy each year
PI 10:	Reduced proportion of hospital admissions of Indigenous children 0-4 years

1.2 PURPOSE OF THE EVALUATION

The evaluation aims to ascertain the appropriateness, effectiveness and efficiency of the NPA IECD in contributing to the achievement of the Closing the Gap targets agreed by COAG.

Specifically, the evaluation involves assessing the extent to which:

- individual Elements and the overall NPA IECD have been appropriately implemented with regard to their aims, implementation plans and the agreed milestones
- there are synergies among the three Elements (i.e. the degree to which the NPA IECD and the individual Elements are integrated and coordinated, and complementary to each other and the NPA IECD objectives)

- individual Elements and the NPA IECD as a whole are effective in delivering the agreed outputs and outcomes of the NPA IECD at different stages of implementation – these outputs and outcomes include:
 - the extent to which each of the individual Elements and the overall NPA IECD meet agreed targets and achieve early results
 - the contribution of individual Elements and the overall NPA IECD in achieving medium-term results
 - the contribution of the individual Elements and the overall NPA IECD in progressing towards long-term goals
 - the extent to which individual Elements and the NPA IECD as a whole are appropriate to the target population and stakeholder needs, including awareness, appreciation and satisfaction with the activities undertaken under individual Elements and the overall NPA IECD among the target population and stakeholders.

1.3 EVALUATION GOVERNANCE

The NPA IECD Steering Committee (the Steering Committee) has overall oversight of implementation of the NPA IECD, including the evaluation. The NPA IECD Evaluation Working Group (the Working Group) provides interim endorsement on key evaluation products, as well as advice and direction on its conduct.

Day to day management of the evaluation has been undertaken by the Department of the Prime Minister and Cabinet (and prior to 18 September 2013 the Department of Education, Employment and Workplace Relations) with close support from the Department of Health (prior to 18 September 2013 the Department of Health and Ageing).

1.4 PREVIOUS REPORTS

The evaluation has produced a number of working documents and reports in support of NPA IECD implementation, the most significant of which include:

An Initial Status Report (May 2012), which sought to provide a 'snapshot' or baseline description of the three elements of the NPA IECD, at a moment in time approximately midway through the period of the Agreement. It outlined the implementation progress of the three Elements to June 2011, focusing on the progress and achievements relating to the implementation activities and outputs identified in the Evaluation Framework. The Final Report draws on content from the Initial Status Report where appropriate.

An Interim Report (September 2013), which provided a descriptive assessment of progress in implementing the NPA IECD, drawing on a range of data sources including state and territory reporting to December 2012. Its focus was on drawing out the key successes and challenges of implementation, as well as early indications of outcomes stemming from NPA IECD investment where available. The Final Report draws on content from the Interim Report where appropriate.

1.5 THIS REPORT

This report is the final report of the evaluation. Its scope spans the entire period of the NPA IECD, and so draws on earlier analysis contained within the Initial Status Report and the Interim Report where appropriate. It also draws on state and territory reporting to December 2013 as well as fieldwork and other intelligence to April 2014. Its focus is on resolving the key evaluation questions as established in the Evaluation Framework.

1.6 A NOTE ON TERMINOLOGY

Throughout this report, the term Aboriginal and Torres Strait Islanders is used for consistency, although it is acknowledged that in some areas Aboriginal, Koori, Murri or Nyoongar are terms preferred by communities.

Children and Family Centres are referred to by their location or alternatively by their Aboriginal and Torres Strait Islander name. This approach is intended to support ease of reference by readers of this report who may not be familiar with local service names. A list of CFCs by their Aboriginal and Torres Strait Islander community names is provided in Appendix C.

Children and Family Centres in NSW are referred to as Aboriginal Children and Family Centres; however for consistency within this report the abbreviation CFC is used for all jurisdictions including NSW.

References to 'Senior Officers' refer to government officials with formal responsibility in regard to the relevant investments who were interviewed as part of the consultation process.

2 Methodology

This section sets out the overall evaluation strategy and sets out the approach taken to develop this report.

2.1 EVALUATION APPROACH

This evaluation commenced in January 2012 and formally concludes in May 2014. It has occurred in parallel with the final two and a half years of the six year NPA IECD.

It draws on a range of primary and secondary source data and information to guide reporting and assessment of progress against the key evaluation objectives outlined in section 1.2.

Key primary sources of data include national field work, case study development, survey activities and key informant interviews that have been conducted across the life of the evaluation, while secondary sources include review of jurisdictional reporting, a number of key published data sets and reviews/evaluations completed on IECD-relevant matters and published by third parties.

2.2 EVALUATION FRAMEWORK

At the outset of the evaluation, an evaluation framework was developed to guide the evaluation of the NPA IECD, focused on those outcomes and outputs that are within the evaluation scope. Each outcome and output is logically associated with the key evaluation questions, indicators of progress, sources of data and timing of data availability. The Evaluation Framework is closely aligned to the program logic model established for the NPA IECD. The summary Evaluation Framework and the program logic model are provided in Appendix A.

2.3 ETHICS COVERAGE

Ethics approval was secured from the former Department of Health and Ageing Departmental Ethics Committee (DoHA DEC) in July 2012 for all project activities. A report was submitted to the Committee in June 2013 as required. All protocols included in the Ethics Application have been adhered to, and no adverse events or reactions have occurred.

The DoHA DEC approval was reciprocally recognised in all jurisdictions except, for New South Wales (NSW). Separate ethics approval for NSW was obtained in 2013 through the Aboriginal Health and Medical Research Council of NSW. This latter approval was conditional on the inclusion on the Evaluation Working Group (EWG) of Aboriginal and Torres Strait Islander community representatives. The EWG was expanded to include a nominee of the National Aboriginal Community Controlled Health Organisations (NACCHO) and the Secretariat of National Aboriginal and Islander Child Care from mid-2013.

2.4 EVALUATION TIMELINE

The evaluation of the NPA IECD comprises a commencement phase and five episodes of data collection and analysis. Table 3 provides a synopsis of the key activities which have been undertaken over the course of the evaluation.

TABLE 3 – EVALUATION TIMELINE AND KEY ACTIVITIES

PHASE	TIMEFRAME	KEY ACTIVITIES
Initiation	Jan - Mar 2012	Commencement meetings
		Finalisation of the project implementation plan
		Finalise communication and stakeholder analysis and engagement strategy
		Develop knowledge review (literature, documentation and data)
		Undertake initial stakeholder interviews on the NPA IECD implementation and key issues
		Comprehensive mapping of NPA IECD services
Episode 1	Mar - May 2012	Develop evaluation framework
		Analyse state and territory progress and annual reports, and Commonwealth annual reports
		Review other available data
		Develop consultation tools
		Develop ethics submission (DoHA HREC)
		Develop ethics submission (NSW)
		Prepare and submit Initial Status Report
		Prepare and submit Progress Report 1
Episode 2	Jul - Nov 2012	Complete fieldwork in 12 sites
		Undertake government stakeholder consultations in all jurisdictions
		Develop of case studies (WBCFC, Halls Creek, Whittlesea)
		Prepare and submit Progress Report 2
		Review Project Implementation Plan
Episode 3	Jan - May 2013	Desktop data collection, analysis and reporting
		Analyse progress reports, follow up inquiries
		Review other available data
		State and Territory officer telephone interviews
		First survey of CFC leaders
		Prepare and submit Progress Report 3
		Prepare and submit Interim Evaluation Report (Part 1: E2 and E3)
		Prepare and submit Interim Evaluation Report (Part 2: E1)
	–	Review of Project Implementation Plan
		Prepare and submit Progress Report 4
		Prepare and submit DOHA HREC progress report
		Communication to stakeholders regarding consultation processes
		Data collection, analysis and reporting
		Stakeholder consultations in all states and territories regarding the progress of the overall NP implementation (centralised consultation and an outreach field visit)
		Development of case studies (WBCFC, Halls Creek, Whittlesea)
Episode 5	Jan – May 2014	Second survey of CFC leaders
		Analyse progress reports, follow up inquiries
		Stakeholder consultations regarding the overall NP implementation
		Overall data triangulation and analysis
		Preparation and submission of Final Evaluation Report

2.5 EVALUATION FIELD VISITS

Two phases of fieldwork were conducted during the evaluation. The first in 2012 encompassed 12 field visits spanning all jurisdictions except for NSW, where additional ethics requirements delayed consultation activity. Most visits were conducted in late 2012, with the Northern Territory (NT) field visit occurring in 2013. Locations for the second phase of fieldwork were generally targeted at Element 2 and 3 investments, based on advice from state and territory governments about where services were gaining traction, repeat visits were undertaken in late 2013 (and Victoria in 2014) to a number of CFCs, including two NSW CFCs. Three CFCs were visited for the purpose of case study development.

The primary focus of fieldwork in 2012 was to explore the process of implementation of CFCs, while some locations also provided opportunity to gain insight into Elements 2 and 3. Fieldwork in 2013 adopted a different approach, with the primary purpose of consultation in states where CFCs were visited in NSW, Victoria, WA, Tasmania, and the ACT to identify evidence of early outcomes and community impacts from CFC implementation.

In both 2012 and 2013 fieldwork was conducted by a two-person team, which included an Aboriginal and non-Aboriginal consultant. Considerable lead time was utilised in the planning of the visits, with multiple telephone contacts and the provision of information to the stakeholders prior to the visit. State government officers provided introduction and entrée in some states, whereas in others the evaluators initiated the contact.

Interviews were generally conducted in a one-on-one or group format, with the format adapted to suit local preferences. Consistency of approach was supported by the use of interview guides across all sites, which were piloted and refined in the early stages of each episode of consultation. Key interviewees included board members, service managers, representatives of partner agencies, CFC and other services staff and service users, although there was variation between locations and between episodes of fieldwork.

Table 4 and Table 5 provide a summary of sites visited over the course of the two fieldwork phases.

TABLE 4 – SUMMARY OF ELEMENT 1 (CFC) FIELD VISITS

LOCATION	FIRST FIELDWORK PHASE	SECOND FIELDWORK PHASE
NSW: Nowra	-	18 September 2013
NSW: Mt Druitt	-	20 September 2013
VIC: Bairnsdale	29-30 October 2012	-
VIC: Whittlesea ¹	14 November 2012	17-18 October 2013
QLD: Mornington Island	19-20 September 2012	-
QLD: Palm Island	24-26 September 2012	-
QLD: Ipswich	27-28 September 2012	-
WA: Halls Creek ¹	26-27 August 2012	23-26 September 2013
WA: Kununurra	28-29 August 2012	23-26 September 2013
SA: Christies Beach	3-6 September 2012	-
SA: Whyalla	3-6 September 2012	-
TAS: Geeveston	24-25 September 2012	9 October 2013
ACT: West Belconnen ¹	13-16 August 2012	31 October - 1 November 2013
NT: Yuendumu	3-4 April 2013	-

¹ These CFCs were the focus of in-depth case study development.

Element 2 and 3 fieldwork took place primarily as part of the second fieldwork phase at locations identified by state and territory governments, although some Element 2 and 3 services were also captured as part of the first phase of fieldwork where they were co-located or integrated with a CFC.

TABLE 5 – SUMMARY OF ELEMENT 2 AND 3 FIELD VISITS

LOCATION	FIRST FIELDWORK PHASE	SECOND FIELDWORK PHASE
NSW: Nowra	-	18 September 2013
NSW: Mt Druitt	-	20 September 2013
VIC: Melbourne	-	5 March 2014
QLD: Palm Island	24-26 September 2012	-
QLD: Redcliffe	-	18-20 November 2013
QLD: Caboolture	-	18-20 November 2013
WA: Halls Creek ¹	26-27 August 2012	23-26 September 2013
WA: Kununurra	28-29 August 2012	23-26 September 2013
SA: Port Augusta	-	10 October 2013
TAS: Geeveston	24-25 September 2012	9 October 2013
ACT: West Belconnen	13-16 August 2012	31 October - 1 November 2013
NT: Wadeye	-	2 October 2013

2.6 KEY DATA SOURCES AND ANALYTICAL METHODS (ELEMENT 1)

The evaluation of outputs and outcomes associated with Element 1 includes analysis and synthesis of data and information from a number of key sources. The most significant of these include:

- State and territory progress reports to June 2013
- Senior officer consultations
- CFC field visits in 2012 and selected repeat visits in 2013
- Two surveys of CFC leaders (2012 and 2014)
- Case study development (2012 and 2013)
- National Early Childhood Education and Care Collection
- The Australian National Audit Office's *Indigenous Early Childhood Development: Children and Family Centres* (ANAO 2013).

The context and scope of each of these evaluation inputs is detailed in the following sections, with the exception of fieldwork described in section 2.5.

2.6.1 STATE AND TERRITORY PROGRESS REPORTING

Progress reports from all states and territories have been reviewed, up to and including reports for the period January-June 2013. These reports focus on progress against key milestones established under bilateral agreements between the Australian Government and the states and territories, and provide high-level information on selection and development of physical sites as well as operational models and service delivery arrangements. Reports also explored workforce recruitment and development activity,

linkages and coordination, community involvement and engagement, data and reporting and risk management. Specific issues or complications are also included in reports for each CFC in development or operation.

A general limitation on state and territory reporting is that they were not structured to provide outcome reporting and did not have a focus on addressing implementation issues and progress against state implementation plans. In addition to this, because informing the evaluation was not their intended purpose the reports were not created to align to the Evaluation Framework.

The January–June 2013 progress reports included data from the first census of CFC activity undertaken in each jurisdiction, which captured information particularly relevant to Pls 1 and 4. Because this was the first census reported on, there is no time series data yet available.³

2.6.2 SENIOR OFFICER CONSULTATION

The review of written reports was supplemented by targeted consultation with key officers in all jurisdictions. The first set of consultations took place in early 2013 via telephone interviews with key officers in all jurisdictions with the exception of Queensland where machinery of government changes meant a suitable interviewee from Queensland Health was not available. These consultations focused on clarifying and supplementing information drawn from state and territory reporting to June 2012.

As part of the second episode of fieldwork undertaken in late 2013, group consultations were held with senior officers from all jurisdictions across the three Elements and focused on the experience of implementation, challenges, successes and early outcomes.

Finally, a summary of evidence was compiled based on an analysis of state and territory reports from July 2012–June 2013 against the key outcomes articulated in the Evaluation Framework. The summary also captured data from the second episode of fieldwork in 2013. This summary was circulated to each jurisdiction for comment, providing jurisdictions both an opportunity to address factual errors and omissions, and to supply additional information or documentation for analysis.

2.6.3 CONSULTATION WITH CFC LEADERS

Two surveys were conducted with CFC leaders. The first was completed in early 2013 and targeted all CFCs providing services from permanent or interim sites. The additional ethics requirements in NSW prohibited participation by NSW sites in this phase of the survey.

In total, 23 operating CFCs were approached and 20 agreed to take part in the survey, which was conducted via structured telephone interviews in March and April 2013. Participants were generally either board members or service managers. The focus of the survey was on exploring themes and issues across four broad domains: integration, partnerships, networking, and referral pathways.

A second survey was completed in March and April of 2014, again targeting leaders at operating CFCs (at the time of survey completion 35 CFCs were providing services from permanent or interim premises).

Taking place in the final six months of the NPA IECD, the second survey comprised two components. Children and Family Centre managers were asked to complete a series of questions with their leadership teams and return to Urbis. These questions focused on outcomes, partnerships and referral pathways, and service integration. A telephone interview then took place with participating CFC managers with supplementary questions about service planning, governance and sustainability.

In total representatives from 17 CFCs elected to participate in the second survey, including CFCs from all jurisdictions except Victoria and the NT (although one response was incomplete).

In addition to the opportunity to participate in the two surveys, in four of the jurisdictions - NSW, Queensland, SA, Tasmania - CFC leaders were also consulted as a group during the second episode of

³ A second census was undertaken in May 2014, but data from this collection was not available at the time this report was being finalised.

field work in 2013. These consultations were generally opportunistic and attached to existing state-based forums.

2.6.4 CFC CASE STUDIES

Three case studies were documented in late 2012 and developed through a follow up visit to explore the implementation of CFCs. The decision was made to repeat case study visits to the same sites to build on earlier work and to focus on developmental progress toward service maturity.

The case studies were designed to produce reflections, learning and innovations that can be shared across jurisdictions and contribute to ongoing implementation. Case studies focused on consultation with people in governance roles at state and at local levels, with community members who have a leadership role/ are on local committees, and also with fund-holders.

The selected locations were:

- Ningkuwum-Ngamayuwu Halls Creek Children and Family Centre (WA)
- West Belconnen CFC (ACT)
- Bubup Wilam for Early Learning Aboriginal Children and Family Centre (Victoria).

These CFCs provided a mix of metro, outer-metro and remote operations, and reflected government managed (ACT), non-government organisation (NGO) controlled (WA), and community controlled organisations (Victoria) that were actively providing services from purpose-built facilities.

The case studies provided an in-depth perspective on the processes and success of community engagement, the approach to design and establishment, the mix of service offerings and programs, and the experiences of the community with the CFC. Case studies sought to draw out key lessons and success factors for each location. The repeat visits conducted approximately 12 months after the first provided an analysis of emerging practices that have been effective in contributing to the success of the programs delivered under Element 1 of the NPA IECD.

The field visits were conducted by a team that was made up of an independent Aboriginal researcher and an Urbis consultant. At least one consultant in each team had visited the CFC in the first round.

2.6.5 NATIONAL EARLY CHILDHOOD EDUCATION AND CARE (ECEC) COLLECTION

The National Early Childhood Education and Care (ECEC) collection contains estimates on children enrolled and attending preschool programs, including data on Indigenous enrolments. Data is collected under the National Partnership Agreement on Early Childhood Education (NP ECE), and is relevant to PI 2 (Increased proportion of Indigenous three- and four-year-olds participating in quality early childhood education and development, and child care services).

The latest report of the collection is *Preschool Education, Australia 2013* (ABS, 2013) and includes data on Indigenous participation in preschool programs in all settings. The extent to which outcomes can be meaningfully attributed to the NPA IECD is limited, although the report does provide useful contextual data to indicate overall progress across the various reforms to early childhood education.

2.6.6 ANAO REPORT ON INDIGENOUS EARLY CHILDHOOD DEVELOPMENT: CHILDREN AND FAMILY CENTRES

The ANAO completed an audit of DEEWR's effectiveness in supporting the delivery of Element 1 of the NPA IECD in 2013 (ANAO 2013). The audit found that DEEWR's ability to determine the impact of Element 1 funding was compromised by longer than expected construction times; limited coverage in state and territory reporting of expected outcomes or reporting against the PIs; and slow development of an agreed data collection mechanism for CFCs. DEEWR was not well positioned to determine the impact that funding provided to date has had in relation to the NPA IECD's objectives. The ANAO also observed that there had been minimal public reporting on progress of the Element 1 compared to other NPs.

The ANAO made two recommendations, both of which were accepted by DEEWR (ANAO 2013):

- “In order to assess the effectiveness of the current investment in Children and Family Centres, the ANAO recommends that the Department of Education, Employment and Workplace Relations, in consultation with relevant state and territory agencies, analyse and provide advice to the Australian Government on the relative effectiveness of CFC service delivery models, and the outcomes being achieved. This analysis would also inform the design of any future initiatives.
- In order to increase public accountability in line with COAG’s expectations, the ANAO recommends that DEEWR prepares and publishes periodic reports about the Children and Family Centres contribution to the National Partnership Agreement on Indigenous Early Childhood Development objectives, specific jurisdictional performance and progress on service system reform.”

In 2013, the first census of operating CFCs occurred (with dates varying across jurisdictions) focused on the Pls 1 and 4 agreed under the NPA IECD.

2.7 KEY DATA SOURCES AND ANALYTICAL METHODS (ELEMENTS 2 AND 3)

The evaluation of outputs and outcomes associated with Elements 2 and 3 includes analysis and synthesis of data and information from a number of key sources. The most significant of these include:

- State and territory Annual and Progress reports to December 2013
- Senior officer consultations
- Field visits to Element 2 or 3 investment sites in all jurisdictions (2013)
- *NPA IECD First annual data report on health performance indicators (5-10)* (AIHW, 2012)
- *NPA IECD Second annual data report on health performance indicators (5-10)* (AIHW, 2013) (pre-publication draft)
- *Indigenous Early Childhood Development. New Directions: Mothers and Babies* (ANAO 2012)
- *National Aboriginal and Torres Strait Islander Social Survey* (ABS, 2002; ABS, 2009)
- *Descriptive Analysis of New Directions Mothers And Babies Services Program* (DH, 2013)
- *Australian Early Development Index* (Australian Government, 2013a).

The context and scope of each of these inputs is detailed in the sections following, with the exception of fieldwork described in section 2.5.

2.7.1 STATE, TERRITORY AND AUSTRALIAN GOVERNMENT REPORTING

Annual and Progress reports from all states and territories for both Element 2 and Element 3 have been reviewed up to and including reports for the July - December 2013 reporting period. These reports are aligned to milestones established under bilateral agreements between the Australian Government and the states and territories and provide information on implementation and progress across a number of domains. These include management and governance structures, service delivery, linkages and partnerships, workforce initiatives, community engagement and data and reporting systems.

Additionally, reports from former DoHA state and territory offices up until the 2011-2012 implementation year have been reviewed in relation to implementation of the New Directions program under Element 3. Reports after this date were not reviewed at state and territory level as New Directions reporting was integrated into online services reporting (OSR) as part of efforts to streamline and improve reporting process. It is envisaged the first wave of OSR data will be included in the 2014 NPA IECD annual report on New Directions.

Review of written reports was supplemented by telephone interviews with key officers in all jurisdictions, which were held in early 2013, with the exception of Queensland where machinery of government changes meant a suitable interviewee was not available. These interviews were tailored to each jurisdiction and focused on clarifying or expanding on key issues arising from a preliminary review of the written reports.

2.7.2 SENIOR OFFICER CONSULTATION

As described for Element 1 in section 2.6.2, the review of written reports was supplemented by targeted consultation with key officers in all jurisdictions in early 2013, group consultations with senior officers from all jurisdictions as part of the second episode of fieldwork, and a working summary of evidence was circulated to each jurisdiction for comment in late 2013/early 2014.

2.7.3 AIHW NPA IECD ANNUAL REPORTS ON HEALTH PERFORMANCE INDICATORS (5-10)

The AIHW Data Report *NPA IECD First annual data report on health performance indicators (5-10)* (the AIHW Report) provided national data (by jurisdiction) to support the NPA IECD performance indicators 5-10 (AIHW 2012). At the time of writing, the second annual report (AIHW 2013a) had been endorsed by the NPA IECD Steering Committee but is yet to be endorsed by the Australian Health Ministers' Advisory Council (AHMAC). A pre-publication version was made available for analysis, and may be subject to revision.

The performance indicators underpin several of the longer-term outcomes and late-medium-term results defined in the Evaluation of the NPA IECD Evaluation Framework. While the measurement of these outcomes is beyond the scope of this evaluation, the national data presented within the AIHW Report provides a useful baseline against which jurisdictional progress against the performance indicators reported in chapters 5 and 6 (where available) can be analysed.

The data in the AIHW Report draws on administrative data sets that are updated annually, including the:

- Perinatal National Minimum Data Set
- National Mortality Database
- National Notifiable Diseases Surveillance System
- National HIV Registry.

Performance Indicator 9 also draws from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and in the future will also draw on the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) which provide data every three to four years.

In most cases, trends since 2008 in each of the indicators do not show statistical significance; however this is often attributable to both the nature of the change being measured (medium and short term outcomes), small numbers, and the relatively short comparison period.

Relevant extracts and analysis of the AIHW Report inform the summaries of jurisdictional progress presented in each state and territory chapter.

2.7.4 ANAO REPORT ON INDIGENOUS EARLY CHILDHOOD DEVELOPMENT. NEW DIRECTIONS: MOTHERS AND BABIES

The Australian Government contribution to Element 3 (New Directions) was reviewed by the ANAO in 2012, which concluded that the (then) DoHA had been effective in implementing the initiative. The ANAO made a single recommendation as follows:

- "To support better management of the New Directions: Mothers and Babies Services program, ANAO recommends that the Department of Health and Ageing review its performance framework and strengthen measures to monitor service delivery and determine whether use of services is improving in line with the program's objectives."

The recommendation was accepted by the department. As part of its response, the Department of Health engaged a consultant to complete a descriptive analysis of the New Directions program, and sought to improve and streamline its reporting processes.

2.7.5 DESCRIPTIVE ANALYSIS OF NEW DIRECTIONS MOTHERS AND BABIES SERVICES PROGRAM

The New Directions program is funded by the Australian Government under Element 3 of the NPA IECD, which aims to increase access to and use of maternal and child health services by Indigenous families. The Department of Health engaged a consultant to undertake a descriptive analysis of the New Directions: Mothers and Babies Services Program (NDMB). The final report was delivered to the department in March 2013. The descriptive analysis aims to describe the New Directions services provided and how these services meet the program objectives.

Results of the descriptive analysis provide insights into the wide range of initiatives and services funded under the New Directions program. These include:

- employment positions, including midwives, Child and Family Health Nurses and Aboriginal Health Workers (AHWs)
- postnatal services including breastfeeding support, parenting advice, nutrition support or education and midwife consultations
- strategies for the delivery of services including home visits, child health clinics, and women's health clinics and mother's groups
- strategies to encourage parents to receive services including transport assistance and home visits, reminders and referrals to other services, and health promotion/resource packs
- agreements/ partnerships developed by New Directions sites with hospitals, allied health providers and community health services (DH, 2013).

While the descriptive analysis does not directly evaluate the service delivery of the New Directions initiatives, the flexibility of the program funding is identified as a driving factor in meeting the localised service needs of communities throughout Australia. The descriptive analysis also provides details of the challenges experienced in the delivery of the New Directions funded services. This includes recruitment and retention of qualified staff, lack of transport for clients, service capacity issues, limited funding, remote service delivery obstacles and difficulties engaging and maintaining contact with clients (DH, 2013).

2.7.6 AUSTRALIAN EARLY DEVELOPMENT INDEX

The Australian Early Development Index (AEDI) is an Australian Government supported research initiative that was completed in 2009 and again in 2012 (Centre for Community Child Health and Telethon Institute for Child Health Research, 2009; Australian Government, 2013a). The AEDI is a measure of how young Australian children are developing. In 2012, data was collected from 289,973 Australian children enrolled in their first formal year of school (Australian Government, 2013a). This represented 96.5 per cent of all enrolled Australian children. The results from the AEDI aim to assist communities and governments to make decisions on services, resources and support to provide Australian children with the best possible start to life.

The results from the AEDI are publicly available and aim to provide information about how children have developed by the time they start school, across five areas of early childhood development.

2.8 ATTRIBUTION OF NPA IECD RESULTS AND OUTCOMES

2.8.1 BROADER CONTEXTUAL ISSUES

There is a multitude of factors that contribute to the gap in health and developmental outcomes between Indigenous and non-Indigenous children (Anderson, 2007, p 35). It is also widely acknowledged that a large number of these factors rest outside the direct influence of health, education and other human service systems. Health, education and other social determinants (for example, poverty, housing, food security, social exclusion and physical environment) interact in complex ways to influence health, education and employment outcomes.

The NPA IECD is one of a number of initiatives that aims to improve the health and developmental outcomes of Aboriginal and Torres Strait Islander children. Other programs operating in parallel to the NPA IECD include:

- National mainstream and Aboriginal and Torres Strait Islander antenatal, maternal, child and adolescent health initiatives across the health continuum (prevention, early intervention and treatment)
- National mainstream and Aboriginal and Torres Strait Islander early childhood education and care initiatives
- State and territory mainstream and Aboriginal and Torres Strait Islander health and early childhood education and care initiatives.

In this complex context it is important to note that while the Evaluation Framework has, by necessity focused on activities associated with the NPA IECD, the NPA IECD is part of a suite of initiatives within COAG's commitment to Closing the Gap in Indigenous disadvantage. The Closing the Gap priority areas, including early childhood, schooling, health, economic participation, healthy homes, safe communities, governance and leadership, focus on many of the known social determinants of Indigenous disadvantage. The NPA IECD is also recognised under the National Early Childhood Development Strategy (NECDS), which comprises a number of Elements such as the NP ECE and the National Quality Agreement.

Although the Evaluation Framework focuses on the health and early childhood contexts, it made provision for the exploration and identification of additional factors that may impact on the expected benefits of the NPA IECD.

2.8.2 SUSTAINABILITY

A key theme that has emerged through the evaluation has been the desirability of sustainable services. In considering the extent to which NPA IECD-funded services and the gains they are making are sustainable beyond the period of the NPA IECD, the evaluation suggests challenges that the definition of sustainability for different investment elements is unclear, as is the timeframes under which sustainability can be feasibly achieved.

In particular, investments in Element 1 have experienced significant delays in the construction of new facilities in most jurisdictions, which have impacted on the level of service maturity at the end of the NPA IECD period. Some investment programs, such as New Directions, have transitioned to recurrent funding but with the expiration of NPA IECD funding in June 2014, the Australian Government will continue to fund state and territory governments to deliver Element 2 activities in 2014-15.

2.8.3 IMPROVED SERVICE DELIVERY

It is acknowledged that there is no standard definition or agreement on what constitutes improved service delivery or 'quality of care' within primary healthcare services. Neither is there any articulation within the NPA IECD as to what 'improved service delivery' would comprise, although that is the aspiration. For the purpose of the evaluation, a number of improved care indicators or proxies have been utilised. These include for instance:

- increases in service utilisation rates among Aboriginal and Torres Strait Islander peoples (for example, earlier antenatal contact and hospitalisation rates)

- changes in clinical data measured at state-wide and national levels (for example, rates of smoking during pregnancy, and the proportion of low birth weight babies)
- change in the cultural competence of the health and early childhood education and care workforce
- reported improvements in service linkages and coordination.

2.8.4 DATA ISSUES, LIMITATIONS AND RESPONSE

In considering the various data sources that are included in the Evaluation Framework, it is important to note the associated data issues and limitations, which are described below.

The reliability of data collected for Aboriginal and Torres Strait Islander peoples is affected by the accuracy of identification of Aboriginal and Torres Strait Islander peoples, and the small population size of Aboriginal and Torres Strait Islander peoples. Although there has been progress in the quality and availability of statistical information on Aboriginal and Torres Strait Islander peoples,⁴ there are ongoing challenges related to the identification of Aboriginal and Torres Strait Islander peoples in data collections. These challenges can be attributed to a range of factors, including:

- different levels of identification across different data collections, as well as within each data collection over time, and between regions, which makes it difficult to assess changes both over time and between different regions
- inconsistencies in whether people are asked about their Aboriginality and in how people identify themselves or are identified in the census and other data collections
- the difficulty of collecting information that may not be conceptually and culturally relevant to Aboriginal and Torres Strait Islanders.

Data collection methods, data definitions and coverage of Aboriginal and Torres Strait Islander communities can vary considerably across states and territories, for different data collections, and from year to year. These variations affect the reliability of data and capacity to make meaningful comparisons across jurisdictions and time periods.

Self-reported data, such as that collected through the NATSIHS and NATSISS may be inconsistent with data collected through other methods. Self-reported data may also be affected by imperfect information recollection by survey participants.

Differences in the frequency of data collection among the identified data sources mean that not all data indicators will have baseline data in the same year, and not all data sources will provide evidence of change during the evaluation timeframe, particularly given the variability associated with the small population size. In particular, eight of the ten PIs of the NPA IECD are reported upon in this report, with no data available for PI 2 and 3. Not all of the reported indicators were expected to show significant changes within the timeframe of the evaluation.

Furthermore, as the timing of the establishment and full operation of CFCs varies between and within states and territories, the capacity to collect data from CFCs, assess the activities, outputs and outcomes (contributions) of the CFCs to the achievement of short-, medium- and long-term outcomes within the timeframe of this evaluation is limited.

It is important to acknowledge that attributing shifts to indicators solely to the activities of the CFCs may be problematic, as there is significant investment taking place concurrently to address Aboriginal and Islander health and wellbeing. Where possible, this evaluation has sought to identify specific measures to assess the impact of the IECD-funded activities on participating clients. It is not possible, however, to make larger claims about the population-level impact within the life of this evaluation.

⁴ As an example of an initiative to enhance data collection, the National Centre for Aboriginal and Torres Strait Islander Statistics (NCATSIS) has been established, with a leadership and coordination role for national statistical activity about Australia's Aboriginal and Torres Strait Islander peoples (ABS, retrieved March 2013 from <http://www.abs.gov.au/websitedbs/c311215.nsf/web/Aboriginal+and+Torres+Strait+Islander+Peoples+-+ABS+Contacts,+>).

Health performance indicators (PIs 5-10) are reported within the AIHW Report series and provide outcome statistics based on national data collections. The AIHW Report identifies that four of the six health-related PIs (PIs 5, 7, 8 and 10) can be sourced directly from national data collections, while PIs 6 and 9 cannot, requiring the adoption of interim proxy measures (AIHW, 2012, p 8) for these indicators.

The Evaluation Framework identifies quantitative indicators that may, over time, show changes in risk factors and behaviours at a population level. However, these indicators were not likely to show significant changes within the lifetime of the evaluation. This does not indicate necessarily that the NPA IECD itself has not produced significant changes in outcomes; rather, it may indicate the fact that statistically significant changes in health indicators at a population level take time to emerge.

It is also important to recognise that many social determinants outside of the health and early childhood education sector also influence people's level of health and wellbeing. The Evaluation Framework has also focussed on the system changes that may be evident as a result of this NPA IECD, such as improved processes and relationships for collaborative and coordinated service delivery.

Data based on small numbers are often highly volatile and it is difficult to detect statistically significant changes, particularly in short timeframes. Single years with statistical significance testing are used for trend analysis. For current period analysis, two to five years of combined data is used in some cases to enable meaningful statistical analysis.

PART II: The national picture

3 Australia's progress under NPA IECD

This section provides an analysis of national progress toward the objectives of the NPA IECD.

3.1 NATIONAL REPORT CARD

Table 6 provides a snapshot of progress against the ten performance indicators, drawing on data collated by the Australian Bureau of Statistics (ABS) for PI 2 and the AIHW for PIs 5-10, as well as information collected through state and territory reporting (PI 1, PI 4). No data are available to provide an indication of progress against performance Indicator 3, and state and territory data for PIs 1 and 4 cannot be aggregated at the national level due to differences in reporting and interpretation of data elements.

Performance Indicator 2 confirms that Aboriginal and Torres Strait Islander children continue to be underrepresented in preschool enrolments and attendances. Nationally, Aboriginal and Torres Strait Islander children make up 5.7 per cent of the estimated population aged 3-5 (ABS 2013), but only 4.5 per cent of the proportion of recorded enrolments in preschool in the year before fulltime school (ABS 2014). The number of CFCs that provide preschool programs is small compared to the total number of Aboriginal and Torres Strait Islander children enrolled in the year before full time schooling (reported at 12,400 children nationally in 2013) (ABS 2014). It is not expected that CFCs alone will significantly impact the underrepresentation of Aboriginal and Torres Strait Islander children.

Aggregation of data from NSW, SA and the NT indicates that the proportion of pregnant Aboriginal and Torres Strait Islander women with an antenatal contact in the first trimester of pregnancy in each year increased between 2007 and 2010, from 60 per cent to 66 per cent (PI 5). These gains coincide with the early stages of the NPA IECD, and it is likely that NPA IECD efforts (particularly New Directions and state and territory investment under Elements 2 and 3) have made a contribution to this outcome. It remains to be seen whether the national trend is replicated in all jurisdictions over the longer term, although anecdotal reports are positive.

There are no direct measures for PI 6 and so proxy measures are utilised. Rates of access to sexual and reproductive health services may be partly correlated with notifications for some sexually transmissible infections and blood borne viruses (BBVs), as increases in access and testing may lead to increased notifications. Changes in notification rates over time may reflect real changes in the incidence of STIs and BBVs, but may also be attributable to the introduction of easier and more sensitive testing procedures, greater targeted screening, public awareness campaigns, and changes in surveillance practices (NNDSS Writing Group 2011). Estimates for the incidence of STIs and BBVs in Aboriginal and Torres Strait Islander populations are likely to underestimate the true figure because of incomplete information about Aboriginal and Torres Strait Islander status (National Centre in HIV Epidemiology & Clinical Research 2010).

These factors mean that it is not possible to determine the attribution or extent of contribution made by NPA IECD investments to changes in notification rates reported as a proxy for PI 6. However, the range of investments made under Element 2 across the jurisdictions have generally aligned with the available evidence for what is effective (Strobel and Ward 2012). Although it is not possible to isolate and quantify the overall impact of NPA IECD investment measures, fidelity to this evidence base suggests that investments are likely to be contributing to changes in PI 6.

Over the decade to 2010, there was a significant decline in the proportion of Aboriginal and Torres Strait Islander babies born of low birth weight in NSW, Victoria, Queensland, WA, SA and the NT combined (PI 7). However, at the jurisdictional level only NSW and SA show significant change, with rates in all other jurisdictions remaining relatively stable. The extent of contribution made by NPA IECD investments is not able to be determined because statistically significant change is not yet evident since NPA IECD inception (2008).

No significant change to the infant mortality rate is observed since 2008 (PI 8), although between 2001 to 2011, there was a significant decline (55 per cent) in the infant mortality rate for Aboriginal and Torres Strait Islander infants in NSW, Queensland, WA, SA and the NT combined. The continuation of the long term trend over the period of the NPA IECD and the extent of contribution made by NPA IECD investments are not able to be ascertained at this stage.

At the national level, rates of smoking during pregnancy by Aboriginal and Torres Strait Islander women have not seen statistically significant decline since 2007 (PI 9). Small but significant declines are evident in NSW over the same period. Smoking cessation programs have been a component of Element 2 and 3 investments in most jurisdictions, and while the extent of contribution is not able to be quantified it is likely that these efforts contribute to longer term change.

Finally, PI 10 relates to hospital admissions for Aboriginal and Torres Strait Islander children under 5. Hospitalisation rates for Aboriginal and Torres Strait Islander 0-4 year olds significantly increased by 12.5 per cent between 2004-05 and 2010-11 in the combined jurisdictions for which data were available. However, it is likely that improvements to identification practices has a significant influence over the reported rates, particularly as only four jurisdictions were considered to have adequate Aboriginal and Torres Strait Islander identification in hospitals prior to 2007 (AIHW 2013b, p 1).

Many of the performance indicators for the NPA IECD reflect longer term objectives, and are not expected to show significant change in the timeframe for this evaluation. As discussed in section 2.8, the data in most cases carry caveats, and there are significant complexities associated with the attribution of change to NPA IECD investment. Where time-series data is available, significant change may not be evident over the period of the NPA IECD (since 2008), but may be observed over longer periods, should activity continue past the funded period of the NPA IECD.

TABLE 6 – NATIONAL PROGRESS REPORT CARD

PERFORMANCE INDICATOR	INDICATOR RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	State and territory data cannot be aggregated at the national level due to differences in collection periods, reporting and interpretation of data elements (for example, different definitions of the denominator).
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 12,400 Aboriginal and Torres Strait Islander children recorded as enrolled (and 11,719 attending) in preschool programs in the year before full time schooling, representing 4.5% of all enrolled (and 4.5% of attending) children. A total of 11,247 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 4.9% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	State and territory data cannot be aggregated at the national level due to differences in collection periods, reporting and interpretation of data elements.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	Between 2007 and 2010, in the three jurisdictions combined for which data are available on gestational age at first antenatal visits over the period (NSW, SA and the NT), there was an increase in the age-standardised proportion of Aboriginal and Torres Strait Islander mothers who attended antenatal care in the first trimester (from 60% to 66%) (AIHW 2013a, p 10), although this change was not statistically significant.
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	Between 2008 and 2012, there were no significant changes in the notification rates for chlamydia, gonorrhoea, syphilis, hepatitis C or hepatitis B among Aboriginal and Torres Strait Islander and other teenagers aged 15-19 (PI 6) (AIHW 2013a, p. 23). Given the small numbers involved, significant change would not be expected over five years. This is the context of longer term trends since 1994-96 which showed a tripling of rates for chlamydia, a doubling for gonorrhoea and a decline for syphilis.
7. Reduced proportion of Indigenous babies born with low birth weight each year	Over the period 2000 to 2010, in NSW, Victoria, Queensland, WA, SA and the NT combined, there was a significant decline in the proportion of low birth weight babies born to Aboriginal and Torres Strait Islander mothers (from 12% to 11% of liveborn singleton babies), and a significant narrowing of the gap between low birth weight babies born to Aboriginal and Torres Strait Islander and non-Indigenous mothers. At the jurisdictional level, significant change was evident only in NSW and SA (AIHW 2013a, p 30).
8. Reduced mortality rate of Indigenous infants each year	Between 2008 and 2011, there was no significant change in the Aboriginal and Torres Strait Islander infant mortality rate or the gap. Over the period 2001 to 2011, in NSW, Queensland, WA, SA and the NT combined, there was a 55% decline in the infant mortality rate for Aboriginal and Torres Strait Islander infants (from 11.2 to 6.6 deaths per 1,000 live births) (AIHW 2013a, p 32-34). Due to small numbers, state and territory specific trends were not calculated.
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	Trend data are available for all jurisdictions, excluding Victoria. At the national level, there was no significant change in rates of smoking or in the gap between Aboriginal and Torres Strait Islander and non-Indigenous mothers during pregnancy between 2007-10. There were significant declines in the age-standardised proportion of Aboriginal and Torres Strait Islander mothers who smoked during pregnancy in NSW (from 48% to 47%) (AIHW 2013a, p 37).
10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	Hospitalisation rates for Aboriginal and Torres Strait Islander 0-4 year olds significantly increased (by 12.5%) between 2004-05 and 2010-11 in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined. Over this period, hospitalisation rates for Aboriginal and Torres Strait Islander children increased at a faster rate than the rates for other children. There were significant increases in Aboriginal and Torres Strait Islander child hospitalisation rates for conditions originating in the perinatal period (24%), injury and poisoning (16%) and respiratory diseases (11%). There was a significant decline in Aboriginal and Torres Strait Islander child hospitalisation rate for infectious and parasitic diseases (32%) (AIHW 2013a, p 45). Changes in hospitalisation rates may be reflective of a number of different factors, including changes in access to, and demand for, hospital treatment. Improvements in the recording of Aboriginal and Torres Strait Islander status in hospital records may also affect hospitalisation rates reported for Aboriginal and Torres Strait Islander children over time.

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by the Australian Health Ministers' Advisory Council (AHMAC).

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

While definitive client outcomes data for NPA IECD investments is lacking, stakeholders have consistently reported that visible gains are being made within Aboriginal and Torres Strait Islander communities that are attributable to NPA IECD efforts. The evaluation sought to establish the extent to which there is evidence for the medium term outcomes that Aboriginal and Torres Strait Islander families are accessing the full range of early childhood services, child care and parent and family support services, and MACH services. The evaluation also focused on the extent to which Aboriginal and Torres Strait Islander parents have increased capacity to meet their children's developmental needs. These medium-term outcomes are expected to be visible at this stage in the long term trajectory of the NPA IECD.

There is evidence that a range of outcomes is being achieved for individuals, although the breadth and consistency of these is highly variable. Many of the outcomes were reported anecdotally and include:

- Consistent reports of increased client and parent engagement with a range of support services and programs, particularly where NPA IECD funded services have opened up referral pathways and networks to other services. This is a particularly important intermediate outcome for a client group with complex needs
- Increases in knowledge and skills related to parenting, nutrition, and sexual reproductive health; as well as some attitudinal change, for example related to substance use during pregnancy
- Local evidence for positive changes in some health behaviours, including reduced smoking during pregnancy, increased rates of breastfeeding, increased access to sexual and reproductive health services, increases in STI testing, and reported improvements in safe sexual practices
- Local reports of improvement on some clinical indicators including declines in hypertension and diabetes during pregnancy and decreased rates of anaemia in children and increased rates of immunisation
- Personal growth and development, particularly through opportunities afforded by some CFC and other child and maternal health programs and services
- Anecdotal evidence that early learning activities in CFCs are leading to children being better prepared for school
- Anecdotal reports of reductions in teenage pregnancies, and increased fertility planning.

Documented local outcomes for children, parents, families and young people identified through this evaluation have included:

- Increases in rates of antenatal contact in first trimester by Aboriginal and Torres Strait Islander women between 2000 and 2010, from 60 to 66 per cent across the three jurisdictions for whom data was available (PI 5: AIHW 2013a, p 10), and anecdotal reports of similar trends in other localities
- Statistically significant decrease in the proportion of low birth weight babies to Aboriginal and Torres Strait Islander mothers in SA and NSW (PI 6: AIHW 2013a, p 30), and anecdotal reports of similar trends in other localities (although state-wide results remained relatively stable).

These outcomes, both anecdotal and documented, have not been observed consistently in all jurisdictions and many instances may not have sufficiently impacted on population level measures and indicators, but they are illustrative of positive impacts at the local level.

Across Elements 1 and 2 in particular, there has been a focus in a number of jurisdictions in implementing programs or utilising resources that have been evaluated as effective in contexts, such as the Triple P Positive Parenting program, Families as First Teachers (FaFT), Core of Life (COL), Circle of Security Early Intervention Program for Parents and Children (Circle of Security) and Mooditj Leader Training. While the depth of evidence varies between programs, the use of evidenced-based approaches should increase confidence in achievement of longer-term positive outcomes.

Significant levels of reported demand for some NPA IECD funded services, particularly including many CFC services and New Directions services indicate that individuals and families are accessing a range of services under the NPA IECD, although there is very limited information available about the mix and breadth of services accessed by individual families.

CFCs have been well received in the communities where they have been established, and as they mature local organisations are beginning to report positive stories about the impact their work is having on local families. Similarly, investments in maternal and child health under Element 3 are generating tangible results where data has been collected; for example, the New Directions funded Anangu Bibi Birthing Program in Port Augusta has seen an increase in antenatal — and earlier contact — as well as reductions in the number of low birth weight babies born to Aboriginal and Torres Strait Islander mothers.

Some of the standout stories of success emerged from areas where the full range of NPA IECD investments have been integrated or coordinated for local communities. The Wayparattee CFC in Geeveston provides a holistic and integrated model of service delivery that provides a point of access to services funded under all three NPA IECD elements, as well as to other programs including allied psychological services.

When CFC leaders were asked about what was different for the community compared to before the CFC was open, a common theme was the availability of coordinated services delivered in a culturally appropriate way. The integration of health and other aspects of early childhood development was also commonly highlighted as a key change and a benefit. Several respondents reported that the CFCs had become a 'hub' or a 'safe place' for community members to engage with.

When asked to identify the most significant outcomes for their local communities, CFCs frequently cited increased access to a range of services and an associated increase in utilisation of early childhood services. Parenting programs and training and employment opportunities were also reported to be delivering benefits to community.

Through the evaluation, CFCs were asked to relate an illustrative example of a success story for their communities — these consistently focused on highly complex, challenging scenarios often involving child protection services and the justice system. The CFCs' capacity to draw in multiple services and provide a tailored, intensive response to an individual or family's complex needs was reported to have had a significant and positive impact on people who had previously been disengaged and often felt disenfranchised by the mainstream system.

A common theme emerging through consultations in many jurisdictions has been the impact that parenting and other skills-based training has had on Aboriginal and Torres Strait Islander people who have undertaken the training programs. Stakeholders commonly report that they are seeing increased confidence in terms of parenting skills, but in some cases there are illuminating stories of broader personal growth, firstly by engaging with services as a client, then as a volunteer, and in some cases, completing training and transitioning to a paid role within the service or elsewhere.

Evaluation of efforts under Element 2 to increase sexual and reproductive health literacy, promote healthy behaviours and enhance service access has generally been limited, but where data was collected there are signs of positive impacts. Similarly, there was evidence in some jurisdictions that information or awareness campaigns have made a difference to the attitudes to sexual and reproductive health behaviours.

3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

At this point in the long-term trajectory of the NPA IECD, the Evaluation Framework anticipates that there should be evidence that Aboriginal and Torres Strait Islander families access the full range of early childhood services, including early learning, child care and parent and family support services, and MACH services. The Evaluation Framework also anticipated that more Aboriginal and Torres Strait Islander teenagers would be accessing sexual and reproductive health programs and services, and more Aboriginal and Torres Strait Islander women and children would be accessing MACH services.

3.1.2.1 CHILDREN AND FAMILY CENTRES

Data on the range of early childhood services being accessed by Aboriginal and Torres Strait Islander families is limited, although CFCs reported for the first time in 2013 on services accessed by children and

by families during a census week, undertaken at in each jurisdiction at various times over the year. Differences in the interpretation of data elements means that data collected cannot be easily aggregated at the national level.

Useful data is now available on the range of programs offered at, or through, CFCs, and this paint a picture of considerable diversity in service design. Table 7 summarises a range of different services types reported by CFCs to be provided at, or through, the CFC as at June 2013. These data indicate that parenting and family support, child support activities and community events were offered by all CFCs. Child health services, health promotion and early learning activities are also frequently offered, while approximately two-thirds of CFCs offer each childcare, formal early childhood education, child support services and maternal health services.

There is a correlation between the self-reported level of organisational maturity of a CFC and the extent to which it delivers services in an integrated way, with more mature organisations more likely to be working with partners and other services in a collaborative or integrated way. It should be noted that some CFCs are still in their establishment phase and will continue to add service offerings as they mature. This is particularly relevant for those services which are yet to transition into their permanent premises, a pre-requisite for childcare offerings in some instances.

Factors which were identified by CFCs as being supportive of effective partnerships included co-location, consistent and honest communication, commitment to a common purpose, community engagement and leadership, commitment to 'following through' complex or challenging cases and shared program development. Factors thought to hinder effective partnerships included perceptions that funding arrangements (including competitive tendering) created tensions, rigid organisational boundaries, lack of knowledge or empathy about the client group among potential partner organisations and staff turnover (at CFC and in partners) requiring relationships to be re-built.

TABLE 7 – TYPES OF SERVICES AVAILABLE AT OR THROUGH CFCs

SERVICE TYPE*	% CFCs	SERVICE TYPE*	% CFCs
Childcare	– 64.7%	Maternal health	– 67.6%
<i>creche</i>	– 11.8%	<i>antenatal and postnatal care/services</i>	– 55.9%
<i>occasional care</i>	– 17.6%	<i>prenatal, perinatal & postnatal support programs</i>	– 52.9%
<i>long day care</i>	– 41.2%	<i>breastfeeding support/infant feeding</i>	– 41.2%
<i>mobile care</i>	– 5.9%	<i>women's health clinic</i>	– 20.6%
<i>after hours school care</i>	– 8.8%	<i>doctors, nurses, specialists</i>	– 44.1%
<i>adjunct care</i>	– 32.4%	Health promotion	– 88.2%
Early childhood education	– 64.7%	<i>health promotion activities</i>	– 88.2%
<i>preschool/kindergarten</i>	– 55.9%	<i>teenage sexual health programs</i>	– 14.7%
<i>long day care</i>	– 35.3%	Parenting and family support	– 100.0%
Early learning activities	– 88.2%	<i>information/resources</i>	– 85.3%
<i>early literacy/numeracy programs</i>	– 73.5%	<i>advice</i>	– 76.5%
<i>transition to school programs</i>	– 52.9%	<i>skills development</i>	– 79.4%
<i>early learning programs provided by schools</i>	– 38.2%	<i>group activities</i>	– 85.3%
Child health services	– 91.2%	<i>counselling services</i>	– 73.5%
<i>child health checks</i>	– 88.2%	Other	– N/A
<i>immunisations</i>	– 58.8%	<i>disability services</i>	– 29.4%
<i>early childhood allied health</i>	– 79.4%	<i>cultural programs</i>	– 91.2%
<i>doctors, nurses, specialists</i>	– 58.8%	<i>community events</i>	– 100.0%
Child support services**	– 61.8%	<i>non-parenting support (e.g. legal aid, Centrelink)</i>	– 61.8%
<i>counselling services</i>	– 47.1%	<i>skills development to support employment</i>	– 55.9%
<i>disability services</i>	– 38.2%	<i>somewhere to study/learn</i>	– 44.1%
Child support activities**	100.0%	<i>a community meeting place</i>	– 70.6%
<i>playgroups, paint and play</i>	– 94.1%		
<i>school holiday programs/activities</i>	– 41.2%		
<i>story time/other library services</i>	– 55.9%		
<i>toy library</i>	– 23.5%		
<i>other: cultural programs</i>	– 79.4%		

Source: June 2013 state and territory reporting.

* Percentages within each grouping do not add up to group total, as respondents could select as many service types as applied. Group totals represent the proportion of CFCs offering at least one service in that group.

** 'Child support' in this context refers to general services provided in support of children's development, and not to services associated with the Child Support Agency.

The breadth of services available at CFCs is shown in Table 8, which indicates that three quarters of CFCs are offering services in at least seven of the nine service groups described in Table 7:

TABLE 8 – SERVICES AREAS OFFERED BY CFCS

SERVICE AREAS*	% OF CFCS
9 (maximum)	26.5%
8	20.6%
7	26.5%
6	17.6%
5	0.0%
4	5.9%
3	2.9%

* 'Other' services excluded.

9 SERVICE AREAS

Childcare
Maternal health
Early childhood education
Early learning activities
Child health services
Child support services
Child support activities
Health promotion
Parenting and family support

3.1.2.2 SEXUAL AND REPRODUCTIVE HEALTH SERVICES

There is no national data available that provides a direct measure of the level of access to, and uptake of, sexual and reproductive health services. The indicators utilised by the AIHW's reporting on PI 6 are notification rates for STIs and BBVs; these relate only to one type of service (STI and BBV testing); and are likely to be highly sensitive to other factors and so are not a reliable guide to levels of access.

There are data available at the jurisdictional level which suggests that NPA IECD funded efforts to enhance access to sexual and reproductive health services have been successful, at least in some areas. Data from NSW for example shows a 30 per cent increase in attendance at sexual and reproductive health services and a 40 per cent increase in rates of testing for chlamydia/gonorrhoea since inception of Element 2 programs in that jurisdiction. Queensland, WA, the ACT and the NT also report increases in teenagers accessing sexual and reproductive health programs and screening services.

Distribution of sexual health resources, including information and contraceptive packs and condoms, has also been a feature of Element 2 programs in most jurisdictions. Several jurisdictions report high, or increasing, rates of distribution, which is likely to correlate — at least to some extent — with safer sex practices. Similarly, outreach and education programs offered in many jurisdictions are also likely to be having a positive impact on service access and utilisation, because they bring services into familiar environments for young people, such as schools. These approaches have also led to the development of culturally respectful education sessions, and expertise in their delivery that both support longer-term sustainability for ongoing delivery, particularly in remote communities.

3.1.2.3 MATERNAL AND CHILD HEALTH SERVICES

Combining data from NSW, SA and the NT indicates that the proportion of pregnant Aboriginal and Torres Strait Islander women with an antenatal contact in the first trimester of pregnancy in each year increased between 2007 and 2010, from 60 per cent to 66 per cent (PI 5), although this increase was not statistically significant. There are consistent reports of improvements in the rates, timing and number of contacts with antenatal and postnatal maternal health services among Aboriginal and Torres Strait Islander women.

New Directions funding has enabled services to increase total service capacity and capability (through broadening of service offerings in funded organisations) and many of these organisations continue to report difficulty meeting demand (DH 2013, p 41). While there are limiting factors in some areas, primarily due to challenges associated with securing a workforce to expand services, these observations are consistent with improving access in New Directions funded communities. State and territory funded activity under Element 3 is also reported to be having a substantial impact. Increased access to and uptake of maternal health programs is explicitly reported by NSW, Victoria, and in parts of Queensland, SA, Tasmania and the NT.

Many of the strategies adopted by state and territory and New Directions funded MACH initiatives are focused on reducing barriers to access, and in particular through home visiting or outreach programs, and

transport arrangements. A core strategy which appears to underpin NPA IECD investment in this space is to position service delivery in culturally safe contexts (discussed further in 3.1.3). In particular, 75 per cent of New Directions funded organisations are ACCHOs (DH 2013), while maternal and child health services are also offered in 67 and 91 per cent of CFCs nationally, many of which are community controlled and all of which have an explicit focus on creating culturally safe operating environments (see Table 7).

The 2008 NATSISS (ABS, 2009) provides information on reported barriers for Aboriginal and Torres Strait Islanders in accessing health services in general. While the data is not specific to antenatal or maternal and child health services, it provides some broad indications of the barriers that exist for Aboriginal and Torres Strait Islander people in accessing health services.

The survey shows that 32 per cent of Aboriginal and Torres Strait Islander people aged 15 years and over had problems accessing doctors; 22 per cent accessing hospitals; 18 per cent accessing AHWs; and 9 per cent accessing other health workers. The survey results show that Aboriginal and Torres Strait Islander women were more likely to have problems accessing services than men (33 per cent compared to 27 per cent). As the NATSISS was conducted in 2008, the first year of the NPA IECD, future releases of the NATSISS may potentially allow comparisons on measures. The next NATSISS is expected to be undertaken in late 2014.

3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

This section explores the extent to which Aboriginal and Torres Strait Islander families and communities value the NPA IECD-enhanced services, and whether they are perceived to be both culturally secure and appropriate for their needs.

Efforts to provide culturally accessible services are commonly framed in terms of cultural safety. The notion of cultural safety has been defined as: “an environment that is safe for people, where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening” (Williams 1999, cited in Australian Human Rights Commission 2011, p 123). A key feature of cultural safety is that whether or not a health service is considered to be culturally safe is a judgement of the client, not the service provider (Eckermann et al. 2010, p 188).

Understanding cultural safety as a client-assessed concept provides context for the challenges associated with measurement of outcomes in this domain. Concrete data on cultural safety is difficult to secure, and most evidence collected through the course of the evaluation has been focused on documentation of fidelity to processes and implementation strategies that are expected to lead to culturally safe service models, in turn enhancing accessibility.

The provision of services in environments that support cultural safety is a common strategy for NPA IECD services. Three-quarters of New Directions funded services are ACCHOs, while in most cases CFCs report being highly successful in creating a service and operating environment that supports perceptions of cultural safety in clients. In centres that are operating out of permanent premises, the physical features of the buildings have generally been designed through community consultations and with a view to creating a welcoming space. All CFCs report providing space for community meetings, and this may engender a greater sense of community ownership of the facilities.

Other strategies include the provision of services through outreach or outplacement strategies, which situate service delivery in contexts that are familiar to, and comfortable for, potential users of the service. These include home visiting programs and the delivery of mobile services, which reduce the cultural barriers to services that may traditionally have been delivered in confronting or culturally alienating settings, such as hospital outpatient units, sexual health services and mainstream primary care environments.

Engagement of Aboriginal and Torres Strait Islander staff is also consistent with accepted practices for the development of culturally safe services, and this has been a key focus for most CFCs. While the level of Aboriginal and Torres Strait Islander workforce within a CFC varies depending on skillsets available in local communities, many CFCs are also offering entry-level or training pathways and opportunities for Aboriginal and Torres Strait Islander people. These workforce strategies are likely to support the cultural appropriateness of offered services, and strengthen the perception of CFCs as investments in communities, not just buildings and services. A high proportion of the total staff employed through New

Directions funding are culturally specific roles, including AHWs, Aboriginal Maternal and Infant Health Workers (AMIHWs), or Aboriginal Health Education Officers (AHEOs).

Some services - particularly CFCs - are also supporting cultural safety by providing pathways for clients to become involved in service operation and delivery through volunteer roles, and in some cases with pathways to training and employment. These approaches foster deeper relationships between community and service and over time are likely to contribute to development of a local workforce and community capacity (as discussed in 3.1.4).

Developing relationships between Aboriginal and Torres Strait Islander organisations and mainstream services is also a key strategy for creating accessible pathways to services. These relationships take a range of forms, from informal referral networking, more formal referral pathways, capacity building training exchanges or formal partnerships in support of co-located or integrated service offerings. Partnership arrangements commonly enable mainstream services to leverage the trust and credibility with community that is often a hallmark of community controlled services, as well as to draw on the cultural knowledge and cultural strengths of Aboriginal and Torres Strait Islander communities. These relationships are evident, for example, through New Directions funded services, which are frequently engaged in formal or informal partnerships with local hospitals.

Partnerships are also a feature of many state and territory initiatives such as the Wulumperi Aboriginal and Torres Strait Islander Sexual Health Unit within Melbourne Sexual Health, which works with Victorian ACCHOs to strengthen their capacity to provide culturally accessible pathways to sexual health services for Aboriginal and Torres Strait Islander people. This program is a good example of an approach to broadening the capacity of existing organisations that have 'cultural capital' with their communities through partnerships.

Participatory planning and engagement practices in most instances (outlined in 3.1.5) are also likely to have facilitated the development of relationship between CFC and their communities, and to have informed development of culturally appropriate implementation strategies for Element 2 and Element 3 programs.

3.1.4 BUILDING AND STRENGTHENING CAPACITY

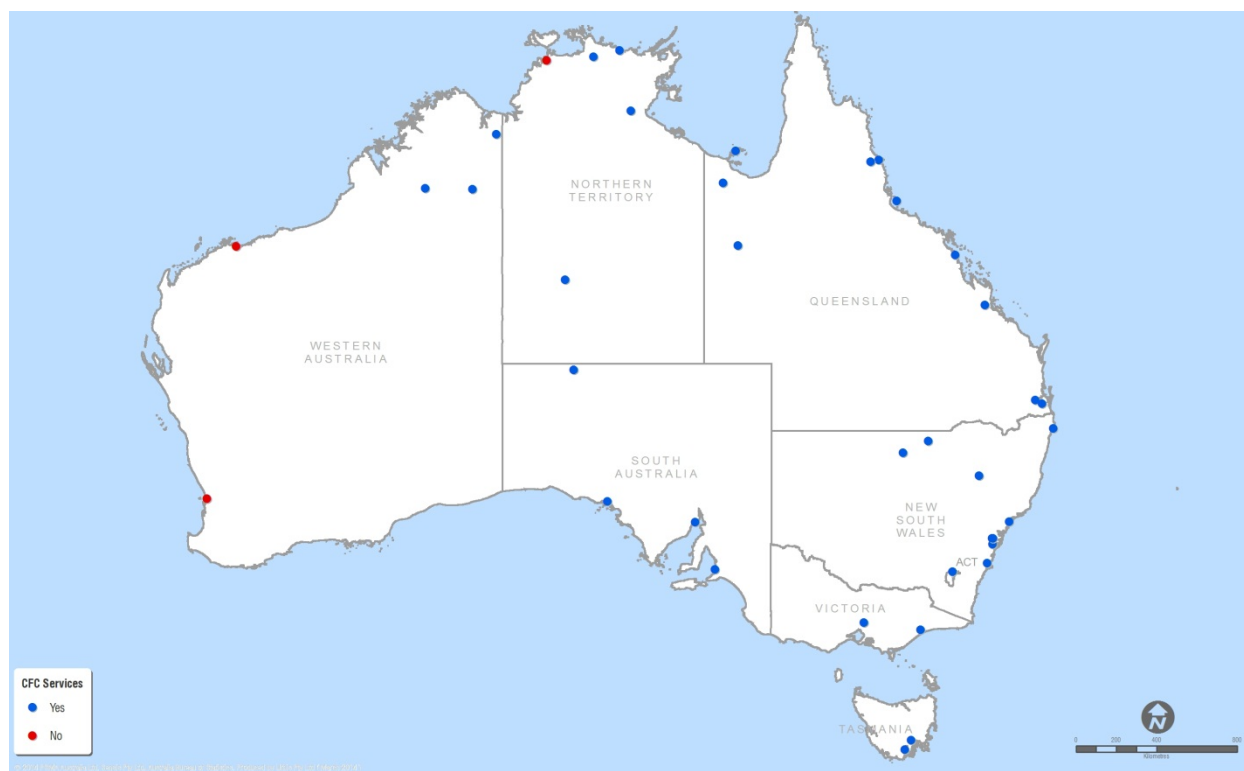
This section examines the impact of the NPA IECD on building capacity within both the Aboriginal and Torres Strait Islander community but also within non-Indigenous services. It also considers key workforce issues impacting on capacity development.

3.1.4.1 CHILDREN AND FAMILY CENTRES

Children and Family Centres were expected to significantly enhance the capacity of local Aboriginal and Torres Strait Islander and mainstream services to provide effective services by enabling and facilitating co-location, integration and partnership activities between providers and with the community. The breadth of services offered at or through CFCs indicates that significant progress has been made in this regard (see 3.1.2.1), although there are a range of different approaches that have been adopted to suit local contexts.

Of the planned 38 CFCs, 35 were providing services to their local communities to June 2013 (see Figure 2). The NPA IECD initially envisaged that all CFCs would be constructed and operating by June 2012. The timeframes were subsequently revised to reflect delays in construction and commissioning of centres, and this has decreased the timeframe in which progress and outcomes can be assessed (ANAO, 2013).

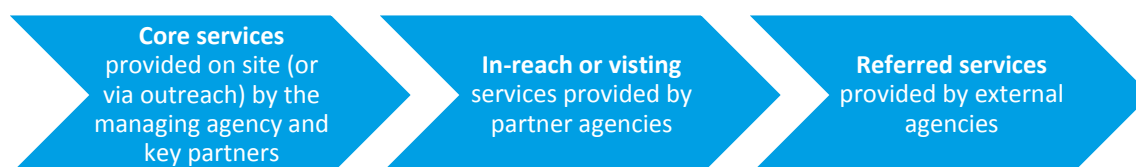
FIGURE 2 – CHILDREN AND FAMILY CENTRE LOCATIONS AT JUNE 2013



CFC SERVICE MODELS OF PARTNERSHIP AND INTEGRATION

All services are working towards an integrated model of service delivery. Most CFCs provide a clear articulation of the nature of integration they are seeking to achieve. Some CFCs have a detailed understanding and philosophy against which they are developing and implementing services, and which clearly underpins their operations. The integrated service model is one shared by constructed, fully operational centres, as well as those that are still in the construction phase of the physical facilities.

FIGURE 3 – CFC SERVICE MODELS



As depicted in Figure 3, commonalities in approach include the provision of a suite of core services, encompassing on-site, mobile, outreach and home visiting services. This is achieved by the CFCs as the managing agency, and through their relationships with key partners, with additional services accessible to clients through a mix of approaches. Core services are often 'universal' services accessed by a range of individuals and families, and which act as a gateway to other services that can engage clients, who can then selectively access other, more targeted services. This includes, for example, parent and family support offered by all CFCs, and childcare services provided about two-thirds of CFCs. In some cases, it may include case-management approaches, which coordinate or broker access to services on a client or family basis.

In cases where a significant central physical facility has been established - whether permanent or interim - and where multi-use, shared spaces, such as consulting rooms are available, partner services are commonly offered through an in-reach model. For example, these services may include child health services provided on location by visiting health or medical providers, or specific programs offered on a cyclic basis by state-wide services. In Halls Creek this is the model, under which the CFC provides the venue for community to access visiting specialists, as well as a venue for the mobile playgroup service, with facilities to store resources.

Finally, other services may be accessed externally, in many cases formalised through a referral pathway from the CFC. Most commonly, these appear to be services that are already well established elsewhere in the community, for example, Centrelink and some specialised health services.

Factors that may influence the configuration of services as core, in-reach, or referred services include the specific service needs of the local community; the presence of already established providers; the philosophy of the CFC management; and the constraints of the physical operating environment. Consequently, the mix of services offered and the means of integration is context dependent, as might be expected and varies between, and within, jurisdictions.

Case study insights

The three CFC case studies represent implementation of NPA IECD Element 1 in three very different contexts and with markedly different models of service integration. Ningkuwum-Ngamayuwu in Halls Creek is located in a very remote location, is operated by an Aboriginal development organisation partnering with non-government organisations. West Belconnen is situated in urban Canberra and is operated by the ACT government. Finally, Bubup Wilam is a community controlled organisation in outer-metropolitan Melbourne.

Differences between the CFCs in their approach to partnership and service integration are noteworthy. While Ningkuwum-Ngamayuwu provides a significant range of services in partnership with both Aboriginal and Torres Strait Islander and non-Indigenous organisations, stakeholders considered that it would take some time for these organisational relationships to translate into a coherent integrated service model.

Conversely, Bubup Wilam had an explicit focus on developing a core identity and suite of services as an Aboriginal organisation working with Aboriginal children only, and has consciously limited the extent of formal partnership and engagement with external agencies (preferring a case-by-case model).

In the ACT, the West Belconnen CFC, with a considerably smaller proportion of Aboriginal and Torres Strait Islander clients than either Ningkuwum-Ngamayuwu or Bubup Wilam, has a significant range of mainstream services which provide services through the centre, as well as some specific arrangements with Aboriginal services to support the centre's focus on Closing the Gap.

There are three main Aboriginal services in the ACT. The West Belconnen Child and Family Centre co-facilitate groups and have a strong referral partnership with the two larger organisations; Winnunga Nimmityjah and Gudan Gulwan Youth Aboriginal Corporation. The range of mainstream services such as case management, group programs, community development programs, events and activities, MACH and Women's Health are accessed by Aboriginal and Torres Strait Islander clients.

Each of these approaches to partnership and integration reflects a different conceptualisation of the purpose and function of the CFCs, which is likely to reflect the particular context of implementation, but also the ethos and philosophy of the managing organisation.

Each case study site also reported that Aboriginal and Torres Strait Islander families were using services, and provided examples of positive outcomes being achieved at the local level. However, at both Ningkuwum-Ngamayuwu and West Belconnen, it appeared that there was potentially latent capacity within the CFC and its programs to increase participation by local Aboriginal and Torres Strait Islander families.

3.1.4.2 SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The extent to which the NPA IECD has contributed to increased systemic capacity to provide effective sexual and reproductive health services to Aboriginal and Torres Strait Islander young people is not able to be directly quantified. There is however, a range of anecdotal evidence that is suggestive of intermediate outcomes that are expected to be supportive of longer term gains.

This includes a greater emphasis in most jurisdictions on capacity building within existing services, rather than on service delivery *per se*. Several jurisdictions have focused on building and strengthening the workforce through provision of scholarships, traineeships and other formal pathways for Aboriginal and Torres Strait Islander people, and in the provision of training and support. The latter has included training for mainstream services which is aimed at strengthening cultural competence, and conversely, training and support to workers in ACCHOs and other organisations working with Aboriginal and Torres Strait

Islander people aimed at strengthening knowledge, skills and capability to provide services relating to sexual and reproductive health.

The capacity of both mainstream and community controlled services to engage with their clients and communities on sexual and reproductive health issues has also been strengthened through the provision of key resources and training programs, including, in many instances a 'train the trainer' model, or the well-respected Mooditj Leader Training.

Investment in workforce development, as well as the adaptation and production of health educational resources, information and professional training packages, suggests that the NPA IECD is likely to have increased the capacity of the health system to provide sexual and reproductive health services to communities. Some stakeholders have observed that in this sense, the outcomes following from investments under Element 2 are likely to be more sustainable than those achieved through Elements 1 and 3, where NPA IECD funding has commonly been used to directly employ frontline service staff.

3.1.4.3 MATERNAL AND CHILD HEALTH SERVICES

The New Directions program currently funds 85 providers for the provision of enhanced maternal and child health services. The program has directly bolstered the capacity of funding recipients to provide services through employment of staff as well as investment in training and other capacity-building resources such as vehicles, equipment and information technology. The confirmation of this funding as recurrent in the 2011-12 budget has provided stability and continuity for these services and enables them to continue operation with an increased level of capacity.

A range of state and territory based initiatives have also been implemented that are reported to have strengthened capacity within the maternal and child health and Aboriginal and Torres Strait Islander health sectors. These have included establishment of the Building Strong Foundations (BSF) services in NSW, which has strengthened local capacity in 15 communities, and significant expansion of the Child Health and Parent Service (CHaPS) in Tasmania and the Midwifery Group Practice (MGP) in the NT.

Intra and inter-sector engagement and collaboration have also been a focus of efforts in many jurisdictions, through the establishment of regular forums focused on building relationships and coordinating effort. These have included collaborative efforts in some jurisdictions, involving CFCs under Element 1, for example in Tasmania and the ACT; and with Element 2 funded services, such as linkages with COL program workers across the ACT.

There is also evidence that current activities have created new referral pathways, as well as strengthened existing ones. The state and territory reports indicate that relationships between organisations are being improved and new ones created, such as those between service providers and schools. Stakeholders confirmed these observations and there was a clear acknowledgement that Element 3 activities had meant agencies had increased communication and partnership with other stakeholders.

Training and workforce development efforts have also sought to provide another avenue to strengthen capacity within organisations and the workforce delivering MACH services in most jurisdictions. These efforts have included provision of targeted training focused on specific clinical issues (for example, the Deadly Ears training program in Queensland) as well as more general training (for example, the Enhanced Aboriginal Child Health Schedule training in WA) and scholarship programs.

A consistently identified risk to capacity enhancement in the MACH sector is the recruitment and retention of skilled staff, with difficulties securing staff and high turnover rates reported in some jurisdictions. Stakeholders have reported that early childhood and family health providers have difficulty competing with other sectors which are able to provide more attractive salaries and conditions. While there is anecdotal evidence that these risks have been partly mitigated through the use of scholarship programs and other incentives to help service providers attract recruits, workforce constraints are a significant challenge to the development and sustainability of capacity in MACH services.

Flexible models of service delivery, including home visiting programs and outreach programs have also been implemented to improve the capacity of some services to reach key target communities, including through the Early Childhood Development Program in SA. The CHaPS in Tasmania has developed a new model of care that is intended to enhance collaborative practice and provide more flexible services, deepening the service's capacity to engage with vulnerable families. These efforts have included an

explicit focus on engaging closely with Aboriginal and Torres Strait Islander organisations, and with mainstream and Aboriginal and Torres Strait Islander focused CFCs.

3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

This section explores the extent to which Aboriginal and Torres Strait Islander people are actively engaged in service design and planning. Reflections are made on the effectiveness of management and governance structures in supporting the implementation of the NPA IECD.

The NPA IECD included provision for extensive consultation in the planning and development of implementation plans, including “key partners and stakeholders including but not limited to Indigenous communities, non-government organisations delivering the services and industry peak bodies et cetera...” (COAG 2008, cl 51). This commitment was reflected in a requirement that outcomes to consultation be documented within state and territory reporting over the life of the NPA IECD (COAG 2008, cl 53).

While strategies for consultation with Aboriginal and Torres Strait Islander communities have varied across elements and between jurisdictions, the prominence given to consultation and engagement within the NPA IECD itself is also evident in jurisdictional implementation plans and subsequent reporting. There is a pattern in some states and territories of a higher level of formal consultation and engagement during the early stages of implementation planning, in many cases utilising existing forums (such as Aboriginal Health Forums (AHFs) or their equivalent). As implementation has progressed, ongoing engagement has in some cases devolved to the local level.

The extent to which consultation with Aboriginal and Torres Strait Islander communities undertaken in support of NPA IECD has been effective in securing community engagement is not able to be directly measured in most instances, with the process of consultation generally reported rather than the specific outcome. However, there is some evidence (particularly for Element 1) that consultation has helped to shape programs and services. The universally positive perceptions of programs, expressed by service users engaged during fieldwork across all elements, are suggestive that programs are appropriately designed and meeting community needs. A significant caveat on this observation is these consultations were with engaged service users, and may not be representative.

3.1.5.1 CHILDREN AND FAMILY CENTRES

In most cases, intensive local consultation is documented as a feature of CFC development. Community engagement was a key part of CFC planning and operation. The presence of an overarching strategy for engagement spanning service design, development and implementation, supported by strong local leadership and marked by celebration of progress with community is consistently identified as supportive of effective engagement. Eighty-eight per cent of CFCs responding to the April 2014 survey reported that governance structures had been enabling of community input to the extent that they exerted meaningful influence over decision making.

There is a range of governance and management arrangements in place across the CFCs (see Table 9). In NSW, Victoria, Queensland and WA, the appointment of centre operators has been through competitive tender, which has resulted in a mix of managing organisations, some of which are community controlled, some not-for-profit and in other cases, consortia of both. In SA, Tasmania, the ACT and the NT, operation of all CFCs is closely associated with government agencies, with staff employed by the relevant government agencies. Management control and key strategic decision-making is often devolved to the local level.

The governance and management structures vary between jurisdictions and have been influenced by the context of implementation. This is particularly evident in those jurisdictions in which the CFC rollout was closely aligned with broader initiatives and programs. In SA and Tasmania for example, the development and operation of the NPA IECD funded CFCs drew heavily on approaches that also applied to the establishment of non-Indigenous CFCs in those jurisdictions (Department of Education, 2010; Government of South Australia, 2013).

Notwithstanding the various processes for appointing or commissioning managing organisations, 40 per cent of CFCs responding to the first Urbis survey of CFC leaders indicated that they were community controlled, making this the most common model of management and operation nationally.

Most governance arrangements incorporated reference groups or advisory committees to support CFC planning, implementation and operation. Such committees have an important role in establishing the 'tenor' of the project, as well as undertaking a strategic role, providing a positive and functioning framework for partnership building, the establishment of a shared vision, and community engagement. Another key role for these committee structures appears to have been around negotiating different expectations during the planning and development phase.

Effective utilisation of reference or advisory committees that engage with local communities is likely to lead to services that better meet the needs of the community, as well as engage community members both in the design of services and use of services.

Service partners and local providers were often engaged within governance structures, although processes varied. In some jurisdictions the implementation of conceptual frameworks for development of localised service models appeared to facilitate structured engagement of service provider stakeholders. The Platforms model for service development appears to have been particularly influential in NSW, Victoria and Tasmania, and also incorporates a strong focus on engaging local service providers as well as other community stakeholders (Centre for Community Child Health, 2009).

The Platforms model is a place-based service redevelopment framework. It was developed by the Royal Children's Hospital Centre for Community Child Health in Victoria, and is intended to help communities build community partnerships to lead the reconfiguration of services, identify, plan and respond to the needs of their children, and monitor and evaluate their work to ensure outcomes for children are improving. The model is used to develop service linkages and partnerships in the particular context of a CFC's local environment, allowing each centre to tailor their service response.

TABLE 9 – CFC GOVERNANCE AND MANAGEMENT ARRANGEMENTS

JURISDICTION	MANAGEMENT AND GOVERNANCE
New South Wales	Centre operators appointed by competitive tender, resulting in a mix of community controlled and NGO operators. Local Reference Groups established in each CFC area, generally including community members, local Aboriginal organisation and partner agencies.
Victoria	Local Government and a church-based NGO were the original intended fund holders for the two Victorian CFCs. The NGO promoted the local ACCHO as the lead agency and the centre is now part of a community controlled health service. In the second instance, local government continues to be the fund holder, but the Centre operators are a community controlled entity.
Queensland	Centre operators appointed by competitive tender, resulting in a mix of community controlled and consortia of community controlled and NGO. Service agreements require appropriate advisory and partnership bodies to be established. Local Advisory Groups were established at the outset; some now discontinued or have evolved into subsequent governance structures.
Western Australia	Centre operators appointed by competitive tender, resulting in a mix of community controlled and consortia of community controlled and NGO. Most Centre Operators are closely engaged with a CFC Reference Group, while in some locations this group has evolved into existing or new community governance structures such as sub-committees of larger advisory bodies.
South Australia	Centre implementation and operation led by Department for Education and Child Development. Governance structures include a primarily internal Leadership Group, a Partnership Group engaging with other service partners, and a Parent Engagement Group focused on services, users and community.
Tasmania	Centre implementation and operation led by the Department of Education. Local Enabling Groups established to support development and implementation have in some instances moved into an advisory board role.
Australian Capital Territory	Centre implementation and operation led by the Community Services Directorate. Community engagement is achieved through consultation during development and is ongoing.
Northern Territory	Centre implementation and operation led by the Department of Education and Children's Services. ⁵ Various governance arrangements are in place depending on local circumstance; generally involve a reference or advisory group with significant influence on key decisions.

In SA, the governance approach adopted for all CFCs incorporates a specific Partnership Group engaging key service providers in the planning and provision of integrated strategies and directions to support achievement of CFC outcomes (Government of South Australia, 2013). This appears to facilitate a collective endeavour and may reduce 'competitive tensions'. In Whyalla, for example, the local enabling group (LEG) has evolved into a Partnership Group which has reportedly engaged a large number of providers who are supportive of the new CFC, rather than being concerned by the entry of a new service into the network.

⁵ Between 2012 and 2013 NT government introduced a brief amalgamation between Department of Education and Department of Education and Children's Services. This amalgamation is no longer in place.

Two broad stakeholder groups were consistently identified as a priority for engagement: local Aboriginal and Torres Strait Islander community members and organisations, and service providers providing services that were either in-scope for CFC integration or via a referral pathway.

All jurisdictions also report placing significant value on local contextual and community knowledge, which was recognised as a critical success factor for the CFCs. In all instances there appeared to be mechanisms in place for some form of engagement with strategic and operational decision making by the Aboriginal and Torres Strait Islander community, although this takes varying forms. Community members were the decision makers in community controlled CFCs, while in CFCs operated by government agencies or NGOs there were generally formal consultative mechanisms in place. In these circumstances, community members were provided a voice in the governance arrangements through the establishment of reference groups and advisory committees. The physical design of the CFC building was consistently cited as an example of community influence in the critical early stages. The extent to which these groups continue exert influence over decision making was not always clear, although it was reported in some jurisdictions that their initial influence remains.

The play area of Bubup Wilam Early Learning Children and Family Centre was also presented with the 'Children's Services' Award, in the Kidsafe 2012 National Playspace Design Awards. The Award recognised that the 'strong references to the local Indigenous community in this multipurpose playspace reflect a commitment to cultural recognition and understanding.'⁶ Although falling outside the period of focus for this report, the evidence of community engagement in delivering value to the design was also specifically recognised in the 2013 Award for Public Architecture received by the Geeveston Children and Family centre architects.

Engagement has also occurred through local advisory committees, which involve a mix of community and other members. The initial role of the local advisory committees was 'to work to get buy-in from key government partners and support the lead agency. [There is also] a focus on community engagement' (Field Notes, Queensland, 26 September 2012). The role of advisory committees appears to have changed in some instances since the development and implementation phase, with some transitioning to advisory bodies within formal governance structures associated with the ongoing operation of some CFCs.

Case study insights

Each of the case studies provided mixed perspectives on the extent of continuing engagement with community. The extent and intensity of community involvement in each of the sites has changed over time, as the services have matured. In the case of Ningkuwum-Ngamayuwu and West Belconnen, formal structures which had existed during conceptualisation and planning stages had dissolved, replaced by more ad hoc, informal mechanisms.

While such an evolution is to be expected, and in the case of the West Belconnen Centre, the dissolution of formal consultation structures was reported to have been intentional, there were some signs that each of the three CFCs could enhance their approaches to community engagement, particularly in the sense of ongoing participation in advisory forums. A useful ongoing focus for community engagement may be on understanding evolving community needs and in driving growth in service participation by Aboriginal families.

Engagement also occurs across Centres and the broader sector at the state-wide network level: in some jurisdictions (particularly those with greater numbers of CFCs), state-wide forums have been established. For example, in Queensland, for example, a state-wide implementation reference group has been established, on which peak Aboriginal and Torres Strait Islander bodies are represented. The level and implications of the different forms of community involvement or ownership of CFCs appears to be of some interest to stakeholders in the communities where CFCs have been established.

3.1.5.2 SEXUAL AND REPRODUCTIVE HEALTH

State and territory reports indicate that consultation and engagement with Aboriginal and Torres Strait Islander people has taken place through Element 2 funded programs in a range of ways, and at a number of levels (state-wide, regional and local levels). These have included engagement of state-level or regional forums, time-limited, specific purpose consultation projects, including, for example, local focus groups with Aboriginal and Torres Strait Islander communities). In some cases, community forums

⁶ *Bubup Wilam for Early learning recognised in national awards* (2012, October). Retrieved 23 September 2013 from <http://www.whittlesea.vic.gov.au/your-council/news-and-publications/news/bubup-wilam-for-early-learning-recognised-in-national-awards>.

provide ongoing forums for engagement and participation in the service planning process, and in the NT, a community development approach to ongoing community consultation has been used.

Ongoing engagement and participation in program planning and decision making has also in some cases been supported through service delivery partnerships with community organisations. Aboriginal and Torres Strait Islander organisations who are partners in service delivery are positioned to provide direct input to program design and delivery, but are also likely to be well positioned to leverage community networks to engage other organisations and key community members.

Activities undertaken as part of implementation have also provided forums for service engagement with communities (for example, educational forums on sexual and reproductive health issues). Aboriginal and Torres Strait Islander community members employed by Element 2 funded services are also frequently reported to have a critical role in developing and sustaining relationships with community, and providing a less formal mechanism for soliciting community feedback.

Some particular challenges have been reported in relation to community engagement and participation on sexual and reproductive health issues, reflecting sensitivities surrounding sexual health for some members of the community. There have also been challenges at the local level where key stakeholders have significant competing priorities and demands on their services.

3.1.5.3 MATERNAL AND CHILD HEALTH

Community engagement and participation through New Directions services has been strongly supported by the focus on funding ACCHOs. More generally, many New Directions funded services report conducting community consultations, using client surveys or establishing a community reference group in support of community engagement and participation in service planning and development. Engagement is also promoted through delivery of presentations, participation in community meetings and the utilisation of community-appropriate promotional and marketing collateral. At the national level, consultation with key stakeholders occurred through the state-based AHFs or their equivalent as part of planning for funding rounds.

Service delivery by or in partnership with Aboriginal and Torres Strait Islander organisations is also a common approach to support engagement with community for state and territory initiatives. In some jurisdictions, community engagement and participation is also supported by regulatory requirements for child and maternal health service providers to have in place formal strategies or action plans which document how they will enhance engagement with local Aboriginal and Torres Strait Islander communities and organisations.

Community consultation is generally reported to be a key element of state and territory funded Element 2 initiatives in support of engagement and participation. Specific strategies have commonly included community advisory or reference groups, as well as targeted development of linkages and relationships with local Aboriginal and Torres Strait Islander organisations and community groups, ongoing engagement or consultation with community Elders and other significant community members, and direct consultation with service clients.

The extent and success of community engagement is reportedly complicated by local factors in some instances. In Tasmania, engagement with communities at the local or ground level has reportedly been complicated by the relatively low rates of identification and non-homogenous nature of the Aboriginal and Torres Strait Islander population.

Similarly, workforce issues have presented challenges to community engagement in some jurisdictions, where it has been difficult to recruit and retain local staff with community networks and relationships and who have the required skillset to support maternal and child health services. These challenges have been ameliorated in some contexts through partnering non-Indigenous workers with community members who may act as brokers of engagement, or through seconding Aboriginal and Torres Strait Islander staff from other areas as an interim solution.

3.2 DATA AND REPORTING

Data and reporting issues at the national level are explored within 2.5 to 2.8 inclusive.

3.3 LONG TERM TRAJECTORY

The longer term child health and development outcomes articulated for the NPA IECD are not within the scope of this evaluation, as they were not expected to be realised within the life of the NPA IECD. These longer term outcomes are set out in context within the Program Logic model provided in Appendix A.

There is insufficient evidence at this stage to state with certainty that these longer term goals and outcomes will be achieved, although this evaluation has found that there are encouraging signs in the anecdotal evidence and earlier progress markers to suggest that there is a trajectory of improvement which will become clearer over time.

Continuing the development of consistent national and state-level data to inform ongoing monitoring and evaluation of reform outcomes is likely to be central to enabling questions about the ultimate success or otherwise of the NPA IECD to be answered.

A key data source for future assessment of the achievements of the range of investments associated with the NIRA and including the NPA IECD is the AEDI. As described earlier, the AEDI is an Australian Government supported research initiative that was completed in 2009 and again in 2012 (Centre for Community Child Health and Telethon Institute for Child Health Research, 2009; Australian Government, 2013). The published reports provide some evidence of improvement on a number of developmental markers between 2009 and 2012, including for Aboriginal and Torres Strait Islander children.

The NPA IECD is one of a number of initiatives that are likely to be influencing the results of the AEDI for Aboriginal and Torres Strait Islander children. AEDI results provide a picture of overall collective progress achieved through the suite of relevant interventions, including NPA IECD but also activities under the banner of closing the gap more broadly, as well as the National Partnership Agreement on Early Childhood Education and related early childhood initiatives.

Overall, the impact of the NPA IECD on AEDI outcomes for 2012 cannot be separated from the effects of other activities. Even if it were possible to separate the influences, any effect in 2012 is likely to be small. Given that the AEDI measures development in the first year of formal schooling, the focus of the NPA IECD on younger children means that the most of the cohort of children to benefit from NPA IECD initiatives may not have reached schooling age.

Analysis was undertaken on an unpublished AEDI data set to explore in more detail the change between the two time points for Aboriginal and Torres Strait Islander children in each state and territory, focusing specifically on the group rated as vulnerable. These data are presented in Table 10 following.

Across the domains of physical health, social competence, emotional maturity and communication, Aboriginal and Torres Strait Islander children are twice as likely to be rated as vulnerable than non-Aboriginal and Torres Strait Islander children. In the language domain Aboriginal and Torres Strait Islander children are nearly four times more likely to be rated as vulnerable. At the same time, the results also show an improvement across each of the domains of approximately two percentage points, with a marked improvement in language of 7.1 per cent. The degree of improvement between Aboriginal and Torres Strait Islander and non-Indigenous children is also significant, with a notable degree of change in the domains of social competence, language and communication.

The proportion of Aboriginal and Torres Strait Islander children considered to be developmentally vulnerable on at least one domain decreased between 2009 and 2012 by a statistically significant 5.2 per cent, compared to 1.6 per cent for non-Indigenous children. The proportion of Aboriginal and Torres Strait Islander children vulnerable on two or more domains decreased by 4.4 per cent, compared to 1.0 per cent for non-Indigenous.

All states and territories except for SA saw statistically significant improvement in at least one developmental domain. Statistically significant gains in the physical health domain at the national level were largely driven by a 10 per cent improvement in the NT. No other jurisdiction recorded a significant change on this domain for Aboriginal and Torres Strait Islander children.

The triennial AEDI survey will provide an important measure of progress in Aboriginal and Torres Strait Islander early childhood development. The next survey (scheduled for 2015) may begin to show the flow-on impacts of NPA IECD initiatives as the target cohort reach school age, although significant issues of

attribution will remain. What can be said is that overall, policies and programs implemented between 2009 and 2012 appear to have improved outcomes for Aboriginal and Torres Strait Islander children. Notwithstanding the relatively worse baseline position for Aboriginal and Torres Strait Islander children in 2009, these improvements substantially exceed those recorded for the non-Indigenous population.

TABLE 10 – PROPORTION OF AEDI SURVEY POPULATION RATED AS VULNERABLE IN 2012, AND CHANGE FROM 2009

	PHYSICAL HEALTH			SOCIAL COMPETENCE			EMOTIONAL MATURITY			LANGUAGE			COMMUNICATION			DV1			DV2		
	%	change		%	change		%	change		%	change		%	change		%	change		%	change	
NSW																					
Indigenous	17.7	-0.8		16.9	-0.2		12.9	0.5		14.8	-1.8	*	16.5	-1.1	*	36.7	-2.4	*	21.0	-1.5	*
Non-Indigenous	7.8	-0.4	*	8.0	-0.4	*	5.8	-1.4	*	4.2	-1.1	*	8.1	-0.7	*	19.0	-1.5	*	8.5	-1.2	*
All	8.3	-0.4	*	8.5	-0.3	*	6.2	-1.3	*	4.8	-1.1	*	8.5	-0.7	*	19.9	-1.4	*	9.2	-1.1	*
Victoria																					
Indigenous	20.7	1.1		16.4	-3.3	*	14.4	-4.2	*	20.3	-0.2		17.0	-1.9		39.6	-2.8	*	23.2	-3.4	*
Non-Indigenous	7.6	0.1		8.0	-0.3	*	7.1	-1.1	*	5.9	0.0		7.9	-0.3	*	19.2	-0.8	*	9.3	-0.5	*
All	7.8	0.1		8.1	-0.3	*	7.2	-1.1	*	6.1	0.0		8.0	-0.3	*	19.5	-0.8	*	9.5	-0.5	*
Queensland																					
Indigenous	19.1	-1.0		19.1	-1.4	*	14.8	-2.7	*	21.8	-13.6	*	20.8	-0.8		43.0	-7.7	*	25.8	-5.5	*
Non-Indigenous	11.0	0.6	*	11.0	-0.7	*	8.8	-1.8	*	8.2	-6.1	*	9.9	0.2		24.9	-3.4	*	12.8	-1.9	*
All	11.6	0.5	*	11.5	-0.7	*	9.3	-1.8	*	9.1	-6.5	*	10.7	0.2		26.2	-3.5	*	13.8	-2.1	*
WA																					
Indigenous	24.2	-0.5		17.7	-0.9		16.7	-1.6	*	30.4	-7.3	*	23.6	1.5	*	49.0	-3.5	*	30.1	-2.4	*
Non-Indigenous	8.7	-0.4	*	7.7	0.7	*	7.7	-0.4	*	7.0	-3.3	*	8.0	0.1		21.2	-1.7	*	9.9	-0.9	*
All	9.8	-0.4	*	8.4	0.6	*	8.3	-0.5	*	8.6	-3.5	*	9.1	0.2		23.0	-1.8	*	11.2	-1.0	*
SA																					
Indigenous	27.9	0.4		26.7	3.5	*	24.2	1.5		26.1	3.1	*	24.1	0.8		51.4	2.1		35.7	3.5	*
Non-Indigenous	9.5	0.2		10.6	1.0	*	8.7	-1.2	*	6.0	0.5	*	8.3	0.8	*	22.6	0.7	*	11.2	0.5	*
All	10.2	0.3		11.3	1.2	*	9.3	-1.0	*	6.8	0.6	*	8.9	0.9	*	23.7	0.9	*	12.2	0.7	*
Tasmania																					
Indigenous	17.6	-1.0		12.2	-1.9		12.4	-3.5	*	17.2	4.1	*	11.7	0.8		36.3	1.8		18.8	-2.1	
Non-Indigenous	9.3	-0.2		7.9	-0.6	*	7.8	-0.5		6.3	-1.1	*	6.2	-0.7		20.3	-0.9	*	9.4	-0.9	*
All	9.9	0.0		8.2	-0.5	*	8.1	-0.5		7.1	-0.6	*	6.6	-0.4		21.5	-0.4		10.1	-0.7	*
ACT																					
Indigenous	19.6	-3.2		19.8	4.9	*	19.6	5.7	*	10.4	-4.4	*	20.6	1.8		45.4	8.7	*	26.3	0.6	
Non-Indigenous	10.4	1.1	*	8.3	-0.4		6.9	-2.0	*	3.8	-1.7	*	7.9	-0.9	*	21.5	-0.5		9.5	-1.1	*
All	10.6	1.0	*	8.6	-0.3		7.2	-1.8	*	3.9	-1.8	*	8.1	-0.9	*	22.0	-0.3		9.8	-1.1	*
NT																					
Indigenous	26.0	-10.0	*	24.5	-9.3	*	23.4	-3.2	*	42.4	-7.7	*	26.3	-13.1	*	59.2	-9.2	*	38.2	-12.0	*
Non-Indigenous	8.2	-0.6		9.0	0.3		7.5	-1.1	*	7.4	-0.5		7.2	0.3		20.7	-2.1	*	10.2	0.5	
All	15.0	-5.7	*	14.9	-4.8	*	13.5	-2.8	*	20.8	-5.7	*	14.4	-6.7	*	35.5	-7.5	*	20.9	-6.6	*
Australia																					
Indigenous	20.4	-2.0	*	18.7	-2.0	*	15.6	-1.7	*	22.4	-7.1	*	19.9	-2.3	*	43.2	-5.2	*	26.0	-4.4	*
Non-Indigenous	8.7	0.0		8.8	-0.2	*	7.2	-1.3	*	5.9	-2.0	*	8.4	-0.2	*	20.9	-1.6	*	10.0	-1.0	*
All	9.3	-0.1		9.3	-0.3	*	7.6	-1.3	*	6.8	-2.2	*	9.0	-0.3	*	22.0	-1.6	*	10.8	-1.1	*

* Indicates change is statistically significant.

PART III: Jurisdictional achievements

4 Australian Government (New Directions)

4.1 SUMMARY OF ACHIEVEMENTS

Overall, New Directions services are delivering benefits for their local communities, although it is not possible to quantify these benefits. Common features of the program align closely with the evidence for what works in providing antenatal care, including implementation largely through ACCHOs, engagement of a significant number of Aboriginal and Torres Strait Islander staff, integration with primary care services, development of relationships and referral pathways with tertiary institutions and flexibility of service provision (Hunt 2006; Herceg 2005). Key achievements have included:

- Transition of the New Directions program to an ongoing program and funding of 85 organisations nationally.
- Flexibility in the funding guidelines which has supported local innovation and targeted service planning that directly addresses priority needs of local communities. The key example has been local efforts focused on overcoming transport and engagement barriers through outreach and home visit programs.
- Consistent anecdotal evidence of improvements in outcomes on a number of markers that are reportedly attributable to New Directions funded services. These include improvements to birth weights, immunisation rates and antenatal contact, and decreased rates of smoking, hypertension and diabetes in pregnant women.
- A substantial increase in the range and volume of antenatal, postnatal, and general maternal and child health services being provided through funded organisations.
- As 75 per cent of funded organisations are community controlled and a third of the front line roles funded by New Directions are culturally designated roles (i.e. generally reserved for Aboriginal or Torres Strait Islander people), the program has directly supported longer term development of increased capacity of Indigenous communities.

4.2 IMPLEMENTATION PROGRESS

The New Directions: Mothers and Babies Services program represents the Australian Government's own-purpose contribution to Element 3. The Australian Government initially committed \$90.3 million over five years to the New Directions program; however, the 2014-15 Budget provided additional funding to increase the number of services from 85 to 136 sites from 2015-16.

The New Directions program is intended to increase access to child and maternal health care for Aboriginal and Torres Strait Islander families, funding organisations to provide Aboriginal and Torres Strait Islander children and their mothers with:

- access to antenatal care
- standard information about baby care
- practical advice and assistance with breast-feeding, nutrition and parenting
- monitoring of developmental milestones, immunisation status and infections, and
- health checks for Aboriginal and Torres Strait Islander children before starting school.

New Directions services were funded in five annual 'waves' (commencing in 2007-08) and the program transitioned to an ongoing program from 2011-12. Against an original target of funding 82 service providers in 2012-13, the Department of Health and Ageing's annual report for 2012-13 noted 85 services had been funded (DOHA, 2013: 137). Fifteen funded organisations are located in urban areas, 38 in regional Australia and 32 are funded in remote locations (see Table 11). Within the grant assessment process, particular emphasis has been placed on the priority communities identified in the COAG's

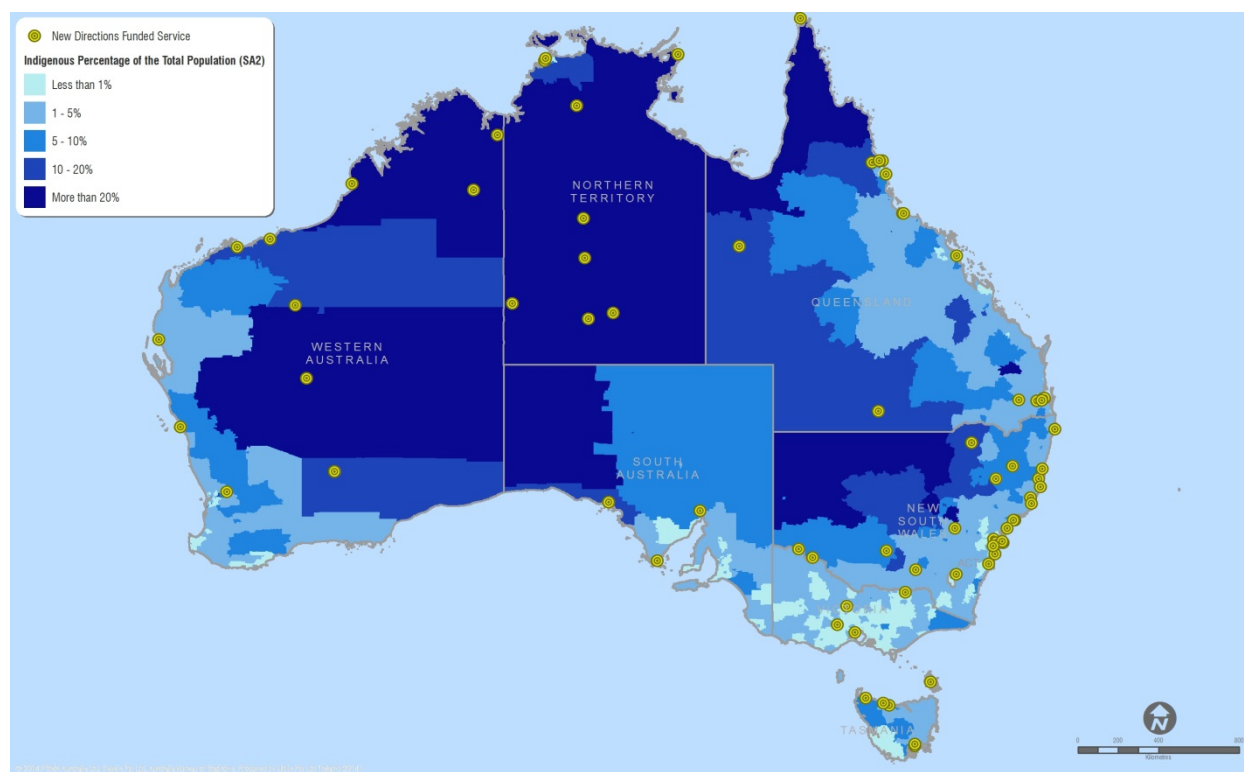
National Partnership Agreement on Remote Service Delivery (RSD NP). Organisation providing services to 12 of the 29 RSD NP priorities communities received New Directions funding.

TABLE 11 – 2012-13 NEW DIRECTIONS FUNDED SERVICES (BY STATE AND REMOTENESS)

STATE/TERRITORY	URBAN	REGIONAL	REMOTE (RSD NP COMMUNITIES)	TOTAL
NSW	6	18	-	24
Victoria	1	5	-	6
Queensland	4	5	8 (2)	17
WA	-	5	8 (3)	13
SA	-	1	3	4
Tasmania	1	4	1	6
ACT	1	-	-	1
NT	2	-	12 (7)	14
	15	38	32 (12)	85

Figure 4 shows the geographical distribution of New Directions funded services across Australia. It is important to note that the map shows the physical location of the funded services, not the communities where services are provided; in some cases (particularly in regional and remote areas), services may have quite extensive geographical service catchments. Nonetheless, Figure 4 does appear indicative of a geographically broad distribution of funding.

FIGURE 4 – LOCATION OF NEW DIRECTIONS FUNDED SERVICES



The types of organisations funded by New Directions include Aboriginal Community Controlled Health Organisations (75 per cent), state and territory government health services (19 per cent) and Medicare Locals (6 per cent).

The 2012 ANAO audit of New Directions implementation found that coordination of program effort under New Directions has been informed by other initiatives at the state and federal level that are directed at child and maternal health (ANAO, 2012, p22); and that collaboration between and within governments at all levels was evident in support of service integration (ANAO, 2012:p 50).

A key mechanism for fostering integrated services on the ground is the requirement for New Directions funded services to initiate and maintain linkages with other early childhood services in their region. Funded services are reported to have established strong linkages and partnerships with other health service providers in their region; there is also evidence that relationships and referral pathways extend to the broader child and family sector (DH 2013). Referral pathways are generally thought to be effective, although services identify that there remain some gaps in terms of access to specific referred services, including transport to enable access to services. Different approaches and network models reflect the varying circumstances, existing services system and the opportunities in each jurisdiction.

4.2.1 PUGGY HUNTER MEMORIAL SCHOLARSHIP SCHEME

Further to designating positions and funding community controlled services, investment in a sustainable workforce has occurred through the Puggy Hunter Memorial Scholarship Scheme, funded by the Australian Government and administered by the Royal College of Nursing Australia since 2002. The scheme aims to increase the representation of Aboriginal and Torres Strait Islander peoples in health professions and increase their professional health qualifications. Financial assistance is provided to Aboriginal and Torres Strait Islander peoples currently undertaking study in a health-related discipline at an Australian educational institute (Certificate IV level and above) in the areas of Aboriginal and Torres Strait Islander Health work, allied health (except pharmacy), dentistry/oral health (excluding dental assistants), medicine, midwifery and nursing.

Through the Puggy Hunter Memorial Scholarships Scheme, over 900 full-time and part-time scholarships have been awarded to eligible applicants since 2002 with a total of 621 scholarship recipients completing their studies between 2002 and 2013. For the 2014 cohort, offers have been made to 140 applicants.

4.3 OUTCOMES AND PROGRAM ACHIEVEMENTS

4.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

New Directions funded services provide a range of services which are expected to result in strengthened outcomes for individuals and families. While data to quantify impact is not available, there are strong and consistent anecdotal reports from program stakeholders that funded services are influencing outcomes for the better. Conversely, some funding recipients reported that the level of funding available was insufficient for them to make a significant impact in their communities, or limited their activities to only one aspect of child and maternal health (DH 2014, p 64-65).

Some of the diverse outcomes variously reported include some reductions in smoking among pregnant women, declines in hypertension and diabetes during pregnancy, improved antenatal contact, improvements in birth weights, increases in breast feeding rates, improved immunisation rates, decreased rates of anaemia in children, and improvements in engagement with fathers (DH 2014).

New Directions funded services report a high proportion of clients with existing issues such as health problems, housing instability and drug dependency prior to their pregnancies. New Directions services are frequently asked or expected by clients to assist with broader health and social issues in addition to antenatal care, postnatal care and child health services. In many instances the needs of clients for broader support is more immediate than the health needs in relation to their pregnancy. Significant time and staff resources can be spent on working with women to address these complex needs before they are able to deliver core maternal and child health services. While these efforts divert some resources from core activities, they may also be supporting outcomes for clients that are not captured within the program logic or reporting for New Directions.

While outcomes are variable across funded services depending on their focus of effort and local contextual factors, these reports are broadly consistent with the overall goals of the NPA IECD and suggest that New Directions is making a significant contribution to local outcomes.

4.3.2 INCREASING SERVICE ACCESS AND UTILISATION

There is limited data available on the uptake of New Directions funded services by Aboriginal and Torres Strait Islander people. In part, this is reported to be attributable to a range of barriers to data collection experienced by funded organisations (DH 2013, p 29). However, it is clear that New Directions funding has increased the number of organisations providing a diverse range of maternal, child and family health services. The types of services in which increased provision is reported as a result of New Directions included (DH 2014, Figure 1, p 24):

- antenatal consultations
- non-clinical support during birth
- postnatal check-ups
- child health and development checks
- education and/or health promotion activities
- mental health/social emotional wellbeing.

There was an increase in the proportion of organisations who reported providing each of these types of services post-New Directions funding. Most notably, organisations reported provision of antenatal consultations (73 per cent), postnatal check-ups (85 per cent), child health and development checks (83 per cent) as a result of New Directions funding, from a baseline of 58 per cent in all categories prior to New Directions (DH 2014, p 23-24).

The same survey indicated that in three categories of service (antenatal consultations, postnatal check-ups, child health and development checks), the proportion of organisations who reported currently providing services using funding sources other than New Directions noticeably *declined*. While overall, the proportion of funded organisations offering each type of service being delivered appears to have increased substantially, the drop in reported provision of those same service types through other funding sources may point to a funding substitution effect. On the data available it is not possible to confirm the presence or extent of impact of any cost-shifting that may be indicated.

Challenges faced in mainstream hospitals

It was the worse two weeks of my life - even when I got to the maternity ward I had to plead with the nurses to let me bathe her and they wouldn't. If it wasn't for the Port Augusta midwives I would be lost. They got me transferred back here and I was in hospital for two months because I was so stressed out by the whole thing in Adelaide. I got to eventually go home and they helped me to breast feed because I couldn't do it - they really hung in there with me.

Aboriginal mother

While service availability appears to have increased, it is also reported that more than half of funded services continue to experience some or significant difficulty meeting demand (DH 2014, p 43). Some of these challenges relate to difficulties securing the workforce, but at the general level is likely to reflect community utilisation of services. Ultimately, the increase in service availability, coupled with apparently high rates of service utilisation supports the contention that New Directions has directly increased access to child and maternal health services by Aboriginal and Torres Strait Islander people.

Direct access to services provided by the funded organisations is supported by referral pathways, generally being reported to be effective. While the strength of the referral pathways varied between organisations, almost all report mechanisms in place for ensuring appropriate referrals and follow up of clients (DH 2014, p 44-45). Of particular note is the high numbers of services referring to counselling, family support and drug and alcohol services which reflects the complex needs of the client group.

It is clear that a key enabler of localised success in the New Directions program is the flexibility afforded by the funding model. This enables funded organisations to respond to the unique needs of each community, as well as to coordinate with other programs to reduce the duplication of effort. The design of each program is based on an identification of gaps at each site. Outreach services are a common feature of funded programs, as are home visiting programs and service integration and partnerships with other services that already have 'touch points' with Aboriginal and Torres Strait Islander people, facilitating engagement by and with New Directions services.

4.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

There are no direct measures of how culturally accessible New Directions services are; however the high proportion of funding that has been directed to community controlled organisations is strongly suggestive that the outputs resulting from input funding are delivered in culturally accessible ways. Engagement of Aboriginal and Torres Strait Islander people within health services is a well-recognised strategy for supporting cultural safety and accessibility. A high proportion of the total staff engaged through New Directions funding include Aboriginal Health Workers, Aboriginal Material and Infant Health Workers or Aboriginal Health Education Officers.

New Directions services generally report having formal or informal agreements with the relevant hospitals in their areas, seen as key to addressing barriers to accessing care for Aboriginal and Torres Strait Islander clients. The importance of these relationships is underscored by the challenge faced by Aboriginal and Torres Strait Islander women giving birth in hospitals, issues which are "magnified when there is not an environment that promotes cultural safety..." (DH 2014, p 62) While in general, these relationships appeared to be positive, ten per cent of respondents to the DH survey reported that the relationship between the service and the hospital was a barrier for the success of the program (DH 2014, p 62).

There is also evidence of a range of relationships outside the health sector, with 60 per cent of respondents reporting a partnership (formal or informal) with community services, 55 per cent with schools, and 50 per cent with early childhood education services (childcare or preschool) (DH 2014, p 45). Referral pathways also existed with a broader network of services, with more than half of funded services reporting referrals including parenting support, social work and family support services (DH 2014, 46). While these partnerships and referrals were evident at the organisational level, the extent to which the relationships influenced or integrated with operation of the New Directions funded services is not clear.

Mawarnkarra health service mums n bubs, Roebourne (WA)

"The way we have provided the program has changed over the years at the request of the local community to meet their needs. Initially clients came to the clinic but response was poor so a vehicle was leased in case transport was a strong barrier. However providing a home / community based service appears to be the outright winner. We pack daily a parents medical bag and infant / child medical bag. These bags contain screening equipment and basic over the counter medicine i.e. Panadol baby drops. Each day we go to the homes to screen clients as per our computer recall list. Mawarnkarra's female General Practitioner accompanies us once a fortnight to perform an ultrasound (foetal) and print off pictures for clients and their families. We believe that this ultrasound procedure has increased our clients' requests for ante natal screening. The visual images of the growing foetus appear to reinforce that no alcohol and no drugs can make the foetus stay healthy."

"Engaging the whole family is a vital component of this program. With cultural respect being upheld, and with the clients consent, all family members are involved in all aspects of antenatal, postnatal and parenting. The program is unique as the team's daily workload is structure as per the clients' request, i.e. Either home visit or at a location that suits the client. The clients love the fact that all their family can be involved with the screenings and there is no waiting time to be screened! Holistic primary health care provides a clear picture of the client's total needs and so appropriate care and strategies can be developed to have healthy outcomes."

This case study is an extract of an article that originally appeared in the September 2011 new directions mothers and babies services e-newsletter

4.3.4 BUILDING AND STRENGTHENING CAPACITY

New Directions has delivered funding to 64 Aboriginal Community Controlled Health Organisations (ACCHOs). This funding has enabled employment of specialised child and maternal health staff within ACCHOs (DH 2014, p 26), allowing these services to build on existing primary care capabilities and

community relationships and an existing culturally safe context. In the large majority of organisations, New Directions activities are integrated (although not exclusively) into primary care services (DH 2014, p 25).

Twenty-five per cent of funded organisations are public health services and Medicare Locals, which in general are perceived by Aboriginal and Torres Strait Islander people to be less culturally secure than ACCHOS. New Directions funding to these organisations has enabled capacity building of a different nature, facilitating enhancement of mainstream services in ways that increase capacity to operate in a culturally secure way.

The workforce engaged through New Directions funding provides insight into the nature of the capacity strengthening. A survey of funded organisations undertaken in 2012 solicited information from 54 respondent organisations about the type of roles they employed and the total full-time equivalent (FTE) staff across these roles (DH 2014, p 26-27). Re-analysis of data provided on 215 FTE roles funded in the respondent organisations shows that less than ten per cent of FTE were allocated to administrative or program management roles, with the remaining FTE assigned to service delivery functions (see Table 12).

TABLE 12 – MOST FREQUENTLY FUNDED NDMB ROLES (RANKED BY PROPORTION OF TOTAL FUNDED FTE)

PROFESSION/ROLE TYPE	PROPORTION OF TOTAL NDMB FUNDED FTE
Nurse – Midwife (including students)	23%
Aboriginal Health Worker or Aboriginal Health Education Officer	20%
Nurse - Child and Family Health Nurse	15%
Aboriginal Maternal and Infant Health Worker	13%
Administration and program management	9%

Data source: DH 2014, p 26-27.

Specialised nursing and midwifery roles (including students) consumed the largest proportion of the total FTE (38 per cent of all FTE). Culturally designated roles including Aboriginal Health Workers, Aboriginal Maternal and Infant Health Worker and Aboriginal Health Education Officers made up 33 per cent of New Directions funded FTE.⁷

Employment of staff is the most frequently reported investment of New Directions funding, reported by 96 per cent of funded organisations. However, 80 per cent also report investment in staff training, and a high proportion in other capacity-building resources including vehicles, equipment and information technology. New Directions has enabled services to expand and enhance their service offering through engagement of skilled staff, and in many cases improve service 'reach' and engagement through home visiting services.

4.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Three quarters of New Directions funded services are ACCHOs which are generally key organisations integrated within their local communities. The most common mechanism reported for soliciting community input and/or feedback is reported to be through client surveys (61 per cent). More than half of funded organisations also report having undertaken community consultation, while just over 40 per cent report having a formal community reference group associated with New Directions services (DH 2013, p 45).

Strategies employed to promote New Directions services within the community consistently include delivery of presentations or talks, or attending community meetings, or through other community consultation activities. Promotional collateral and other marketing strategies have also been employed (DH 2014, p 75).

⁷ It is not known what proportion of these roles was filled by Aboriginal and Torres Strait Islander people. However, these roles are often reserved for or 'designated' for Aboriginal and Torres Strait Islander people.

At the national level, consultation with key stakeholders occurred through the state-based Aboriginal Health Forums (AHFs) or their equivalent. Participation in AHFs varies between jurisdictions but includes the National Aboriginal Community Controlled Health Organisation (NACCHO) or affiliates in the relevant jurisdiction, as well as representatives from the state or territory government and the Australian Government. A key purpose of engagement with ACCHOs within these forums was reported to have been to facilitate planning to ensure that “services and investment were rolled out in a coordinated and complementary way, taking into account existing services delivered by state/territory governments and the community controlled sector” (DoHA, 2012).

4.3.6 DATA AND REPORTING

The AIHW has been commissioned by the Department of Health to collate national data for the health related PI 5-10, and to date has produced two annual reports (AIHW 2012; AIHW 2013a).

In 2012, an Australian National Audit Office (ANAO) Report found that there was limited performance data available for which to determine the extent that activities being delivered as part of New Directions are having an impact. The report stated that the data collected only captured the number of service providers being funded as a proxy indicator for improved access. At the Australian Government level, the report also concluded that assessing the effectiveness of the implementation of New Directions was challenging because of a range of influencing factors such as housing, education, employment and other social determinants of health.

In response, the (then) DoHA engaged a contractor to undertake a Descriptive Analysis of New Directions Mothers and Babies Services program which was completed in March 2013 and published on the Department’s website in 2014 (DH, 2014). The analysis provides a description of the services being provided under New Directions and how these services meet the objectives of the program. The Descriptive Analysis also included exploration of data and reporting issues, and concluded that while “data collection is an important component of measuring performance this needs to be balanced with the capacities and needs of services to collect and provide relevant and meaningful data...” (DH 2014, p 62).

Efforts are underway to improve performance monitoring and reporting, with New Directions funded services required to report on national Key Performance Indicators (nKPI) since July 2013. The nKPIs include outcome information related to birth weight, child immunisations, maternal health, antenatal care and (from July 2014) smoking status during pregnancy. These data were not available at the time this report was being prepared.

5 New South Wales

5.1 SUMMARY OF ACHIEVEMENTS

Implementation of the NPA IECD in New South Wales has been largely successful across all three Elements. Key achievements include:

- Evidence that CFC services are reaching community members who may not otherwise engage in key services, with uptake of services high across operational CFCs; and, critically, two-thirds of parents accessing services were doing so for the first time
- A focus on community engagement and capacity building across all Elements, with extensive examples of community partnership and collaboration that not only increases service access, but which also serve to increase the capacity and skills within communities
- An increase in Aboriginal and Torres Strait Islander teenagers and pregnant women accessing prevention and early intervention sexual and reproductive health and/or mental health and drug and alcohol services within existing culturally safe services
- Aboriginal traineeships within Mental Health, Drug and Alcohol Services which have built Aboriginal workforce capacity in NSW
- The implementation of proactive strategies, which were often focused on investment in training and development to overcome issues associated with the recruitment and retention of Aboriginal and Torres Strait Islander staff in order to provide services in NSW.

5.2 PROGRESS ON IECD ELEMENTS

The implementation of NPA IECD has been broadly successful, although the establishment of CFCs has been slower than anticipated, due to delays in construction. A total of nine of CFCs have been funded in NSW under Element 1, with seven being fully operational and others still being constructed.⁸

Element 2 commitments include the delivery of eight Mental Health Drug and Alcohol Services (MHDAS) across selected Aboriginal Maternal and Infant Health Service (AIMHS) sites with assertive outreach to outlying areas. A separately funded initiative is the operation of ten teenage sexual and reproductive health services. In addition to program implementation, there has been a focus on social marketing and awareness-raising activities, with two social marketing campaigns being implemented in line with Element 2 commitments. These include the release and evaluation of 'Stay Strong and Healthy — It's Worth It' campaign, and the implementation and evaluation of the 'It's Your Choice! Have a Voice! Rights, Respect and Responsibility' campaign.

Element 3 activities centre on the establishment and operation of 15 BSF for Aboriginal Children, Families and Communities services. Take-up of BSF services is high, remaining above 90 per cent across the program as a whole, with some services achieving up to 100 per cent within each reporting period. The majority of BSF clients have been referred through maternity hospitals and AIMHS services. NSW has also implemented the Aboriginal Housing and Accommodation Support Initiative (AHASI) under Element 3. AHASI is designed to assist people with mental health problems and disorders who require accommodation and support.

5.3 PROGRESS AGAINST PERFORMANCE INDICATORS

Table 13 shows a snapshot of performance against the indicators agreed for the NPA IECD. It should be noted that in most instances, significant qualifications are attached to data items and these should be interpreted with caution.

⁸ By June 2014, all NSW CFCs are expected to be completed and operational.

TABLE 13 – NSW PROGRESS REPORT CARD

PERFORMANCE INDICATOR	JURISDICTION RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	In NSW, 92.1 per cent of 0-8 year old Aboriginal and Torres Strait Islander children accessing services in the through CFCs in the census week were reported to be fully immunised for their age, and 80.1 per cent had received the latest age-appropriate health checks, and 78.6 per cent were up-to-date in both immunisations and health checks.
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 3,121 NSW Aboriginal and Torres Strait Islander children recorded as enrolled in (and 2,996 attending) preschool programs in the year before full time schooling, representing 4.5% of all enrolled (and 4.4% of attending) children. A total of 2,269 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 5.6% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	During the 2013 census week in NSW, 393 families and 229 Aboriginal and Torres Strait Islander children accessed services at or through CFCs in NSW.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	The age-standardised rate of access by Aboriginal and Torres Strait Islander mothers in the first trimester was 72.2% in 2010. The age-standardised rate rose from 67.7% to 72.2% between 2007 and 2010, although this increase was not statistically significant. (AIHW 2013b).
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	No data was reported by the AIHW for NSW against this indicator.
7. Reduced proportion of Indigenous babies born with low birth weight each year	In the period 2008-2010, 10.1% of babies born to Aboriginal and Torres Strait Islander mothers in NSW were of low birth weight, compared to 4.2% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers aged less than 20, the proportion of low birth weight babies is 11.5% compared to 6.4% among non-Indigenous mothers (AIHW 2013a). The NSW Chief Health Officer's Report 2012 reports that there has been a significant decrease in the proportion of babies of Aboriginal and Torres Strait Islander mothers who are of low birth weight, for the period 2001 to 2010 (Centre for Epidemiology and Evidence, 2012)
8. Reduced mortality rate of Indigenous infants each year	The NSW Chief Health Officers Report 2012 reports that there has been a significant decrease in the Aboriginal infant mortality rate over the past 10 years, from 10.9 deaths per 1000 live births (in 1999 to 2001) to 5.2 deaths per 1000 live births in 2008 to 2010, and a significant decrease in the gap between Aboriginal and non-Aboriginal infant deaths (Centre for Epidemiology and Evidence 2012).
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	In 2010, the crude proportion of Aboriginal and Torres Strait Islander mothers in NSW aged less than 20 who reported smoking during pregnancy was 50.1%, compared to 29.4% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers older than 20, the crude proportion who reported smoking during pregnancy was 48.2% compared to 9.5% of non-Indigenous mothers (AIHW 2014). Between 2007 and 2010, the rate of smoking during pregnancy fell by a statistically significant 2.2% for Aboriginal and Torres Strait Islander mothers. In 2008, the proportion of Aboriginal and Torres Strait Islander mothers in NSW who reported drinking alcohol during pregnancy was 17.4%, while 3.9% reported using illicit substances. The latter figure has a relative standard error of between 25% and 50% and should be used with caution.
10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	In the period 2009-10 to 2010-11, hospital separation rates for Aboriginal and Torres Strait Islander children in NSW aged under 5 was 285.6 per 1000, compared to 238.7 per 1000 for non-Indigenous children (AIHW 2013a). Between 2004-2005 and 2010-2011, the rate of hospital separations for Aboriginal and Torres Strait Islander children in NSW aged under 5 increased by 26.6%.

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by AHMAC.

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

5.3.1 ELEMENT 1

NSW received \$74.7m in Commonwealth funding over six years to establish nine CFCs. The implementation and operation of the CFCs has been overseen by both the Department of Family and Community Services (Communities and Early Years) and the Department of Premier and Cabinet. A two-phased approach to implementation was undertaken, with the first phase including Doonside, Ballina and Campbelltown. Mt Druitt, Toronto, Nowra, Brewarrina, Gunnedah and Lightning Ridge were identified as CFC sites in Phase 2.

During the development phase of the CFCs, Local Reference Groups (LRGs) were established in each location, which advised government on the location and service mix within each CFC. Consultation on preferred sites was conducted across the state with major Aboriginal and Torres Strait Islander peak bodies via the NSW Two Ways Together Coordinating Committee. The selection of CFC sites was also informed by an analysis of demographic data and regional advice from NSW agencies, including an assessment of service system capacity; opportunities to build on current service; and the existence of community governance networks to assist the development of the centres.

CFCs are managed by lead agencies that were engaged through a tender process, and are supported by state-wide initiatives designed to assist implementation, including the Platforms model. Local consultative mechanisms that build engagement with the Aboriginal and Torres Strait Islander community have been a feature. These have included advisory boards and community working parties, which commonly include a high proportion of Aboriginal and Torres Strait Islander people.

The delivery of services under Element 1 was significantly affected by delays in the construction of facilities. Delays were attributed to obstacles encountered in securing suitable land, obtaining local planning approval and gaining community endorsement.

5.3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

A quarter of all families who have accessed any services through CFCs have engaged with parenting and family support programs. Comments from CFC leaders and staff suggest that accessing parenting and family support programs are likely to impact on the capability of parents to meet their children's development needs. Several CFC leaders reported observing a change in parental behaviour as a result of engaging in CFC programs. Other CFC leaders reported that parents had stated that they felt more confident in knowing what to do for their children and as a result, were able to identify times when their children may require additional support. Leaders also suggested that parents showed greater confidence when approaching health service providers, including health and education providers, when they were unhappy with the service they were receiving.

The impacts that the CFC services can have on individuals and families is exemplified in the story related during fieldwork of a parent who attended a session on ear health at the CFC, and subsequently discovered through a referral to an ear health service that all four of her children required intervention. Services were then provided to the entire family as a result of her engagement with the CFC.

5.3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

CFC services are reported by stakeholders to have been embraced by the community. These anecdotal reports are supported by the significant number of service providers engaged, the range of services provided, as well as evidence of increasing community use. Reporting in NSW indicates that more than 200 service providers are engaged to provide services; and that 30 types of services are provided to children and 35 to families. During the census week 2013, a total of 393 families and 229 Aboriginal and Torres Strait Islander children accessed services. In addition, one-quarter of the families who have accessed services through CFCs, have engaged with parenting and family support programs. CFCs have experienced full enrolment of early childcare places that have been made available.

In terms of take-up of the range of services provided, CFC staff and leaders are able to provide a number of examples where engagement with CFCs has resulted in increased service access and utilisation more broadly. As an example, Shellharbour service users were successfully being referred to, and consequently accessing, a range of early childhood services, including hearing services, ear, nose and throat specialists, paediatric, MACH services, and dental services.

A key achievement of NSW CFCs appears to be their success in reaching members of the community who have not accessed services in the past. Sixty-five per cent of parents accessing CFCs had not

accessed services previously. Staff at several CFCs report receiving regular feedback from parents that engagement had resulted in them accessing health services that they had not previously accessed, either because they were not aware the services were available, or because they were not confident using, or approaching services.

A key enabler to increased access and service use is the friendly, approachable and culturally appropriate environment that staff have created across the different staffing models of CFCs. Parents who had accessed CFCs note that the ability for staff to put them at ease and provide information in way that was non-confrontational and inclusive was critical in their decision to engage:

When I came here, I got that warm feeling

Aboriginal mother, Yenu Allowah

They listen and understand what you want – they don't just have their view

Aboriginal mother, Cullunghutti

A barrier to growth in service access and use, however, has been difficulty in recruiting and retaining staff. Challenges to recruitment were reported by many NSW CFCs, with key concerns related to difficulties filling advertised positions, and a shortage of appropriately qualified applicants. Recruitment and retention issues were also attributed to a lack of appropriate support for staff to 'deliver on the enormous brief, and the unique challenges associated with working in one's own community' (CIRCA, 2013, p.23). CFCs have adapted their recruitment strategies to mitigate these issues, with most CFCs experiencing difficulty adopting workforce-building strategies, including the offering of training pathways to qualifications. A challenge now will be maintaining the workforce for a prolonged period, building internal capacity and ensuring that parents continue to feel comfortable engaging with staff from CFCs

Facilitating access

Cullunghutti aboriginal cfc has a purpose-built outreach trailer that enables staff to travel to isolated parts of the community to provide early learning activities, parenting programs and community events. Through a media strategy the centre provides regular editorial up-dates on the centre's development and upcoming events. A facebook page enables young parents from playgroups and programs to stay in contact and be continually updated about opportunities.

5.3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

All CFCs in NSW employ processes that contribute to the provision of culturally appropriate services, which engage parents in a culturally respectful manner. High proportions of Aboriginal and Torres Strait Islander staff and high levels of local community involvement in the planning and operating of services, aim to ensure CFCs are respectful of Aboriginal and Torres Strait Islander culture.

The value of these two approaches is reflected in comments by senior officers, who feel that the high level of involvement of local community members and Aboriginal organisational staff on LRGs has underpinned the adoption of culturally appropriate practices. Local communities are highly engaged in all but one CFC site and many of the partner organisations identified by NSW CFCs are Aboriginal and Torres Strait Islander controlled organisations. In several cases, the agency that operates the CFC is an ACCO.

A focus on culture

Wininga-li CFC has employed a number of strategies that are designed to ensure that all services are implemented in a culturally appropriate manner – with much of this focus being the result of the 100 per cent aboriginal staff model employed by this CFC. Local language is embedded in all aspects of the centre, and a local language nest is being developed to pass language to children accessing the centre. Local elders also play a key advisory role, providing guidance and community endorsement for practices employed within the CFC.

The role that parents play in the provision of culturally accessible services is also critical. Parents contribute considerably to the implementation of culturally appropriate services and practices within CFCs and parents from almost all sites report being actively involved in decision-making at all levels, from the provision of food through to the program topics and design of the centre.

5.3.1.4 BUILDING AND STRENGTHENING CAPACITY

Building capacity across service providers is critical and a significant range of partnerships and collaborative relationships have been formed across NSW, including 'MOUs, service level agreements, cross promotion, informal relationships, joint funding agreements, sub-contracts, joint training activities, and brokerage agreements for specialist interim service providers' (IECD NSW Bi-Annual Report 1–30 June 2013, NSW, p5). While the maturity of these relationships may vary from service to service and region to region, it is likely that these partnerships are having an effect on the capacity of the local community to provide culturally appropriate and high quality services for Aboriginal and Torres Strait Islander community members.

There is also some evidence that the benefits associated with the ways of working modelled by CFCs can extend beyond services directly affiliated with the CFCs. Winanga-Li CFC reported that their approach to partnership and collaboration with external providers has resulted in these providers reviewing how they may work in a similar way with other local services:

We have had feedback from external service providers to indicate that they are now giving more consideration to the way they work with other services as a result of having seen the benefits of working in an integrated way with Winanga-Li.

IECD NSW Bi-Annual Report, 1 January–30 June 2013, p53

As noted, CFCs reported difficulties with recruitment and retention, and while this has impacted negatively on the ability of CFCs to facilitate increased access, a positive outcome has been the contribution that CFC activities make to community capacity building, including CFC efforts to train and skill the local workforce. Several CFCs across NSW are in the process of implementing formal training initiatives and have focused on recruiting local community members who undertake formal training as part of the role. For example, the Nikinpa CFC is developing a childcare training program which will enable community members to qualify for childcare positions at the CFC and elsewhere. These training pathways contributes to the development of a local workforce, which in turn likely to support capacity strengthening within the community.

Capacity building for a wide range of stakeholders, including staff, lead agencies and community controlled agencies, will be important to the ongoing success of CFCs. The strategies to overcome difficulties, including identifying community staff with requisite skills, will continue to be critical.

5.3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Across NSW, there is a high degree of engagement in CFCs by local community members, which has included a high level of participation in the setting up of the centres, the design of services, as well as the identification of service gaps.

All centre managers were required to undertake consultation with the local Aboriginal and Torres Strait Islander community and service network to develop a strategic plan outlining centre priorities and strategies, as part of the establishment of CFCs. A consequence of this high degree of community engagement has been the development of a network of more than 70 Aboriginal and Torres Strait Islander leaders in NSW who are directly involved in the delivery of CFC services, by providing strategic input, increasing community engagement in CFCs and participation in services.

A facilitator of community engagement and participation has been the LRGs, which from the implementation phase, have encouraged involvement in both the design and development of CFCs. Senior officers and CFC leaders felt that this early engagement in aspects including the selection of sites, development application processes and staff recruitment had resulted in the community taking ownership of the CFC and its services. In turn, other members of the community were encouraged to participate in the CFCs because of a reduction in fear and an increased confidence to participate. For example, parents who had accessed the Yenu Allowah CFC consistently identified with the 'brand' and felt a strong sense of ownership in the CFC, which underpinned a willingness to engage and participate in the life of the centre.

It's an identity for all of us — we're choosing to come.

Parent, Yenu Allowah CFC

Another approach to community engagement in NSW has been a focus on the employment of local Aboriginal and Torres Strait Islander people in key roles, which has built engagement with the centre and increased a sense of community ownership. In particular, 'the employment of local Aboriginal community members to key roles within the centre, e.g. as centre manager, family connectors, were seen as critical for generating a sense of pride and community ownership, and enhancing community engagement' (CIRCA 2013, p32).

NSW reporting highlight relatively few barriers related to engaging the community in CFCs and services. The only exceptions here are the impact that local family tensions can have on the willingness of some individuals to engage and participate in both the practicalities of CFCs and the overarching governance arrangements and difficulties recruiting and retaining local staff.

5.3.1.6 DATA AND REPORTING

NSW indicates that there is an emerging focus on the integration of standardised data collection and reporting tools that will contribute to evidence-based decision-making. The NSW approach to developing reporting measures is a results-based accountability framework, which, if implemented would deliver useful data for policy development and to refine implementation. SmarterSoft have been engaged to develop an online mechanism for data collection and reporting, although at the time of writing this report, there was no evidence about the impact of SmarterSoft on data collection and reporting processes. The ACFC data portal was developed to as a pilot to improve data collection and reporting. However, due to lack of training and familiarity, the portal was under-utilised during implementation. This portal was reported to be under review, ready for improved reporting to assist informed decision making post June 2014.

An interim evaluation of CFCs in NSW has been completed by the Cultural and Indigenous Research Centre of Australia (CIRCA), with qualitative interviews being conducted between October 2012-May 2013. A total of 75 people were interviewed and results have been presented to five CFCs during LRG meetings; there is ongoing discussion with CFCs and other key stakeholders about key learnings gathered as part of this evaluation (CIRCA 2013). A final report is expected in August 2014.

5.3.2 ELEMENT 2

NSW received \$26.8 million over six years for the implementation of Element 2 activities. A range of actions have been undertaken to achieve state-wide goals, including:

- the implementation and operation of eight MHDAS into AMIHS
- the implementation and operation of ten sexual and reproductive health services through the NPA IECD's sexual and reproductive health program (S&RH), with two of these being established within Area Health Services (AHS) and six within ACCHOs
- the development and implementation of two marketing and awareness raising activities, specifically the 'Stay Strong and Healthy — It's Worth It' campaign and the implementation and evaluation of the 'It's Your Choice! Have a Voice! Rights, Respect and Responsibility' campaign
- the commissioning of an evaluation of the MHDAS to assess effectiveness and achievements against milestones
- an evaluation of the S&RH program undertaken by the Kirby Institute.

As part of the implementation of Element 2 activities, consultation and input was sought from a range of key stakeholders, including the Aboriginal Health and Medical Research Council (AH&MRC) and the AMIHS.

5.3.2.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

There is some evidence that engagement in Element 2 programs has had a positive impact on individuals and their families.

With regard to S&RH services, there has been an almost 30 per cent increase in Aboriginal and Torres Strait Islander people attending the services since implementation, and of those people, between 10 and 20 per cent had a chlamydia/gonorrhoea test. Analysis of GRHANITE data also indicates that there has been a two per cent increase in the number of females tested for chlamydia/gonorrhoea; and a forty per cent rise in males being tested. Importantly, after being involved in S&RH services, young men had a higher degree of knowledge about sexual health; were more comfortable talking to people about sexual and reproductive health; felt more comfortable asking their partner to use a condom; and used condoms more often (NPA IECD Element 2 Progress Report, July–December 2013, NSW, p10).

Similarly, comments from key stakeholders indicate that MHDAS services may have an impact beyond the primary contact. Senior officers felt that the MHDAS model differs to the usual acute care focus, because the approach was viewed as assisting not just the mother, but also the child, who benefits from the early supports established around them. MHDAS provides services to approximately 300 women per annum.

There is also some evidence to suggest that the "Stay strong and healthy – it's worth it" awareness campaign has had an impact on attitudes and behaviours, with the effects extending to positive outcomes for individuals and families. For example, prior to the campaign being launched, 48 per cent of parents surveyed indicated that alcohol or other drug use during pregnancy was a serious issue, a figure that increased to 71 per cent after the campaign. This attitude change has the potential to directly impact on outcomes for individuals and families as a result of a reduction in negative behaviour.

5.3.2.2 INCREASING SERVICE ACCESS AND UTILISATION

A key focus of Element 2 investment in NSW has been on increasing access for Aboriginal adolescents to S&RH. An analysis of comparative data suggests that this investment is having an impact. Since the implementation of S&RH program activities, NSW reporting shows an almost 30 per cent increase in the number of young people, including young Aboriginal and Torres Strait Islander women, attending services. Young men in particular, are more likely to utilise S&RH services as a result of Element 2 activities, with an almost 40 per cent increase in testing rates for chlamydia/gonorrhoea since the inception of the S&RH program. Encouragingly, reporting also indicates that S&RH program activities are promoting young people to attend Aboriginal Community Controlled Health Services (ACCHS) and as a result, engage with broader health services.

Comments from key stakeholders also provide evidence of the impact of activities under Element 2 on access and utilisation of antenatal services. Staff report that the MHDAS project has increased the opportunity for Aboriginal and Torres Strait Islander pregnant women, their partners, families and community members to access culturally safe prevention and early intervention mental health, drug and alcohol services. Key facilitators to this increased access are: the co-location of MHDAS clinicians and Aboriginal staff in selected AMIHS; community engagement with local Aboriginal community members; health promotion activities; developing partnerships and working alongside community members; and developing referral and clinical pathways between MHDAS and other health services. The above have contributed to reducing stigma and increasing service utilisation.

Reaching a broad audience base

As part of Element 2, the 'Stay Strong and Healthy — It's Worth it' social marketing campaign was implemented across NSW.

The campaign aims to raise awareness among Aboriginal pregnant women, their partners families and community members about the risks of drug and alcohol consumption and the challenges of mental health issues during pregnancy. Campaign resources, which include storybooks, posters and postcards have been extensively distributed, with the initial print-run being exhausted after one month.

Since July 2012, over 40,000 resources have been distributed across the state for use by community members. Online access is also evident, with more than 50,000 visits to the campaign facebook site being recorded.

The MHDAS service model also includes assertive outreach to increase access in some remote communities such as Wilcannia, which increases service access to community members in this remote service delivery site under the NPA IECED.

5.3.2.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

The provision of culturally appropriate and culturally accessible services was recognised as one of the key challenges to ensuring that young people engage with sexual health issues, and feel comfortable approaching Element 2 services. As a result, there has been a systemic and program-specific focus on the provision of culturally appropriate and accessible services in NSW.

Contributing to culturally safe and accessible service provision under MHDAS is the 'Respecting the Difference' cultural training framework and policy, which complements existing cultural competency training in Mental Health Drug and Alcohol directorates in Local Health Districts, which are specific to Aboriginal and Torres Strait Islander communities.

Ongoing engagement with the Aboriginal and Torres Strait Islander community at both state and local levels has provided opportunities for community stakeholders to express their views about culturally safe services. Feedback from local Aboriginal community focus groups indicates high program acceptability with Aboriginal clients and communities, with cultural safety being seen to have played a large part in this level of acceptance. Aboriginal clients valued a 'one-stop shop' approach reducing stigma and assisting service transitions. Strong links with state-wide infrastructure through the Aboriginal Health and Medical Research Council AH&MRC of NSW were also seen by senior officers as supporting people to work more appropriately on the ground to provide culturally safe and accessible services under Element 2.

5.3.2.4 BUILDING AND STRENGTHENING CAPACITY

Capacity building has been primarily linked to the incorporation of Aboriginal and Torres Strait Islander traineeships linked to MHDAS. Eight Aboriginal traineeships have been funded, which has resulted in increased Aboriginal workforce capacity in the area of drug, alcohol and mental health, with a focus on the area of maternal and child health.

There has also been considerable emphasis placed on strengthening clinician and trainee capacity through the provision of the latest evidence-based information. The MHDAS Online Resource Toolkit was released in October 2013, and has been developed by the Training and Support Unit for Aboriginal Mothers, Babies and Children's Programs to support MHDAS clinicians and Aboriginal trainees. Data related to this resource is being collected by the Health Education Training Institute.

Challenges associated with recruitment and retention have had an impact on the ability of activities under Element 2 to build and strengthen community capacity. For example, in Walgett, rural and remote workforce shortages means that staffing positions are based in Bourke, where the recruitment pool is considered to be stronger, and outreach services can be provided to Walgett and Lightning Ridge from there. Access to a consistent pool of local community members with requisite skills to assist in the implementation of Element 2 activities will continue to be a challenge to building community strength and capacity.

5.3.2.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Considerable community consultation and engagement has been undertaken at an institutional, clinical and local community level. During the development of the MHDAS and S&RH program, the AHMRC of NSW was consulted for input into local and state-wide implementations. In addition to this, for MHDAS local Aboriginal and Torres Strait Islander community focus groups have been held to support local service improvement, with 38 Aboriginal focus group participants providing feedback across seven local health districts (LHDs). Community engagement is also supported on an ongoing basis through the involvement of local AHWs in health promotion activities.

Since the development of the S&RH program, consultation has been undertaken with the AHMRC the Aboriginal STI, HIV and Hepatitis Advisory Committee (ASHHAC) to develop an implementation plan; and an ASHHAC subcommittee has been established to advise on the establishment, implementation and evaluation of the program. In addition, the two consultation projects were undertaken with Aboriginal and Torres Strait Islander communities and services to inform program planning:

- NSW Services were invited to identify and provide feedback on good practice examples of sexual and reproductive health services and programs
- A community consultation project was undertaken with Aboriginal communities on adolescent sexual and reproductive health strategies, services and programs.

Community engagement has also been supported through the involvement of local AHWs in health promotion activities, with AHWs attending home visits with the AMIHS midwife and MHDAS clinician.

5.3.2.6 DATA AND REPORTING

NSW reporting shows a growing emphasis on the collection of data and reporting of outcomes, with a particular focus on evaluation of the effectiveness of programs.

A comprehensive performance and evaluation framework has been finalised for MHDAS following a consultancy that included broad consultation with all stakeholders, as well as advice from an expert group and the NSW NPA IECD Implementation Group. Local activity reports are being provided at six-monthly intervals and MHDAS staff have been requested to undertake data collection training as part of their mandatory orientation training. An independent evaluation of the MHDAS model is currently underway.

A similarly comprehensive evaluation framework has also been developed for the S&RH program following consultation with stakeholders and advice from an Expert Group and the NSW NPA IECD Implementation Group. Funded services are required to report to NSW Health at regular intervals.

In addition, a formal evaluation of the S&RH program has been conducted by the Kirby Institute. An evaluation of 'It's Your Choice! Have a Voice! Rights Respect and Responsibility' has also been conducted, although data from this evaluation was not made available at the time of writing this report.

5.3.3 ELEMENT 3

NSW provided funding of \$21.50m to support this element of the NPA IECD. One of the core activities that support Element 3 in NSW has been the establishment of BSF for Aboriginal Children, Families and

Communities. Ultimately, the aim of the BSF program is to 'ensure that Aboriginal children achieve and maintain optimal health so they have the best possible start at school and arrive healthy and ready to learn' (NPA IECD Element 3 Progress Report (BSF), July–December 2013, p3). A total of 15 BFS services have been established in NSW, with each BSF focussing on consolidating the delivery of culturally appropriate service; establishing local service advisory committees, which meet regularly; and consolidating continuity of care to local Aboriginal mothers through the establishment of referral pathways.

NSW has also implemented the AHASI, which is designed to assist people with mental health problems and disorders requiring accommodation and support. The aim of AHASI is to support people to participate in the community, maintain successful tenancies, improve their quality of life and assist in the recovery from mental illness.

5.3.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

Information about specific outcomes attributable to BSF and AHASI services is limited at this time. Much of the reporting in NSW focuses on service access, utilisation and the degree of community consultation and engagement with key Element 3 activities. However, an increase in service access and utilisation, as reported in 2012–2013 service access data for the BSF program, is likely to have a positive impact on outcomes for Aboriginal children and their families.

A total of 100 service packages have been offered under AHASI, which is line with the objectives outlined in the Implementation Plan. Data from the AHASI Formative Evaluation has been provided to the Ministry of Health and Peak Stakeholders Workgroup, however this data is not available for this report.

5.3.3.2 INCREASING SERVICE ACCESS AND UTILISATION

Reporting on BSF activity and impact in NSW indicates that the implementation of services has resulted in an increase in service access and utilisation. Service activity data for 2012–2013 shows that there has been continual growth in referrals received by the established BSF services over the past 12 months. Across the state, 90 per cent of mothers engage in BSF services and in some locations take-up is recorded at 100 per cent (NPA IECD Progress Report (BSF), July–December 2013).

5.3.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

There is limited data available in relation to the provision of culturally accessible services under Element 3, although the degree of community consultation and engagement evident in both BSF services and AHASI does provide some confidence that services are likely to be culturally appropriate and accessible.

AHASI services, in particular, show evidence of engaging with local communities, with reporting indicating that services are engaged in supporting community cultural events and activities, to '[strengthen] links within the community and [develop] culturally appropriate services' (NPA IECD Annual Report (HASI), 1 January–30 June 2013, p3). Cultural reference groups have also been established across 15 AHASI sites, and the establishment of these alongside the AHASI peak stakeholders workgroup, which includes representatives from peak AHASI partner agencies, is a key strategy supporting provision of culturally accessible services in NSW.

BSF teams, which are based on the successful AMIHS model, consist of Aboriginal Health Workers and Child and Family Health Nurses working collaboratively to provide culturally safe and secure health services. Aboriginal Health Workers act as cultural guides, liaising between families, services and staff and lead on community development initiatives. Health promotion activities across the BSF program also purposefully involve clients in the design and administration of activities to ensure cultural relevance and appropriateness. For example, in 2012, Gayaa Gaayl involved service users identifying images, totems and photographs to accompany targeted health messages. A local BSF services website has also been developed, which includes local artwork and animal totems.

5.3.3.4 BUILDING AND STRENGTHENING CAPACITY

Element 3 activities have resulted in increased on-the-ground engagement with Aboriginal and Torres Strait Islander organisations through both formal and informal partnership arrangements and collaborative working. The 100 supported accommodation packages provided through AHASI are delivered in partnership with, ACCHS, OATSIH-funded services and NSW Aboriginal Lands Councils. In addition, quarterly forums between local services have established strong relationships, and built strength and capacity among local service providers. These forums include representatives from local partner agencies such as mental health and housing providers, Aboriginal and Torres Strait Islander workers and NGOs.

The establishment of BSF services has resulted in increased local community engagement and collaboration between services. Partnerships have been established with a range of Aboriginal and Torres Strait Islander and non-Indigenous agencies which aim to build capacity within the 'mainstream' sector as well as the Aboriginal and Torres Strait Islander community to pursue improve health outcomes for families. The areas of focus for these collaborations have been diverse, and have included the development of community gardens, the establishment of driver's licence courses in partnership with a local driving school and digital diary workshops in partnership with local TAFEs and libraries.

During the establishment phase recruitment and retention of local staff at BSF sites was a challenge, in particular, identifying local community members with the required skills, and retaining those staff members for extended periods. Older services — those established in 2009 and 2011 — reported improved staff retention rates. This may indicate that for newer services, the pressure associated with engaging local staff may reduce, as services gain traction in their local community. It should also be noted that as a result of funds to all services being annualised, more services reported full staff complements with better retention rates.

Building capacity through training

The training and support unit (TSU) for Aboriginal mothers babies and children has been heavily involved in building capacity within local communities through the provision of training tailored to the BSF program. TSU initiatives have included the provision of:

- Orientation, training and professional development of BSF staff
- Strengthening foundations workshops
- Self-directed learning packages
- An online mental health learning tool.
- a biennial state-wide conference for staff working in Aboriginal health programs

A focus on workforce up-skilling, training and retention has also been a key strategy for developing local capacity. For example, the TSU for Aboriginal Mothers, Babies and Children has been funded to roll out a number of training and professional development initiatives. All BSF staff are required to attend the Strengthening Foundations workshops, complete self-directed learning packages and participate in TSU forums that are held bi-annually.

5.3.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

The formation of advisory groups and comprehensive stakeholder engagement strategies are central to the establishment of activities under Element 3. As noted, the AHASI cultural and community reference group has been established in 15 HASI locations across NSW, intended to ensure continued community engagement throughout the life of the initiative. In addition, the continued operation of the Aboriginal stakeholders workgroup, which includes representatives from peak AHASI partner agencies, helps to maintain a high level of community engagement and participation in activity design and implementation.

While the establishment of advisory groups and high level stakeholder engagement underpins community engagement and participation strategies, the AHEO role is also critical to the success of the BSF program. The AHEO role involves establishing strong community engagement and linkages that support and promote the program as a culturally safe and appropriate service to families and communities.

5.3.3.6 DATA AND REPORTING

There is evidence of a renewed focus on data and reporting in NSW, particularly in relation to BFS services. In late 2013, BSF services were, for the first time, expected to report on the approved BSF Key Performance Indicators (KPIs). This data is designed to provide a baseline measure of the impact of BSF services on health outcomes and show performance against national and state measures. Service Standards are being developed which are designed to assist in the continued quality improvement of the

program and provide a basis for future evaluation of the program. The NSW government is also in the process of progressing and evaluation of the NSW Health Aboriginal Mothers, Babies and Children's Program, which will use the new BSF KPI data.

Limited information on the data collection and reporting processes for Aboriginal HASI services is available.

6 Victoria

6.1 SUMMARY OF ACHIEVEMENTS

Victorian implementation has been largely successful across all elements. Key observations include the following:

- Victoria's two CFCs are both managed by community controlled organisations and appear well integrated into, and supported by, their communities
- Element 2 activities are focused on two projects: the expansion of Koori Maternity Services (KMS) and development of the Victorian Indigenous Young Person's Sexual and Reproductive Health Project (Wulumperi)
- Implementation objectives for Element 3 have been achieved by the establishment of Aboriginal-specific project sites, under the Best Start initiative, playgroups, and the creation of outreach MACH services that target Aboriginal families.

6.2 PROGRESS ON IECD ELEMENTS

The Whittlesea CFC (Bubup Wilam) commenced operations in February 2012 and the Bairnsdale centre (Dala Yooro) in April 2013. A range of early childhood education, health and parenting support services has been established at each CFC, with implementation being considered largely successful.

Element 2 activities are focused on the expansion of the KMS and the development of the Wulumperi project. Successful expansion of the KMS means there are now 14 KMS programs in operation across Victoria, providing assistance to Aboriginal women and non-Aboriginal women with Aboriginal babies. The Wulumperi project has successfully developed a range of innovative and tailored information, as well as training resources, which have been delivered in a number of school and community settings, and which encourage Aboriginal and Torres Strait Islander teenagers to access sexual and reproductive health programs.

Funding under Element 3 has been invested in the establishment of Aboriginal-specific early-years project sites under the Best Start initiative, playgroups, and the creation of 18 outreach MACH services that are attached to Victoria's universal MACH service.

6.3 PROGRESS AGAINST PERFORMANCE INDICATORS

Table 14 shows a snapshot of performance against the indicators agreed for the NPA IECD. It should be noted that in most instances, significant qualifications are attached to data items and these should be interpreted with caution.

TABLE 14 – VICTORIA PROGRESS REPORT CARD

PERFORMANCE INDICATOR	JURISDICTION RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	In Victoria, 100 per cent of Aboriginal and Torres Strait Islander children accessing services in the through CFCs in the census week were reported to be fully immunised for their age, and 96 per cent had also received the latest age-appropriate health checks.
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 982 Victorian Aboriginal and Torres Strait Islander children recorded as enrolled in (and 897 attending) preschool programs in the year before full time schooling, representing 1.3% of all enrolled (and 1.2% of attending) children. A total of 900 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 1.4% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	During the 2013 census week in Victoria, 28 families and 94 Aboriginal and Torres Strait Islander children accessed services at or through CFCs in Victoria.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	The age-standardised rate of access by Aboriginal and Torres Strait Islander mothers in the first trimester was 51.5% in 2010.
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	In 2010-12, the rate of notifications of syphilis among Aboriginal and Torres Strait Islander teenagers aged 15 to 19 in Victoria was 0.0 per 100,000 population, compared to 3.8 among non-Indigenous teenagers.
7. Reduced proportion of Indigenous babies born with low birth weight each year	In the period 2008-2010, 11.7% of babies born to Aboriginal and Torres Strait Islander mothers in Victoria were of low birth weight, compared to 4.6% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers aged less than 20, the proportion of low birth weight babies is 13.8% compared to 7.4% among non-Indigenous mothers (AIHW 2013a).
8. Reduced mortality rate of Indigenous infants each year	Due to small numbers, state and territory specific trends were not calculated.
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	In 2010, the crude proportion of Aboriginal and Torres Strait Islander mothers in Victoria aged less than 20 who reported smoking during pregnancy was 47.5%, compared to 36.9% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers older than 20, the crude proportion who reported smoking during pregnancy was 42.2% compared to 10.9% of non-Indigenous mothers (AIHW 2014). In 2008, the proportion of Aboriginal and Torres Strait Islander mothers in Victoria who reported drinking alcohol during pregnancy was 23.0%, while 9.3% reported using illicit substances. The latter figure has a relative standard error of between 25% and 50% and should be used with caution.
10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	In the period 2009-10 to 2010-11, hospital separation rates for Aboriginal and Torres Strait Islander children in Victoria aged under 5 was 263.2 per 1000, compared to 205.8 per 1000 for non-Indigenous children (AIHW 2013a). Between 2004-2005 and 2010-2011, the rate of hospital separations for Aboriginal and Torres Strait Islander children in Victoria aged under 5 increased by 44.0%.

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by AHMAC.

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

6.3.1 ELEMENT 1

Victoria received \$16.65m in Commonwealth funding over six years for Element 1 of the NPA IECD. The state's Implementation Plan includes the following key components:

- Identify locations and establish one rural and one urban Aboriginal CFCs
- Ensure a range of universal services, including MACH; early learning and care; and secondary services, including family and parenting support, are accessible for Aboriginal children and their families in an integrated setting
- Ensure there is an appropriately qualified and culturally competent staffing mix, including Aboriginal and non-Aboriginal staff, and joint professional development
- Establish a single governance structure with strong Aboriginal community involvement to manage the centres
- Build strong community support for the centres through consultation with the Victorian Advisory Council on Koori Health and the NPA IECD Advisory Group, community and local government.

Victoria has established two CFCs: at Whittlesea and Bairnsdale. The approach to developing both sites was similar, with local consultative groups being established and initial community consultations being undertaken. In Whittlesea, a community development worker was also engaged during this period to link existing services and facilitate community consultations.

Guidance for the establishment of the CFCs was overseen by a reference group at the state level, as well as a project control group at the local level. Appointment of the centre operators occurred via a competitive tender process and resulted in both centres being community controlled. In terms of governance, Bubup Wilam has an elected Board of Management with Aboriginal community representation.

At Dala Yooro, the Gippsland and East Gippsland Aboriginal Cooperative (GEGAC) is the lead agency for the centre. GEGAC leads partnerships with Uniting Care Gippsland, Gippsland Lakes Community Health and East Gippsland Shire Council. A service development group has also been established to advise on the development of the model for service delivery. This group has approximately one-third Aboriginal representation, and is made up of key stakeholders and service providers who will be working with the centre.

It was intended that both CFCs would establish integrated early learning and care services within each centre, as well as a combination of outreach services, to meet identified service gaps. These gaps included the KMS, MACH services, playgroups, occasional care and parent support. Bubup Wilam has a strong focus on early childhood education and offers long day care; early literacy/numeracy programs; transition to school and early learning programs, which are provided by schools; as well as a three and four year old kindergarten. Dala Yooro's programs have a strong health focus and include immunisation programs and child health checks; early childhood allied health; antenatal and postnatal services; as well as a women's health clinic that provides screening and assessment. Each centre has established relationships with other providers to ensure linkages exist with a wider set of services (Victorian Report July–December 2013).

6.3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

While there is no specific evidence available in relation to this outcome, it is clear that both centres in Victoria are now well established and programs aimed at strengthening outcomes for individuals and families are in place, including parent and family group activities, skills development and advisory supports. There is a significant level of support from both communities, as shown by attendance at centre programs. At Bubup Wilam, for example, staff reported they now have some 65 children attending and can envisage demand increasing

Bubub Wilam early learning Aboriginal child and family centre (Whittlesea, Victoria)

In terms of the program, we have grown and it has been challenging i think across many areas but I think that where we are now is much further along than where we were at the beginning of last year and we are establishing a program and a service that [is] fair to the community

Worker at Bubub Wilam

beyond their capacity.

6.3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

There is already evidence of significant usage across the programs offered at both centres. During the census period 29 July–3 August 2013, some 60 children at Whittlesea and 30 at Bairnsdale were checked for immunisation status and other age-appropriate health checks. Around 65 early childhood and MACH services were provided at Whittlesea and 85 at Bairnsdale over this census week.

The centres continue to mature, with a view to providing links to a wider range of services. Bubup Wilam has a partnership with the Northern Melbourne Medicare Local (NNML), which has provided small grant funding for a consultant to develop health and wellbeing programs to be run through the allied health rooms. The allied health services model is planned to be operational by April 2014. Bubup Wilam will continue to support parents to use interim allied health services until the model is completely developed and operating.

In a similar way, Dala Yooro plans to deliver MACH services in the future and has scoped the potential to better coordinate MACH checks by partnering with GEGAC Medical, and Gippsland Lakes Community MACH services.

6.3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Being managed by community controlled organisations provides a strong foundation for culturally secure services, which is supported by consultative processes with families and community at each centre. Additionally, both centres aim to engage Aboriginal and Torres Strait Islander staff to strengthen a sense of identity and to add to the quality of programs by providing cultural knowledge. At Bubup Wilam 55 per cent of its staff are Aboriginal and Torres Strait Islander and the centre's management is committed to Aboriginal and Torres Strait Islander-only service provision. At Dala Yooro, staff undertake specific training around working and supporting children and families who experience trauma. The centre also works to ensure a culturally safe environment in the context of different traditional family groups. There is also awareness about accommodating non-Indigenous service users, which is being achieved through the design of a culturally inclusive space that celebrates and respects the history and culture of the community, and welcomes diversity. There is an ongoing conversation about how to best achieve this.

6.3.1.4 BUILDING AND STRENGTHENING CAPACITY

Both Victorian CFCs have strong partnerships with Aboriginal and Torres Strait Islander and non-Indigenous organisations.

Bubup Wilam has established successful links with local groups, particularly through the Whittlesea Local Community Partnership Project⁹; and has increased its engagement within the local Thomastown precinct, by engaging with the local primary and secondary schools, and participating in the recreational centre, library and junior sporting activities. Bubup Wilam is currently negotiating partnership agreements with various agencies, based on the principles of community control and self-determination, to provide a range of services that will complement those provided at the centre. Bubup is also in the process of signing a fifty-year lease with the City of Whittlesea to provide an Aboriginal Early Years Centre, which cater for growth in the area and increase the inclusion of Aboriginal and Torres Strait Islander families in the local government area.

Dala Yooro continues to build an integrated service delivery model with existing allied health services at GEGAC and Gippsland Lakes Community Health. Links between the centre and the Child FIRST Alliance, a Department of Human Services-funded program, have been strengthened through the development of a shared action plan and the recruitment of an early childhood development worker. The Communities for Children program (C4C) and Dala Yooro have also developed strong linkages including exploring the development of intervention programs by linking to C4C programs.

⁹ The Aboriginal Partnership Project was announced by the Victorian Government in June 2011. It focuses on strengthening relationships and builds on work that is already happening around the State. Local governments are expected to work with Aboriginal communities to drive positive change in areas such as employment and economic development, health and wellbeing, recognition and respect, civic participation, access to land and protection of cultural heritage.

Capacity building has also occurred at the Victorian CFCs through their recruitment and workforce training activities. It is significant that the centres have aimed to attract qualified staff and to up-skill existing staff. At Bubup Wilam, the chief executive, child education leader and several early childhood teachers are qualified; and a number of Aboriginal staff are completing Diploma and Bachelor courses. The centre is also working with the TAFE sector and, through this partnership, four staff members have completed their Certificate III in children's services, and are now enrolled in the Diploma of Children's Services.

At Dala Yooro, the appointment of an education leader has supported the creation of a continuous improvement plan, and to staff undertaking on-the-job training and development around the National Quality Framework. Several staff members are completing Bachelor and Diploma level courses.

6.3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

The Victorian CFCs are strongly linked into the community and this is reflected at various levels of consultation with families, broader local engagement with local government and community organisations, their governance and auspice type.

The Whittlesea Local Community Partnership Project has supported Bubup Wilam to develop relationships with the varying levels of government in the region, as well as the broader community; and community engagement is reflected in the design of the centre. In 2012, Bubup Wilam achieved a 'Children's Services' Award, in the Kidsafe National Playspace Design Awards, which recognised the strong references to the local Indigenous community in this multipurpose playspace that reflects a commitment to cultural recognition and understanding.

At Dala Yooro, it is reported that positive community engagement has been facilitated through the centre's key workers, including the educational leader, coordinator and playgroup facilitator. Through these workers, the Bairnsdale CFC actively engages and consults with families about decisions on the centre's development; and the broader community is encouraged to access the service. Dala Yooro is built on community land and this brings a sense of ownership between the community, Aboriginal and Torres Strait Islander and non-Indigenous staff. Dala Yooro aims to develop this further by providing a welcoming cultural space at the centre for Aboriginal families and children.

6.3.1.6 DATA AND REPORTING

Both CFCs are in the process of developing data and reporting systems at the local level. Bubup Wilam is currently collecting data across all areas of the service and is working with the Centre for Community Child Health to collate relevant contextual data to inform their business planning. Dala Yooro aims to develop an evaluation framework through links with the C4C team in East Gippsland and the Parenting Research Centre.

6.3.2 ELEMENT 2

Victoria received \$5.35m in Commonwealth funding over five years for Element 2 of the NPA IECD. The Victorian implementation plan for this element includes the following key components:

- Expand the KMS to improve health and development outcomes for children and their families, with a particular focus on reductions in low birth weight and perinatal mortality. This is expected to involve:
 - three additional KMS sites
 - an expanded reach of four of the existing eleven KMS sites
 - workforce capacity-building.
- Extend sexual and reproductive health services for Aboriginal teenagers through:
 - increased sexual health screening, through increased capacity in five Aboriginal Community Controlled Health Organisations
 - inclusion of sexual health information in health promotion activities.

In accordance with the state's Implementation Plan, four KMS sites have been expanded, including the site at GEGAC; and there are now 14 KMS programs in operation across Victoria; 11 of these programs are located in ACCHOs and the remaining three are located in public hospitals. In addition, the Victorian Department of Health has redeveloped state-wide guidelines to support all KMS sites to ensure the provision and take-up of high-quality maternity care, to improve maternal and neonatal outcomes, and to ensure community needs are met.

In relation to the extension of sexual and reproductive health services, the Wulumperi project, in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), aims to develop and deliver sexual and reproductive health education; provide BBV and sexually transmissible infection prevention information; increase young people's sexual and reproductive health knowledge; as well as their knowledge about how to access testing and treatment. This will be done in partnership with the 24 ACCHOs across the state.

Specific activities delivered under Wulumperi include a Secondary Schools Program which works in partnership with secondary schools, local health services — Aboriginal and Torres Strait Islander, mainstream community and sexual health services, and other Aboriginal services to deliver tailored sexual health resources to Aboriginal and Torres Strait Islander students in Victorian secondary schools, and young people not engaged in the school system.

Sacred Sistas is an extension of the Secondary Schools Program and offers further gender-specific sexual and reproductive health education for young Koori women and girls aged 12–30, in either a school, or community setting.

Deadly Dudes is a sexual and reproductive health program, which has been developed for young Aboriginal boys and men, aged 12–30 that will complement the Sacred Sistas program. Deadly Dudes is designed for both male students who have participated in the Secondary Schools program or any young Aboriginal male in the community. Similar to Sacred Sistas, it explores more extensive sexual and reproductive health messages for young boys and men and can be delivered in a school, or community setting.

The Melbourne Sexual Health Centre (MSHC) and Family Planning Victoria provide expert sexual and reproductive health education and training to the Victorian health sector. Under this project, they will assist VACCHO-registered training organisations to develop and deliver an expert, culturally appropriate sexual and reproductive health course for students enrolled within health worker training courses.

The Chlamydia Quality Improvement Program aims to improve screening rates of chlamydia infection by improving the clinical sexual and reproductive health service delivery of Victorian ACCHOs.

6.3.2.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

Victorian reporting notes that assessing outcomes in terms of increasing the provision of sexual and reproductive health services to Aboriginal and Torres Strait Islander teenagers is complex. Reporting of Aboriginality by mainstream services is not robust, and concerns regarding confidentiality prevent many teenagers accessing ACCHOs with sexual and reproductive health concerns. Furthermore, it was reported that there is sensitivity among individuals and organisations around sexual and reproductive health issues, which makes it more difficult to assess increased knowledge and changes in attitude. This provides a context for reporting on the outcomes achieved under both the KMS program and the Wulumperi project.

While there is no specific data available that addresses this outcome, the KMS does provide a wide range of complementary health and social services to Aboriginal women and their families through its linkages with other programs provided by ACCHOs. Furthermore, the state-wide review completed in 2012 indicated that the maternity care delivered by KMS midwives and AHWs has a strong focus on education and strengthening the health literacy of women, so that they can make informed choices about their care and the care of their baby. Health promotion is mostly undertaken opportunistically and many services provide health promotion in a group context. Since the time of the 2012 review, funding under this element of the NPA IECD has further strengthened the KMS, has provided for greater reach in four sites and has established three new sites.

The Wulumperi project appears to have achieved strong outcomes. Victoria reports that in 2012–13, eight sessions of the Sacred Sistas component of Wulumperi were delivered in rural Victoria to Aboriginal

women and health workers. Evaluation data indicated that young women who participated identified increased sexual and reproductive health knowledge as an outcome, and 64 per cent expressed a willingness to attend future sessions. Rural health workers who participated in the program also rated it highly, with 85 per cent describing it as 'good' or 'excellent'; and 88 per cent reporting increased knowledge and confidence in working with young women on sexual and reproductive health issues.

An evaluation of Wulumperi's Secondary Schools program also found that students who took part were able to identify key information about the risks of acquiring chlamydia and hepatitis; the benefits of condom use; and where to access health services in their area. Victoria reported that continued delivery of this program by local healthcare services is likely to have a positive impact in the future on the rates of chlamydia and hepatitis C transmission, as well as early, or unplanned pregnancy within the secondary school community.

Two other components of Wulumperi — the Sexual and Reproductive Health Education and Training, and Chlamydia Quality Improvement Program — are yet to be fully implemented. It is expected that the first courses will be run in early 2014.

6.3.2.2 INCREASING SERVICE ACCESS AND UTILISATION

Although there is no data on increased service usage through KMS, access has clearly been extended by new and expanded services funded under the NPA IECD. These services were all operating during July–December 2013 and continue to work to improve access to antenatal care and postnatal support for Aboriginal women. During this period, the newest service at Peninsula Health was recruiting suitably qualified health professionals to support the program.

Wulumperi has had a significant impact on access to information about sexual and reproductive health. In December 2013, Victoria reported that the Secondary Schools program component of Wulumperi had been delivered across Victoria to 248 young people in 15 secondary schools and other relevant community settings, to reach the target audience. Sacred Sistas had been presented in 18 sessions across Victoria to 96 Aboriginal women and 74 health workers. The program has been promoted extensively within the KMS across Victoria and has been delivered by Aboriginal Health Service Central Gippsland by staff delivering the workshop. Deadly Dudes has been developed as a parallel program to Sacred Sistas and is designed for male students, who have participated in the Secondary Schools program.

Deadly dudes

The secondary schools program has been delivered at Wulgunggo Ngalu learning place, the Parkville juvenile justice centre and Malmesbury detention centre to the young male prisoners.

Our most successful program has been working with the young aboriginal males at Malmesbury detention centre. We have established a strong rapport with the young males and the staff are very supportive and keep in contact with us, the Wulumperi team

The staff have worked closely with the team which initiated the idea to develop a follow up program known as the 'deadly dudes' program. The program is supported with a manual which is suited to the young male participants who have previously completed the standard program. This will include an arts activity program with the use of making 'message sticks' and hear about respectful relationships, contraception, being a 'deadly dude', having knowledge about safe sex and the law around this, including the legal age to have sex. All participants will receive a signed certificate and on the back of the certificate will be the key messages to reflect on.

The Wulumperi project was also represented at a number of local community events across the state, with the purpose of promoting sexual health and screening to participants attending. Examples include a health promotion stall at a Sistas Day out event in Cranbourne, which was attended by 95 Aboriginal women and the presentation of sexual health information to approximately 50 local healthcare workers and community service providers at a forum in Shepparton.

6.3.2.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Victorian reporting has commented on the importance of understanding the sensitivities of sexual and reproductive health issues in Aboriginal organisational and community settings and that 'a gentle and respectful approach' takes time. Because sexual and reproductive health matters are complex, private and sensitive, increased knowledge and changes of attitude are subtle and difficult to assess. Victoria reports that the support of VACCHO is an important element.

Feedback from service users about KMS is reportedly very positive. The state-wide review of KMS indicates the program is facilitating access, and increasing attendance, to culturally safe antenatal care for Aboriginal women, by providing services in a flexible environment, including in a woman's home; and by providing a consistent team of service providers. It is also reported that stakeholder feedback suggests that the KMS offers flexible, non-judgmental care, through ongoing and trusting relationships with KMS midwives and AHWs. Notwithstanding these findings, further work is underway to refine the quality and appropriateness of services.

In this context, VACCHO has been provided funding to undertake a stocktake of all culturally appropriate health promotion material available to Aboriginal women and families attending the KMS. Based on the findings, the Royal Women's Hospital and VACCHO have developed new, culturally appropriate materials to support KMS staff and women. This has included the development of a DVD about a newborn examination.

In relation to Wulumperi, program leaders report that the Secondary Schools program was developed in consultation with the Aboriginal community, VACCHO's KMS and the Victorian Aboriginal Health Service. All Wulumperi programs to educate Aboriginal young people are delivered by Aboriginal workers and this is written into the program. Cultural perspectives, language and protocols are also built into the program and some of the schools are more than happy to ensure the programs only have Aboriginal young people in the groups. The team also works closely with the Koori Education Support Officers in the schools with a large Aboriginal population.

Members of the Wulumperi team reinforce the importance of cultural safety and ensure that a culturally safe space is created for the delivery of each program, which is discussed with the workers at the schools and in communities before it is agreed to deliver the program.

I give so much of myself to the women so it is hard to pass that on in my train the trainer program and very hard to measure its impact. We want to ensure we are embedding culturally sensitive practice and that we support caring and sharing environments for all our participants

Wulumperi worker

6.3.2.4 BUILDING AND STRENGTHENING CAPACITY

Victoria reported that consultation for the activities for the KMS program had involved a wide range of stakeholders including the VACCHO New Beginnings team, KMS midwives and AHWs and that the KMS expansion built upon established VACCHO management and governance structures. A steering committee was developed with representation from VACCHO and the local Aboriginal community, and regional governance structures were also established. The state-wide review is said to have indicated that most KMS sites have strong relationships with other service providers, with further opportunities to strengthen these. Formalised protocols, clinical guidelines and MOUs reflect organisations' commitment to work together.

For the Wulumperi project, Victoria established an overarching steering committee to provide project leadership and oversee the development of implementation plans and service planning. The steering committee involved key Aboriginal and Torres Strait Islander, government and NGOs. At the program level, MOUs were signed between MSHC and VACCHOs to formalise the commitment to work collaboratively to achieve the objectives of the project.

Victoria has noted that in relation to the Wulumperi project a partnership approach has been adopted, which is developing infrastructure for future activity across the state. This means the Secondary School, Sacred Sisters and Deadly Dudes programs are designed to be continued and be delivered by a competent, trained and skilled workforce. Wulumperi has strived to build the capacity of AHWs and students studying health worker courses within VACCHO recognised training organisations.

Recruitment and staff training are also important to capacity building and in relation to the KMS program, the Victorian Department of Health notes that it is delivered by appropriately qualified registered midwives and AHWs. In addition, while VACCHOs and health services have responsibility to ensure that KMS workers receive appropriate education and training to deliver culturally appropriate care, the Victorian Department of Health provides cultural competence training opportunities for health professionals.

In the context of the Wulumperi project, Victoria acknowledges that there is a general need to raise the level of sexual health knowledge of the ACCHO workforce. This is supported by the Wulumperi team, who note that building the capacity of the sexual and reproductive health workforce in Victoria was a key challenge. Managers at the MSHC and VACCHO indicated that this has implications for the cultural integrity and safety of ACCHOs because non-Aboriginal people with particular skill sets and qualifications are being recruited in the absence of appropriately trained Aboriginal people.

6.3.2.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Victorian reporting suggests that both the KMS program and the Wulumperi project place a strong emphasis on consultation and partnership with Aboriginal and Torres Strait Islander and non-Indigenous organisations.

The KMS team has undertaken consultations with VACCHO, KMS midwives and AHWs, as well as mainstream organisations, to inform their program activities. All decisions regarding funding for the expansion or establishment of new KMS sites were based on evidence of demand, as well as consultations with, and the clear support of, VACCHO and the Aboriginal and Torres Strait Islander community.

Wulumperi has an ongoing relationship with VACCHO, the Victorian Aboriginal Child Care Agency, ACCHOs, the Koorie Engagement Support Officer program and the Korin Gamadj Institute. Meetings were also held with Aboriginal organisations to identify the specific needs of each community and during the July–December 2013 reporting period, further consultation meetings were held with Aboriginal organisations. As at December 2013, Wulumperi has worked with 20 of the 24 ACCHOs across the state, with three new ACCHOs engaged: Rumbalara Aboriginal Cooperative, Kirrae Community Health Centre and Ngwala Willumbong.

Wulumperi has also facilitated networks and working groups with representatives from Aboriginal and Torres Strait Islander and mainstream services, as well as state-based organisations, to help build capacity within those organisations. Wulumperi participates in a number of working groups made up of representatives from Aboriginal and Torres Strait Islander, mainstream and state-based organisations. As noted by one manager:

A lot of work was done by the team to build rapport and gain trust by the ACCHOs and schools before the program was delivered. Content was discussed with the steering committee and VACCHO members before the final product/s and resources were delivered.

Wulumperi team member

Wulumperi program staff also report regular representation and participation at community events in a health promotion capacity

6.3.2.6 DATA AND REPORTING

Difficulties accurately assessing and reporting outcomes relating to increased access to sexual and reproductive health programs have already been noted. The state-wide review of KMS also indicated that there is a need to improve the collection and reporting of data relating to the KMS program to identify trends in outcomes over time. Opportunities to improve data collection and reporting are being explored by the Victorian Department of Health in collaboration with VACCHO. Victoria also reported that VACCHO's quality improvement program had been engaged to work with Wulumperi and VACCHO's sexual health policy team to encourage individual ACCHOs to improve their clinical systems and data collection.

6.3.3 ELEMENT 3

Victoria provided funding of \$4.5m to support this element of the NPA IECD. The Victorian Implementation Plan for this element of the NPA IECD aims to increase the proportion of Aboriginal and Torres Strait Islander children attending Aboriginal and Torres Strait Islander and universal MACH services and key age and stage visits.

Victoria has implemented three main projects under this element of the NPA IECD – the Best Start initiative, Supported Playgroups and Parent Groups, and MACH.

The Victorian Government Best Start early-years initiative supports families, caregivers and communities to improve the health, development, learning and wellbeing of all Victorian children. There are 30 Best Start project sites across the state and six are now funded to focus specifically on working with Aboriginal communities. Aboriginal Best Start sites address the following priorities:

- increased levels of physical activity
- increased participation in kindergarten
- decreased rates of notification to child protection
- improved rates of literacy and numeracy.

Activities also aim to increase the knowledge and skills of Aboriginal parents to support their children's engagement with health services, including access to mainstream MACH services; as well as to promote the importance of breastfeeding. In addition, two sites — Mildura and Shepparton — have been selected as Enhanced Best Start sites for the next three years. Their focus is to improve rates of breastfeeding in their municipalities and to improve participation in universal services by vulnerable groups, including Aboriginal children and families. These sites have developed strategies to address these issues.

Supported playgroups and parent groups, which are also state-based programs, are provided in Victoria as a way of engaging with parents and children of vulnerable groups. Aboriginal children and families are one of the key target groups of this program. A total of seven Aboriginal-specific supported playgroups were implemented across the Supported Playgroups and Parent Groups sites in 2012. These include five rural communities: Campaspe, East Gippsland, Greater Shepparton, Swan Hill, Wellington, and two in the metropolitan communities of Maribyrnong and Hume.

In Victoria, the MACH program provides state-wide services in partnership with the Municipal Association of Victoria, local government and the Department of Education and Early Childhood Development. The MACH service provides a schedule of contacts and activities for all families, with an emphasis on prevention, promotion, early detection and intervention for health and wellbeing. A Continuity of Care protocol aims to ensure a smooth transition for mothers and their babies from hospital to home, underpinned by a sharing of information between maternity and newborn services, and MACH services. An Enhanced MACH service responds to the needs of children and families that are at risk of poor outcomes, particularly where there are multiple risk factors. This service is provided in addition to the range of services offered through the universal MACH program and provides a more intensive level of support, including, in some circumstances, short-term case management.¹⁰

An outreach MACH service is now delivered by 13 municipalities to Aboriginal Community Cooperatives and Aboriginal Health Services; while five councils provide outreach services to Aboriginal playgroups. MACH nurses attend local Aboriginal Cooperatives and Health Services to provide key ages and stages consultations to children between birth and school entry. Where there is no outreach MACH service, Aboriginal families continue to access the universal state-wide MACH service, or the Enhanced MACH service as required.

Another Victorian initiative that relates to Element 3 is the Healthy Mothers, Healthy Babies initiative, which was funded until June 2012. This provided vulnerable women, including Aboriginal and Torres Strait Islander women with support during pregnancy (*Evaluation Interim Report*, p88).

6.3.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

While there is no data available which shows the outcomes achieved, Victorian reporting notes that the Best Start program and the Supported Playgroups and Parent Groups initiatives are consistent with the goal of increasing the capacity of Aboriginal and Torres Strait Islander parents, to meet their children's developmental needs.

¹⁰See Department of Education and Early Childhood Development, Enhanced Service, at: <http://www.education.vic.gov.au/childhood/professionals/health/Pages/enhancedmchservice.aspx>

6.3.3.2 INCREASING SERVICE ACCESS AND UTILISATION

There has been a significant take-up of services provided under this element of the NPA IECD. A total of seven Aboriginal-specific Supported Playgroups and Parent Groups were implemented in the six month period July–December 2012 in 29 Local Government Areas where Best Start sites are located. Data for January–June 2013 is not yet available, although, according to state-wide statistics, a total of 115 Aboriginal families attended supported playgroups in this period, which included 165 children (Victorian Report 2012–13).

Key ages and stages clinic consultations provided through the Victorian MACH service, increased in 2011–12 to 7270, an increase of 509 on the previous year. Annual service improvement plans for MACH services across the state also include documentation of specific strategies to increase engagement of Aboriginal children and their families.

It is also noted by Victoria that MACH services currently being delivered are evidence-based interventions undertaken at key ages and stages, including cessation of smoking, promotion of safe sleeping, family violence, dental care and a healthy BMI. Evidence-based health promotion is also reported with key messages provided for healthy eating, dental care, safety, communication, language and play, immunisation, kindergarten enrolment and sun smart information.

6.3.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Victoria indicates that services under this element of the NPA IECD have been established in ways that are consistent with providing culturally safe services. These include strong linkages and partnerships with Aboriginal organisations in the provision of outreach MACH services in 18 municipalities. Cultural respect training is reported to be provided at the discretion of local governments.

Aboriginal organisations are also engaged in service planning and development for Best Start and Supported Playgroups initiatives; and the additional Best Start and Supported Playgroups funded under the NPA IECD are Aboriginal-specific.

6.3.3.4 BUILDING AND STRENGTHENING CAPACITY

A challenging aspect of capacity building under this element of the NPA IECD concerns recruitment and retention of staff. A key issue reported to have affected the implementation of activities at a number of Aboriginal Best Start sites, is the high staff turnover occurring at partner services. There also continues to be challenges reported in the recruitment and retention of skilled playgroup facilitators for Supported Playgroups and Parent Groups. In the maternal and child health area, the Victorian Government has an ongoing MACH Workforce Recruitment and Participation Strategy that aims to attract nurses into the field. This includes scholarships for midwives to train as MACH nurses. In 2011–12, 38 scholarships were allocated, and anecdotal evidence suggests these have helped to attract recruits to short-staffed local councils.

6.3.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Community consultation is a key part of the planning process for the Best Start initiative and that Best Start partnerships use a variety of consultation and engagement strategies. Victoria also reported that MACH services across the state are required to develop annual service improvement plans. Through this process, local councils are expected to improve their engagement with Aboriginal and Torres Strait Islander families and increase their participation in the MACH service. Engagement strategies utilised in these plans include early identification of Aboriginal and Torres Strait Islander births; building linkages with Aboriginal and Torres Strait Islander groups; prenatal home visits offered with Enhanced MACH services; linking the mothers and babies into existing services; and providing open sessions for culturally and linguistically diverse families.

6.3.3.6 DATA AND REPORTING

In Victoria, data collection and reporting for Best Start is occurring through a formal evaluation process being conducted by KPMG. Capacity building workshops have also been held with representatives of Aboriginal Best Start sites to assist them with evaluation of their strategies. Additionally, case studies have been developed featuring the Djillay Lidj and Mingo Waloom sites.

Maternal and child health data in Victoria is collected annually on the number of attendances by Aboriginal and Torres Strait Islander families in the service, as well as a participation rate that is based on

total population. The Victorian Aboriginal Health Service has been funded to facilitate maternal and child health data transfer to the department as part of the Electronic Reporting Solution. The purpose is to improve state-wide reporting and undertake a more regular and detailed analysis of maternal and child health data.

7 Queensland

7.1 SUMMARY OF ACHIEVEMENTS

Implementation of the NPA IECD in Queensland appears to have been broadly successful across all three elements, although it may take some time for outcomes to manifest. Key successes have included:

- An increase in Aboriginal and Torres Strait Islander children, teenagers and adults accessing sexual and reproductive health and/or child and maternal health services
- Increased collaboration and cooperation among services providers, allowing service providers to facilitate access for Aboriginal and Torres Strait Islander families to a range of programs and services operating in the community
- A focus on capacity building and a partnership approach to the rollout of a range of resources and professional training (including train-the-trainer approaches) in the areas of sexual and reproductive health and child and maternal health
- Recruitment of Aboriginal and Torres Strait Islander people to a range of health roles, although recruitment and retention remains a challenge across locations
- Anecdotal evidence that clients believe that services to be culturally secure.

7.2 PROGRESS ON NPA IECD ELEMENTS

The implementation of the NPA IECD in Queensland has been broadly successful. Ten CFCs were funded under Element 1 and all are currently providing a range of early childhood education and care services, parenting and family support services, and child and maternal health services. However, as at 30 June 2013 two CFCs were providing these services from temporary premises due to delays in constructing CFC buildings.¹¹

Queensland's Element 2 commitments involved implementing a range of sexual and reproductive health initiatives, including STI and BBV screening and sexual health education for young people in communities, youth detention centres and prisons. It also involved initiatives to increase the skills of the maternity and child health workforce to deliver interventions encouraging women to abstain from substance use during pregnancy, and to improve antenatal care and maternal health more generally. It also involved the implementation of a range of youth, parenting and wellbeing programs including the COL Program, the Aboriginal and Torres Strait Islander Youth Health and Wellbeing Program, and the Young Parent Support Worker Program.

Queensland's Element 3 commitments include the Making Tracks Enhancement of MACH Services package, which included a home visiting program, child health checks and follow up referrals, brief interventions in relation to breastfeeding, nutrition and child safety, and an immunisation program. It also included a range of maternity initiatives under the Indigenous Health Package, and implementation of the 'Deadly Ears' program, which involved ear, nose and throat outreach clinics and surgery trips for Aboriginal children across Queensland.

7.3 PROGRESS AGAINST PERFORMANCE INDICATORS

Table 15 shows a snapshot of performance against the indicators agreed for the NPA IECD. It should be noted that in most instances, significant qualifications are attached to data items and these should be interpreted with caution.

¹¹ All 10 Queensland CFCs were constructed prior to the expiry of IECD NPA in June 2014.

TABLE 15 – QUEENSLAND PROGRESS REPORT CARD

PERFORMANCE INDICATOR	JURISDICTION RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	<p>During the census period, 80% of all Aboriginal and Torres Strait Islander children who participated in the Immunisation and Health Check Census Week were fully immunised for their age, 70% had received the latest age-appropriate health checks, and 67% were up to date in both immunisations and health checks.</p> <p>Indigenous vaccination coverage rates for Aboriginal and Torres Strait Islander children in Queensland are relatively high for vaccination coverage at 24 and 60 months, with all but one Hospital and Health Service registering vaccination coverage of greater than 90%. For many Hospital and Health services, vaccination coverage at 24 and 60 months is higher for Aboriginal and Torres Strait Islander children than it is for non-Indigenous children. However Indigenous vaccination coverage at 12 months still needs to be improved across the State, except for Cape York. (Qld own data)</p>
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 3,318 Queensland Aboriginal and Torres Strait Islander children recorded as enrolled in (and 3,206 attending) preschool programs in the year before full time schooling, representing 5.3% of all enrolled (and 5.5% of attending) children. A total of 3,264 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 5.6% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	During the reporting timeframe October 2012 to March 2013, 2148 Aboriginal and Torres Strait Islander children and 1729 Aboriginal and Torres Strait Islander Teenagers/ Parents families accessed services at or through six CFCs in Queensland.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	Rates of Aboriginal and Torres Strait Islander women who attended more than five antenatal visits have increased significantly from 77.6% in 2007-08 to 87.5% 2012-13 in Queensland (Queensland Health own data)
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	In 2010-12, the rate of notifications of chlamydia among Aboriginal and Torres Strait Islander teenagers aged 15 to 19 in Queensland was 7,652.9 per 100,000 population, compared to 1,537.7 among other teenagers, for gonorrhoea, 2,780.1 per 100,000 compared to 86.2, for syphilis, 228.6 compared to 3.5, and for hepatitis C, 57.1 compared to 21.8.
7. Reduced proportion of Indigenous babies born with low birth weight each year	<p>In the period 2008-2010, 9.6% of babies born to Aboriginal and Torres Strait Islander mothers in Queensland were of low birth weight, compared to 4.5% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers aged less than 20, the proportion of low birth weight babies is 10.2% compared to 6.2% among non-Indigenous mothers (AIHW 2013a).</p> <p>The rates of low birth weight babies decreased slightly from 9.4% in 2007-08 to 8.9% in 2012-13. An absolute decrease of 0.5% (Queensland own data).</p>
8. Reduced mortality rate of Indigenous infants each year	The Aboriginal and Torres Strait Islander infant mortality rate for Queensland fell by 41% between 2001 and 2010 and the infant rate fell from 10.7 to 7.2 from 2006 to 2010 (per 1000 live births) (Queensland Health data).
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	<p>In 2010, the crude proportion of Aboriginal and Torres Strait Islander mothers in Queensland aged less than 20 who reported smoking during pregnancy was 55.3%, compared to 36.5% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers older than 20, the crude proportion who reported smoking during pregnancy was 53.1% compared to 14.2% of non-Indigenous mothers (AIHW 2014). Between 2007 and 2010, the rate of smoking during pregnancy fell by 6.6% for Aboriginal and Torres Strait Islander mothers, but this was not statistically significant.</p> <p>Rates of women who were pregnant and smoking at any stage of their pregnancy decreased from 53.4% in 2007-08 to 47.5% in 2012-13, an absolute decrease of 5.8% (Queensland Health data).</p> <p>In 2008, the proportion of Aboriginal and Torres Strait Islander mothers in Queensland who reported drinking alcohol during pregnancy was 22.7%, while 3.9% reported using illicit substances. The latter figure has a relative standard error of between 25% and 50% and should be used with caution.</p>

10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	In the period 2009-10 to 2010-11, hospital separation rates for Aboriginal and Torres Strait Islander children in Queensland aged under 5 was 270.8 per 1000, compared to 205.7 per 1000 for non-Indigenous children (AIHW 2013a). Between 2004-2005 and 2010-2011, the rate of hospital separations for Aboriginal and Torres Strait Islander children in Queensland aged under 5 increased by 5.7%.
--	---

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by AHMAC.

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

7.3.1 ELEMENT 1

Queensland received \$75.18m over six years to establish CFCs in ten locations across Queensland including Cairns, Doomadgee, Ipswich, Logan, Mackay, Mareeba, Mornington Island, Mount Isa, Palm Island and Rockhampton.

As at 30 June 2013, the construction of eight CFCs was complete, and construction of the remaining two CFCs was reportedly progressing well.¹² There were delays in the construction of some CFCs in Queensland: the wet season and increased construction costs contributed to the delays, as did difficulties in finalising locations for CFCs and lease agreements.

As at 30 June 2013, all Queensland CFCs were providing services, including the two CFCs providing services from temporary premises. Services varied depending on the needs of the community, and included a range of early childhood education and care services, parenting and family support services and child and maternal health services.

The Department of Education, Training and Employment (DETE) was the lead agency responsible for the implementation of Element 1 in Queensland. Establishment of CFCs was supported by state-wide and local management and governance structures. A Local Advisory Committee guided the establishment of each CFC.

Appointment of centre operators in Queensland was through a competitive tender process, resulting in a mix of centre operators, some of which were community controlled, some not-for-profit and, in other cases, consortia of both. Most centre operators were existing service providers in the community.

7.3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

CFCs in Queensland are providing a range of child and maternal health programs and services. Although there is little documented evidence yet available on what outcomes these are delivering for individual and families, evidence exists of increased access to programs, and services being delivered in a culturally-appropriate environment, which might be expected to lead to increased parental capacity over time.

The consultative approach to CFC service development, in terms of profiling community needs, and the adoption of a number of well-regarded and evaluated programs, such as Triple P, further suggests that programs will be effective and deliver outcomes over the longer-term.

A key challenge to integrating and coordinating CFC programs, reported by stakeholders in Queensland was the time and investment required to build strong relationships to support integration. It was suggested that the necessary investment time meant services may only now be starting to see outcomes, such as strengthening outcomes for individuals and families.

7.3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

CFCs have adopted an integrated model of service delivery which seeks to coordinate access for Aboriginal and Torres Strait Islander families to a range of programs and services, including kindergarten programs, playgroups, toy libraries, parenting services, health screening, assessments and immunisations, pre and post natal support, and specialist services. This integrated model of service delivery was underpinned and facilitated by strong partnerships, networks and referral pathways.

Stakeholders reported CFCs were providing new and essential services to Aboriginal and Torres Strait Islander children and families. As an example, the CFC on Mornington Island is providing families with access to long day care for the first time. In Doomadgee, children were accessing ear healthcare through the Deadly Ears Program operating through the CFC. CFCs were also reportedly reaching families that had not previously accessed services. The range of programs and services meant several generations of one family could visit the one centre at one time to address diverse needs through integrated service delivery.

Addressing barriers to access, including a lack of transport, has been critical for improving access. All Queensland CFCs provide transport to support community access to programs and services.

¹² All 10 Queensland CFCs were constructed prior to the expiry of IECD NPA in June 2014.

Based on self-report data, during the period October 2012–March 2013, 11,456 services were provided to Aboriginal and Torres Strait Islander clients through six CFCs. Data was not collected for the other four CFCs, which were in the 12-month establishment phase. In these six centres over the same period, 2,148 Aboriginal and Torres Strait Islander children and 1,729 Aboriginal and Torres Strait Islander teenagers and parents accessed services, including early childhood education and care services, parenting and family support services, and child and maternal health services.

Eighty per cent Aboriginal and Torres Strait Islander children participating in the immunisation and health check census week in March 2013 were reported to be fully immunised for their age; 70 per cent had had all age-appropriate health checks, and 67 per cent were both fully immunised and had had age-appropriate health checks.¹³

Relationships and linkages between CFCs and partner organisations have reportedly led to enhanced access for Aboriginal families. Several CFCs reported hosting or participating in networks and meetings of local service providers, which improved communication and collaboration between providers. It also allowed CFCs to facilitate access for Aboriginal families to other services operating in the community.

While strong relationships were critical to the effective operation of CFCs, a key challenge for some CFCs was reported to be managing expectations among some existing services that the CFC would pay for all supports provided to families. According to senior officers, there was a perception among some services that CFCs received substantial funding and consequently should pay for any support delivered to families through CFCs. The CFC's budget and business model, however, did not permit such levels of support, and negotiating these expectations has been a challenge in some cases.

Mackay CFC – facilitating access for families

The Mackay CFC has been working with a family of nine children, cared for by their grandparents, to facilitate access to a range of services. In the first instance, the CFC assisted the family to access income support and liaised with child protection bodies on behalf of the family.

To ensure educational and developmental needs were being met, developmental screening was undertaken for each child, and referral services provided. Brokerage funding was used to support regular sessions with an occupational therapist for one child with immediate needs.

The CFC will continue to provide ongoing support to the family as and when such support is required.

7.3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Queensland CFCs have implemented a range of measures to support provision of culturally accessible services. These include employing Aboriginal and Torres Strait Islander staff, engaging Aboriginal and Torres Strait Islander organisations and community members in governance and management structures, hosting community and cultural events, and using culturally appropriate and inclusive language and imagery.

CFCs commonly have mechanisms for engaging Aboriginal and Torres Strait Islander community members in the planning and implementation of services. An example occurred in Mornington Island in March 2013 when the CFC Local Advisory Committee, comprised of representatives from all cultural groups, met with CFC leaders to determine a culturally appropriate response to Sorry Business. As a result, culturally appropriate guidelines and processes were developed to ensure continuity of service delivery and maintenance of child-to-staff ratios during Sorry Business.

The name and imagery used by CFCs were seen as critical for connecting with communities and contributing to cultural security. Several CFCs commissioned local artists to create artwork and/or design logos for the centre. Communities also selected culturally appropriate names for CFCs to encourage a sense of ownership. Selecting a name was a challenge in communities with multiple languages and tribal groups such as Doomadgee. In Doomadgee, the community committee and local mayor agreed on the name 'Dumaji CFC'. It was thought that using the traditional spelling of the town name would speak to different language groups and unite local families 'under a shared place name and history'.

¹³ Note these figures should not be interpreted as the number of children who were immunised at the CFC, but a record of children who attended the CFC during Census week who were immunised.

7.3.1.4 BUILDING AND STRENGTHENING CAPACITY

A focus on partnerships and workforce development has helped to support the capacity of individuals, services and organisations.

The evidence suggests CFCs have developed strong partnerships and linkages with organisations, leading to mutually beneficial capacity building. This has involved, for example, non-Indigenous organisations providing advice to CFCs on early childhood education and care, and CFCs providing advice to non-Indigenous organisations about supporting Aboriginal and Torres Strait Islander children and families. This partnership model has assisted evidence-based and culturally appropriate support across both Aboriginal and Torres Strait Islander and non-Indigenous organisations.

According to senior officers in Queensland, the NPA IECD has led to more community leadership and engagement in early childhood service provision. For example, some Aboriginal and Torres Strait Islander organisations that previously provided limited early childhood support now offered early childhood support as a core service.

CFCs have been actively involved in supporting staff and local students to obtain qualifications in children services, counselling or business, and in providing in-house professional development. At the state-level, there has been a coordinated approach to professional development and support for CFC staff, with DETE hosting bimonthly web and teleconferences for CFC centre operators to collaborate, support and learn from each other.

Some CFCs have demonstrated considerable flexibility in building the capacity of their organisation and the local community. The Palm Island CFC, for example, was unsuccessful in recruiting an AHW, so adopted a different approach and worked with the Remote Jobs in Community Program to offer two primary healthcare traineeships to community members wanting to pursue a career in health work. The successful candidates were supported through a Certificate III in Indigenous Community Services and Primary Health under the guidance of a CFC-employed nurse. The approach provided a pathway to professional development for the individuals involved and enabled the CFC to ensure service continuity.

While education and training of staff reportedly has had a positive impact on staff retention, staff recruitment and retention remains a challenge for many CFCs. Senior officers reported some CFCs experienced significant delays in recruiting appropriately skilled Aboriginal and Torres Strait Islander workers, which some advised had had a negative impact on service delivery. Where appropriately skilled Aboriginal and/or Torres Strait Islander staff were unable to be recruited, non-Indigenous staff were appointed, or a different method of service delivery may have been implemented such as using a partner organisation to deliver services through the CFC.

7.3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

The evidence suggests there have been high levels of community engagement with community organisations and with Aboriginal and Torres Strait Islander people on the establishment and operation of Queensland CFCs. Indeed, the implementation model in Queensland required lead agencies to undertake extensive planning in service development, which included direct engagement with community and local stakeholders.

Local Advisory Committees were convened in each community during the CFC establishment phase to engage the community, and provide more general support and assistance. Over time, these committees have evolved into, or been replaced by, other structures such as local reference groups, advisory boards, community committees and Elders' groups. While there is variation in the role and composition of these groups, they appear to play a critical role in providing advice on community needs, and culturally appropriate implementation of programs and services. Some groups are also involved in CFC staff recruitment.

Local arrangements were supported by a state-wide implementation reference group, which was comprised of peak bodies and other stakeholders who provided high level advice on CFC implementation.

A number of strategies adopted by CFCs contributed to positive engagement with Aboriginal and Torres Strait Islander people. These included official opening ceremonies and open days, which were a good way to promote the centre to community members in a non-threatening way, as well as participation in

community events, such as NAIDOC week events and community fun days. Some CFCs also maintained regular communication with community members through print and online media.

According to senior officials the key enablers to effective partnerships and community engagement included:

- taking time to invest in relationships and partnerships, and build trust with the community
- recruiting a CFC leader who was Aboriginal or Torres Strait Islander and already connected to, and respected by, the community
- recruiting staff with the requisite skills and understanding to engage with community
- identifying specialist Aboriginal and Torres Strait Islander positions within teams to help build cultural competency
- having a CFC building that was welcoming and appealing to community members.

Senior officials reported there were often unrealistic expectations around the time needed for effective community engagement, emphasising that community and service engagement takes time and was unlikely to deliver quantitative outcomes in the short term. Another key challenge to partnerships and community engagement was the competitive funding environment, which sometimes had an impact on the willingness of organisations to collaborate. Developing partnerships between Aboriginal and Torres Strait Islander and non-Indigenous organisations were reportedly not straightforward, particularly where these were being established for the first time. In some cases, these challenges led to partnerships not being able to be sustained.

7.3.1.6 DATA AND REPORTING

According to senior officers, data collection and performance measurement was a key challenge. During the first year of operation, CFCs were only required to report milestones. After that, more detailed data collection was required; however data collection guidelines were described as 'vague', not clearly understood, and easily misinterpreted. Some data was required to be self-reported by parents and carers such as current levels immunisation and health checks and was not therefore a reflection of service delivery at the CFCs. According to senior officers, significant liaison and effort was made to address anomalies in quarterly periodic performance reporting. As a consequence, guidelines were revised and workshops were held with CFCs to improve data collection and reporting. The extent to which data collection and reporting has improved as a result is not clear from the available evidence.

7.3.2 ELEMENT 2

Queensland will receive \$29.94m in funding over five years to implement Element 2 activities. Queensland's *Implementation Plan* and latest annual report indicate that a wide range of programs and services have been developed, expanded or implemented under Element 2.

Element 2 investment was designed in response to sexually transmitted diseases being more common for Aboriginal and Torres Strait Islander Queenslanders than non-Indigenous Queenslanders. While the exact proportion of Aboriginal and Torres Strait Islander Queenslanders accessing sexual and reproductive health programs and services over the life of the NPA IECD is unknown, approximately \$10.8 million was invested in education, sexual health screening, referral to specialist services and provision of sexual health resources to young Aboriginal and Torres Strait Islander people in Queensland over the life of the agreement.

As an example, activities under Element 2 have included:

- implementing Aboriginal and Torres Strait Islander youth programs and parenting education for young people, including the COL Program
- establishing an Aboriginal and Torres Strait Islander Youth Health and Wellbeing Program to be delivered by Aboriginal and Torres Strait Islander youth health workers

- promoting safe sex practices to Aboriginal and Torres Strait Islander people and expanding testing for STIs and BBVs, including within youth detention centres and prisons
- increasing community education about women's reproductive health issues
- implementing the Young Parents Support Worker Program to provide support to young mothers aged 14–18 years
- increasing the skills of the maternity and child health workforce to deliver interventions to encourage women to abstain from substance use during pregnancy, and to implement 'For Me and Bub', a smoking and alcohol prevention program
- improving antenatal care and maternal health through the establishment of an Indigenous Maternal and Infant Care Health initiative
- implementing the Ngarrama Antenatal and Birthing program, an antenatal and birthing service for Aboriginal and Torres Strait Islander families who give birth at selected hospitals.

Governance structures at multiple levels were established to support the implementation of Element 2. Steering committees were established to oversee the implementation of specific programs, oversee training for parts of the health workforce, and improve linkages between key stakeholders. Steering committees existed at a state-level, at the level of hospital and health Services (HHS), and at local levels.

7.3.2.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

Senior officers reported that significant activity had occurred under Element 2, but that the impact of the investment may have been diluted because activities were spread across many different initiatives — a total of 55 initiatives across Elements 2 and 3. Concern was expressed that initiatives had focused more on outputs rather than outcomes, and further evidence was needed to clarify what outcomes were being achieved.

Despite these concerns, senior officers suggested there were 'indications' that medium-term outcomes were being achieved, and evidence exists that Element 2 is having a positive impact on individuals and families. There has reportedly been a decrease in the proportion of babies born with low birth weight to Aboriginal and Torres Strait Islander mothers from 10.8 per cent in 2002–03 to 9.3 per cent in 2010–11. However, challenges still remain in tackling smoking during pregnancy and teenage pregnancy rates.

STI and BBV screening has resulted in young people better understanding their sexual health and, where necessary, obtaining treatment. A total of 692 young people participated in a screening program in two correctional facilities enabling the detection of 78 cases of chlamydia and gonorrhoea and 15 cases of syphilis. Under another program, 24 clients were screened for STIs and BBVs, 80 per cent of whom were Aboriginal or Torres Strait Islander. Forty per cent were diagnosed with an STI and treated.

Extensive sexual health promotion activities targeting young people have occurred across Queensland. The extent to which young people have engaged in healthy sexual practices as a result is unknown, although these promotional activities will likely assist to raise awareness of positive sexual health strategies.

7.3.2.2 INCREASING SERVICE ACCESS AND UTILISATION

There has been an increase in Queensland in Aboriginal and Torres Strait Islander teenagers accessing sexual and reproductive health programs and screening services. The sexual health team delivered 850 episodes of care for young people across the Cape York, Torres Strait and Northern Peninsula area. AHWs have also delivered sexual health education and clinical sessions for inmates and provided referrals for newly released inmates into local clinical services. As an example, at the Cleveland Youth Correctional Facility, clinical sessions were delivered three times a week with 3–8 attendees seen per session and 2–3 treatments delivered per week.

Extensive outreach services appear to have contributed to increased service access and utilisation. For example, an Aboriginal and Torres Strait Islander youth outreach clinic was established in Cairns to provide clinical services, such as STI screening and treatment, and referrals. The majority of young people accessing this service were found to have not previously accessed a local health service.

A number of HHS have recorded an increase in the types of sexual and reproductive health resources and information provided to Aboriginal and Torres Strait Islander people. This was reported to have encouraged increased service access. As an example, the Darling Downs HHS recorded a 20 per cent increase from 2011–12 in the number of Aboriginal and Torres Strait Islander people accessing services.

In terms of antenatal care, there has reportedly been a gradual increase in the proportion of pregnant women attending five or more antenatal visits, from 77.6 per cent in 2007–08 to 85 per cent in 2010–11. Some hospitals involved in the Ngarrama program reported that more than half — and in couple of cases, 70–80 per cent of women — received antenatal care within the first trimester. As a point of comparison, performance indicators for Queensland are that 36 per cent of Aboriginal and Torres Strait Islander women received antenatal care in the first trimester in 2009 (AIHW, 2012:4).

Ngarrama program staff reported that women found the Ngarrama service responded more appropriately to their needs, and was easier to access and engage with, compared to mainstream services. The following comments from service users illustrate this point:

I'd much rather come here than go through the main system.

It's easy.

It was about making the experience all about me.

Service Users, Ngarrama Program

A focus on developing holistic and culturally appropriate healthcare through Element 2 initiatives may have contributed to increased service access and utilisation, although there is no quantitative evidence to support this.

7.3.2.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Measures to ensure culturally accessible services under Element 2 initiatives are similar to those measures adopted for Element 1, and include employing Aboriginal and Torres Strait Islander workers, engaging Aboriginal and Torres Strait Islander people in governance and management, providing cultural competence training, and using appropriate and inclusive language and imagery.

Senior officers reported that the level of cultural security differed across initiatives and was heavily influenced by Aboriginal and Torres Strait Islander workers, who were seen as critical to the success of any team. The reported increase in Aboriginal and Torres Strait Islander people accessing sexual health and antenatal services might suggest services are perceived as culturally secure.

Efforts to promote cultural security have occurred at the local level and at the state-level. Queensland Health has developed a new post-natal depression scale that is linked with cultural understanding and knowledge, so that results are interpreted correctly. It complements a Cultural Competency Framework that was introduced over two years ago across all Queensland health services. This scale is now being used in antenatal visits under the NPA IECD.

At the local level, the Ngarrama program engages Elders in the planning and launch of programs, provides cultural competency training to non-Aboriginal staff and accesses external cultural supervision. Ngarrama clients reported feeling confident accessing Ngarrama services, and having Ngarrama workers in their home, because these workers understood cultural issues and challenges, and adopted a non-judgemental approach. Ngarrama clients also felt confident referring others in their community to the program.

7.3.2.4 BUILDING AND STRENGTHENING CAPACITY

There is recognition in Queensland that the long-term sustainability of results under Element 2 initiatives is dependent on developing and maintaining a suitably skilled workforce. Consequently, significant effort has gone into recruiting and retaining staff, and professional development to build the capacity of individuals and organisations. These activities have been supported by the development of partnerships to deliver a range of culturally appropriate sexual health and antenatal services and initiatives.

NPA IECD funding has enabled the recruitment of health workers across several programs, including nurse educators, Aboriginal and Torres Strait Islander youth health workers, sexual health workers, child and maternal health workers and maternal and infant care teams. Substantial recruitment of Aboriginal and Torres Strait Islander staff has occurred across ten major maternity units. These staff have contributed to improved capacity to deliver culturally appropriate services across diverse settings including hospitals, clinics, homes, schools and correctional facilities.

Training and other professional development initiatives have sought to develop the skills of new staff and existing staff in both Aboriginal and Torres Strait Islander and mainstream organisations. The model, content and target audience of training has varied. A train-the-trainer model was used to deliver COL training to Queensland health and education staff, as well as staff from NGOs. Program-specific training for the 'Yarnin up on Hep B' program and Mums and Bubs was provided to health workers in various locations. The former enabled AHWs in Cairns to more confidently speak with patients and the community about Hepatitis B; and the latter provided maternal and child health practitioners with knowledge and skills to undertake alcohol, tobacco and other drug interventions for maternity patients. Cultural practice training was provided to Queensland Health to improve the capacity of health services to engage in culturally safe practices.

Strengthening the capacity of AHWs to deliver services has been a key focus under this Element. Education resources and guides have been developed for and workers have been supported to gain relevant qualifications. All HHS have reportedly developed linkages and partnerships with local services, both mainstream and Aboriginal and Torres Strait Islander to deliver sexual and reproductive health and other services. Such partnerships have facilitated information sharing and capacity building.

Building partnerships to strengthen capacity of young mums

According to stakeholders consulted during fieldwork, a critical successful factor for the Ngarrama program is the successful partnership it has developed with housing provider, chameleon housing, and the program's growing relationship with the department of housing and public works. The Ngarrama antenatal team is referring clients to chameleon housing for assistance in obtaining transitional social housing. Chameleon then works with clients to develop their skills in managing a home including budgeting and purchasing food. In addition, it offers pathways to education and training, including running the aspire program in partnership with a local high school, which offers curriculum studies for pregnant teenagers and new mums within the mainstream school environment.

Professional development for sexual health workers

As part of the Aboriginal And Torres Strait Islander youth health and wellbeing program, a two-day Aboriginal and Torres Strait Islander sexual health worker professional development workshop was held in Queensland to bring together workers for peer support and information sharing. At this workshop, the HIV/AIDS, hepatitis c and sexual health unit team members presented on health promotion activities and general workforce initiatives. The workshop was evaluated, with workers reporting that the gathering was important for improving morale, communication, networking and peer support. The workshop also reportedly improved the capacity of attendees to respond to young women's sexual health issues.

While substantial recruitment has occurred under Element 2, recruitment and retention of staff has been a challenge, owing to the absence of suitably qualified staff and the lack of transport and housing in remote areas. This was reportedly being addressed by some HHS through the establishment of workforce development units to support the growth of the health worker workforce. The extent to which these units are achieving their objectives is unclear from the available evidence.

7.3.2.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Implementation of Element 2 activities has been characterised by strong partnerships with service providers and community engagement.

Hospital and Health Services were reported to have created linkages, coordinated services, developed partnerships, and undertaken community consultation to deliver sexual and reproductive health services, as well as programs such as the Queensland Aboriginal and Torres Strait Islander Young Women's Healthy Life Program. Consultation was reported with a range of stakeholders including Aboriginal and Torres Strait Islander Shire Councils, the Royal Flying Doctor Service, Medicare Locals, local schools and ACCHOs.

For the Mums and Bubs program, close linkages were established with the non-government sector, including the Queensland Aboriginal and Islander Health Council, the Centre for Mothers and Babies and the Queensland Cancer Council.

Consultation with Aboriginal and Torres Strait Islander people has occurred through existing community forums, the employment of a project officer with a specific mandate to undertake community consultation, and the engagement of Elders groups. These channels were used to obtain community input into the planning and delivery of services, as well as the naming and branding of these services.

Education forums were also used as a means of engaging community. In Mornington Island, for example, 28 women attended an education forum in May 2013, which provided information on pap smears, mammograms, helping daughters with puberty, nutrition, and the benefits of physical activity.

7.3.2.6 DATA AND REPORTING

Senior officers reported that data collection has been a challenge across all three elements. In Queensland, each HHS collected data but because each service was autonomous, data collection was not uniform and consistent. Some data collection systems were paper-based, whereas others were electronic.

There is evidence that data collection is occurring at a program level, although the extent to which this data is informing ongoing program delivery is unclear.

In terms of program evaluation, some Element 2 initiatives have been formally evaluated. The COL program was evaluated, with qualitative data indicating that the program was well received in regions and that new facilitators reported increased confidence to deliver the program. The community forums conducted for the Queensland Aboriginal and Torres Strait Islander Young Women's Healthy Life Program were also evaluated with the purpose of measuring success and ongoing community need. An evaluation framework has also been established for the Me and Bub program. The framework includes output measures such as 'number of workers trained' and 'number of client contacts', and outcome measures relating to the impact of the program, e.g. reported use of program advice and materials.

7.3.3 ELEMENT 3

Queensland provided funding of \$21.25m over five years to implement three initiatives under Element 3 of the NPA IECD. These initiatives included:

- the Making Tracks Enhancement of MACH Services package — activities included a home visiting program with a family-centred approach; Well Child Health Checks and follow up referrals; brief interventions in relation to breastfeeding, nutrition and child safety; a slow growth program supported by dietician and community agencies; an immunisation program; and support for a paediatric outreach program
- maternity initiatives under the Indigenous Health Package, which included funding for new positions
- the ear health program Deadly Ears, which involved ear, nose and throat outreach clinics and surgery trips for Aboriginal children across Queensland.

In Queensland, funding was also allocated to services across urban, regional and remote areas to support maternity services to link with other relevant stakeholders, in order to ensure enhanced maternity service provision. For example, there was a dedicated Aboriginal and Torres Strait Islander child and family health worker to support the provision of services to pregnant and parenting Aboriginal and Torres Strait Islander women in the Ayr region. In Mareeba, there was an Aboriginal and Torres Strait Islander maternity support worker who assisted with the delivery of culturally appropriate maternity services.

7.3.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

There is little data available on outcomes that are attributable to Element 3 initiatives. As with Element 2 initiatives, senior officers reported concerns that Element 3 initiatives focused on outputs rather than outcomes. Notwithstanding this, there was anecdotal evidence that Element 3 activities were having positive impacts for individuals and families. The Ngarrama program has reportedly led to improvements in maternal and child health KPIs, and families participating in the program are also reportedly presenting earlier for a range of health services.

There has been an increase in families accessing child and maternal health services, and although evidence is limited, it is expected that increased access will support positive outcomes over the longer-term.

7.3.3.2 INCREASING SERVICE ACCESS AND UTILISATION

Element 3 has provided Aboriginal and Torres Strait Islander children with increased access to ear health and child and maternal health services. Between January–June 2013, ear health promotion and education was delivered to six remote communities; 20 ENT outreach clinics were delivered; and ENT surgery was provided in eight locations. Clinical services were provided to 941 children and 234 surgical procedures performed. In addition, 1037 children received hearing assessments across three communities.

From January 2011–June 2013, primary health care services received clinical leadership support services to enhance ear health management on 68 occasions, 49 additional outreach visits were provided by specialists, 286 additional ear health surgical services were provided to Aboriginal and Torres Strait Islander children, and 1541 Aboriginal and Torres Strait Islander children received additional ENT services. In addition, the program delivered additional audio logical services to 854 children.

In relation to antenatal and postnatal care, funding to Queensland Health maternity services enabled the coordination of antenatal and postnatal services to Aboriginal and Torres Strait Islander women and children. During fieldwork, stakeholders reported families were engaging with antenatal and child health services and then being referred to a number of other services, such as mothers groups, family support services, occupational therapy and mental health services. The extent to which families were using these other services, however, is unclear.

Mums and Bubs programs were operating out of three hospitals and reportedly attended by 70 women each week. In Darling Downs HHS, a drop-in clinic was established and, although Aboriginal and Torres Strait Islander infants comprised 3 per cent of all children seen at the clinic, they comprised 17 per cent of all children immunised at the clinic.

In terms of barriers to implementation, high staff turn-over, difficulties in recruiting Aboriginal and Torres Strait Islander staff, a lack of suitable accommodation for staff, and limitations on travel due to the wet season, were all reported barriers to implementing Element 3 activities and increasing service access and utilisation. The ability of services to follow up with women and children was also a challenge because of the highly mobile population travelling between Ayr, the Torres Strait, Mackay and Mt Isa. One service sought to overcome non-attendance by sending reminder text messages to clients known not to come to appointments, and by holding 'client issues' meetings with staff to identify women and children needing a higher level of supervision, monitoring and care.

7.3.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Measures to ensure culturally accessible services under Element 3 initiatives are similar to those measures adopted for Elements 1 and 2, and include employing Aboriginal and Torres Strait Islander workers, engaging Aboriginal and Torres Strait Islander people in governance and management, and using appropriate and inclusive language and imagery.

Senior officers reported that including an Aboriginal and Torres Strait Islander worker in a multidisciplinary health team with links to Elders and community was key for developing culturally accessible services and effective community engagement. In several locations, Aboriginal and Torres Strait Islander workers were active in promoting culturally appropriate care. At Roma Hospital for example, the AHW developed a culturally appropriate program 'Let's Talk Life', which was co-presented by Elders. At the St George Hospital, a culturally appropriate DVD 'Staying Connected, Staying Strong' was developed to promote the importance of antenatal care.

7.3.3.4 BUILDING AND STRENGTHENING CAPACITY

Training and partnerships between services, Queensland Health, schools and community stakeholders have been critical to improving service delivery and strengthening capacity. Under the Deadly Ears program, a child health nurse was engaged to train 99 health workers and child health nurses to provide ongoing ear screening in communities. In addition, to support Queensland teachers to deliver better education to Aboriginal and Torres Strait Islander children with conductive hearing loss, the Deadly Ears Program worked with the Department of Education to develop and roll out the 'Deadly Kids Can Listen and Learn' online course; training on classroom acoustics called 'One Channel Sound Classrooms'; and an 'EdStudio' module on conductive hearing loss and otitis media.

7.3.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

There is evidence of community engagement across a number of Element 3 activities. For example, consultation with Aboriginal and Torres Strait Islander clients of antenatal services informed the direction of the Strong and Healthy Families project. Separately, a community-based midwife was recruited at Cunnamulla Hospital to work closely with the AHW and to provide continuity of care to patients outside of the hospital setting. The role was supported by the wider community and was a part of a broader strategy established in partnership with community Elders.

The Deadly Ear program has reportedly developed solid linkages with a range of partners to improve ear health service delivery across Queensland. These partners have included DETE, Australian Hearing, the Royal Flying Doctor Service, North and West Primary Health Care and the Queensland Aboriginal and Islander Health Council.

Queensland's Making Tracks initiative is delivered by Apunipima, which is a key member of the Cape York Child and Family Health Strategic Partnership. Apunipima also participates in the Northern Maternal and Neonatal Clinical Network, the Cape York Maternal and Child Health Clinicians' Network, and works in partnership with Deadly Ears and the Department of Community (Child Safety).

In Queensland, it is a statutory requirement for HHS to have a communication and consumer engagement strategy, which is expected to implementation of the NPA IECD.

7.3.3.6 DATA AND REPORTING

As with Element 2, senior officers reported that data collection has been a challenge. In Queensland, each HHS collected data, but because each service was autonomous, data collection was not uniform and consistent. Some data collection systems were paper-based, whereas others were electronic.

Although there is evidence that data collection is occurring at a program level, the extent to which this data is informing ongoing program delivery is unclear.

An evaluation was undertaken of the Baby Basket initiative, which involves a staged delivery of goods to support mothers, with positive feedback about the initiative being received.

8 Western Australia

8.1 SUMMARY OF ACHIEVEMENTS

The implementation of the NPA IECD in Western Australia has been broadly successful and has been achieved in the context of its geography, the dispersed Aboriginal and Torres Strait Islander population across regional and remote areas, and the impact this has had on staff recruitment and retention. Particular achievements include:

- all three Elements have increased the number of services available to Aboriginal and Torres Strait Islander people, as well as the utilisation of these services, by providing more culturally appropriate programs and transport to services
- partnerships with other agencies/services/community groups, which have led to increased integration of services and programs and thereby a more seamless experience for clients
- tailored consultation and governance arrangements, which have been effective in building engagement between mainstream and Aboriginal organisations and in involving local Aboriginal and Torres Strait Islander community members in the design and development of CFCs and IECD programs.

8.2 PROGRESS ON NPA IECD ELEMENTS

Western Australia (WA) has made good progress across all three Elements in line with the implementation strategies outlined in the NPA IECD.

Of the five CFCs proposed under Element 1, three are operational — Halls Creek, Fitzroy Crossing, Kununurra — and two — Roebourne and Swan, were on track for construction to be completed by December 2013. The CFCs in Halls Creek and Fitzroy Crossing offer a range of services and have increased access to, and integration of, services for children and their families. Aboriginal and Torres Strait Islander families and communities reported valuing the services offered by CFCs, and the Halls Creek CFC in particular is reported to be accessed by the community at a consistently high level.

Under Element 2 and 3, fourteen service providers continue to deliver programs across the state; and WA has reported a 100 per cent achievement against all Element 2 milestones. This has been achieved through the establishment and implementation of two state-wide programs: the Aboriginal Maternity Services Support Unit (AMSSU) and the Foetal Alcohol Spectrum Disorder (FASD) program; and through eight regionally-based programs that focus on maternal and child health, and sexual health outcomes.

A significant achievement under the NPA IECD is the number of both informal and formal partnerships between organisations, and the level of community engagement. Under Element 1 there were 104 community consultations and 203 partnership meetings in 2012–2013. WA has also worked with community representatives to develop community initiatives for the FASD project under Element 2; and key linkages between ACCHS, the Aboriginal Health Council of Western Australia (AHCWA) and the Women's and Newborns Health Service Building have also been made. Under Element 3, the Aboriginal Health Improvement Unit (AHIU) has engaged and consulted with the community to help establish programs, and in the six months to June 2013, a total of 250 partnership meetings were held.

WA has also been successful in increasing the uptake of culturally accessible services. In the six months to June 2013, 1589 child health checks were completed, 1295 children received immunisations and 262 women received postnatal services (West Australia Annual Report, Element 3, January–June 2013).

8.3 PROGRESS AGAINST PERFORMANCE INDICATORS

Table 16 shows a snapshot of performance against the indicators agreed for the NPA IECD. It should be noted that in most instances, significant qualifications are attached to data items and these should be interpreted with caution.

TABLE 16 – WA PROGRESS REPORT CARD

PERFORMANCE INDICATOR	JURISDICTION RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	During the census period, 74% of all Aboriginal and Torres Strait Islander children who accessed child care services through CFCs in WA were fully immunised for their age, 29% had received all age appropriate health checks and 25% were up to date in both immunisation and health checks.
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 2,094 WA Aboriginal and Torres Strait Islander children recorded as enrolled in (and 2094 attending) preschool programs in the year before full time schooling, representing 6.4% of all enrolled (and 6.9% of attending) children. A total of 2056 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 6.4% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	During the census period 27-31 May 2013, 172 Aboriginal and Torres Strait Islander children and 122 Aboriginal and Torres Strait Islander families accessed services at or through CFCs in WA.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	The age-standardised rate of access by Aboriginal and Torres Strait Islander mothers in the first trimester was 29.5% in 2010
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	In 2010-12, the rate of notifications of chlamydia among Aboriginal and Torres Strait Islander teenagers aged 15 to 19 in WA was 8,497.2 per 100,000 population, compared to 1,637.4 among other teenagers, for gonorrhoea 4,559.8 per 100,000 compared to 53.8, for syphilis, 55.9 compared to 1.6, for hepatitis C, 99.7 compared to 16.1, and for hepatitis B, 51.9 compared to 33.3.
7. Reduced proportion of Indigenous babies born with low birth weight each year	In the period 2008-2010, 13.1% of babies born to Aboriginal and Torres Strait Islander mothers in WA were of low birth weight, compared to 4.3% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers aged less than 20, the proportion of low birth weight babies is 13.4% compared to 5.3% among non-Indigenous mothers (AIHW 2013a).
8. Reduced mortality rate of Indigenous infants each year	Due to small numbers, state and territory specific trends were not calculated.
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	In 2010, the crude proportion of Aboriginal and Torres Strait Islander mothers in WA aged less than 20 who reported smoking during pregnancy was 46.6%, compared to 28.7% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers older than 20, the crude proportion who reported smoking during pregnancy was 51.3% compared to 9.9% of non-Indigenous mothers (AIHW 2014). Between 2007 and 2010, the rate of smoking during pregnancy increased by 4.0% for Aboriginal and Torres Strait Islander mothers, but this was not statistically significant. In 2008, the proportion of Aboriginal and Torres Strait Islander mothers in WA who reported drinking alcohol during pregnancy was 20.7%, while 8.5% reported using illicit substances. The latter figure has a relative standard error of between 25% and 50% and should be used with caution.
10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	In the period 2009-10 to 2010-11, hospital separation rates for Aboriginal and Torres Strait Islander children in WA aged under 5 was 432.1 per 1000, compared to 226.1 per 1000 for non-Indigenous children (AIHW 2013a). Between 2004-2005 and 2010-2011, the rate of hospital separations for Aboriginal and Torres Strait Islander children in WA aged under 5 increased by 7.1%.

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by AHMAC.

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

8.3.1 ELEMENT 1

WA received Commonwealth funding of \$42.35m to establish and support five CFCs in Halls Creek, Fitzroy Crossing, Kununurra, Roebourne and Swan. The selection of the sites was based on a review of the number, and needs of, Aboriginal children throughout the state; the need for improvements in access levels to existing services and the likelihood of whether the Centres would be utilised in those locations.

The objectives of the CFCs were to provide access to quality early childhood learning and development programs, through the delivery and integration of a range of services for children and their families. The nature of the services provided at each location was expected to reflect the needs of local Aboriginal and Torres Strait Islander children and their families, and to build on the existing strengths of parents and communities. CFCs also had a focus on increasing Aboriginal and Torres Strait Islander employment and skill development, and so where possible, positions in CFCs were expected to be filled by suitably trained Aboriginal and Torres Strait Islander staff. Strong linkages and coordination with existing services across all elements was expected to underpin the CFCs, to ensure integrated delivery.

The Halls Creek CFC (Ningkuwum-Ngamayuwu) has been operational since mid-January 2012 and the centre's auspicing body is the Wunan Foundation, in partnership with Little Nuggets Child Care Incorporated. The number of approved child care places is 23 and the average number of places occupied during the period January–June 2013 being 20. Application has been made for another 30 places in order to provide more child care places and after-school care.

The Fitzroy Crossing CFC (Baya Gawi Buga yani Jandu yani u Centre) has been operating since September 2012 and was officially opened on 2 July 2013. The Centre Operator is Marninwantikura Fitzroy Women's Resource Centre Aboriginal Corporation (MWRC). The number of approved places is 50; however the CFC has been operating at 50 per cent capacity with 24 places occupied during period January–June 2013. Just over half the children attending (51 per cent) are from Aboriginal and Torres Strait Islander families.

The Kununurra CFC has been operational since June 2013 and is operated by the Children's Services Support Unit (CSSU). Prior to the completion of the CFC building, the CSSU operated out of the Language Centre in Kununurra. The number of approved child care places available is 40, with the average number of places occupied in the six months January–June 2013, the CFC was underutilised with the average number of places occupied being 16. Of the children enrolled, 60 per cent were Aboriginal.

8.3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

The Halls Creek, Fitzroy Crossing and Kununurra CFCs offer a range of parenting programs, including Parent Power Group, Strong Families parent support and Australia Parent Factor Workshop, which aim to support and strengthen families. Although the CFCs have worked to increase access to services for children and families, it is too early to see firm evidence of improved outcomes, although anecdotal reports are positive. CFC staff reported that there is some evidence children are experiencing positive outcomes from their participation in CFCs. For example, during consultations with the Kununurra CFC, staff indicated that children's confidence has increased and that the routine and structure of the early learning centre is preparing them for school:

Some kids came in June and didn't speak but have flourished and are now little chatterboxes.

Kununurra Staff Member

Over time, it is likely that the provision of services will lead to improved outcomes for children and their families.

8.3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

The three CFCs currently in operation offer a range of programs and services in conjunction with other service providers. The type of programs and services offered varies across the three CFCs and includes early childhood and parenting programs; health programs and services; culture and language programs, money management and budgeting advice, and legal advice.

Information collected during the 2013 Census week indicated that CFCs in WA were providing 86 different types of services to children and 15 types of services to families. Overall, 122 families and 172 Aboriginal and Torres Strait Islander children accessed services at, or through, CFCs in WA.

The degree to which these services are being accessed by families and children differs across the three CFCs. For example, while an analysis of data and consultation with staff from the Halls Creek and Fitzroy Valley CFCs, indicates that the programs are being accessed at a consistently high level, at both centres, attendance at child health checks and health workshops is lower than attendance at community events.

Levels of access may be influenced by a number of factors, including whether playgroups are run concurrently with adult programs; the capacity of the facility to accommodate a number of programs at the same time; the relevancy of the programs to families; and the provision of transport to and from the CFC.

Staff at the CFCs report they are working towards greater service integration and increasing the utilisation of those services by families and their children. One of the issues raised by staff was the number of families that may participate in CFC programs, but who do not then access medical services. Strategies to increase their use of medical services have included, holding and promoting 'Family Fun Days' to enable families to meet local medical staff; and having open days to promote the CFC among service providers.

CFC staff also reported that many families were not enrolling their children in child care due not only to the cost, but also because they encountered barriers to accessing benefits provided through Centrelink, such as the Child Care Benefit (CCB) and Child Care Rebate (CCR), or the Jobs, Education and Training (JET) Child Care Fee Assistance. To address this, one of the CFCs has recruited a family support worker to assist families in accessing the CCB/CCR.

Coordinating services to provide better outcomes: Kununurra CFC

The Kununurra CFC has conducted a number of meetings with the local school, Anglicare, Ord Valley Aboriginal Health Service (OVAHS) and Boab Health Services to strengthen collaboration. Options identified include OVAHS in-reaching to undertake health checks with children there; the CFC is also looking at providing an after-school program at the centre, as well as education workshops. A team member from OVAHS attends the CFC weekly to teach the children in the early learning centre about healthy eating. The CFC also invited women from the language centre to read books and sing in local language to the children. The children loved this activity and there are plans to engage more Elders more frequently. During consultations, staff indicated that it is important to make sure services were coordinated because there are lots of other programs/services already operating in Kununurra. The ambition was described in these terms::

we plan to bring everyone here. It will be a one stop shop – it will be great.

Notwithstanding this ambition, the importance of continuing to engage with very vulnerable families who are unlikely to approach a service was also raised as important. Achieving the right scale, focus and mix of services is an area of ongoing discussion, in the context of a town with many programs on offer:

by maintaining a smaller size and focusing on community development and child care, it [the CFC] will stay unique.

During the 2013 Census period 74 per cent of Aboriginal and Torres Strait Islander children who received child care through a CFC were fully immunised for their age; and twenty-nine per cent of Aboriginal and Torres Strait Islander children receiving childcare from CFCs were reported to have received the latest age-appropriate health checks for their age. Twenty-five per cent of Aboriginal and Torres Strait Islander children were reported as being fully immunised and having received the appropriate health checks for their age.

Senior government officials and CFC staff reported however, that there were issues related to collecting reliable health data as required as part of the Census. This is due to immunisations being captured centrally on the National Immunisation Register (NIR), while child health checks are still largely paper-based. For the NIR to be cross-referenced, both the name and the date of birth of children need to be provided by the CFC to the Department of Health. CFC staff reported that many parents were reluctant to give consent for health services to have this information, and that as a result, immunisation rates and health check data among children from Halls Creek and Fitzroy Valley CFCs was low. To address these issues, CFCs are looking at ways of gaining parental permission to share information such as during the enrolment process for childcare.

From a cross-NPA IECD perspective, one of the barriers to achieving integration and coordination of activities across the Elements identified by senior government officials was the fact that Element 2 activities commenced six months after Element 1 activities. As a result, senior government officials thought it would have been more realistic to focus on co-location as the outcome initially rather than full integration.

8.3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

The provision of culturally accessible services is a priority shared by the CFCs and is reflected in the observations made by senior government officers, CFC managers and staff, and parents using the centre.

A key consideration for cultural accessibility has been the convenience of the location and the welcoming nature of the built-environment. During the establishment phase of the CFCs, local coordinators were required to conduct community consultations on the design of services and programs to be delivered at, and through, each CFC. These consultation processes were instrumental in helping to ensure that the CFC building designs were reflective of the community's needs.

Definitely this place is welcomed by the community. Everyone is really excited about it. People think the space is fabulous. The fact that we have an early learning centre near the meeting space, [we] have a fire pit; It's a very culturally appropriate, culturally welcoming place.

CFC Staff member

Parents indicated that a culturally accessible service would be located near schools and transport, and in an environment where they felt comfortable and had the opportunity to engage with other Aboriginal and Torres Strait Islander parents:

I'm Aboriginal and I joined the Neighbourhood House but there were lots of white people. I felt shame, felt uncomfortable. When we had open[ing] day [at the CFC] we felt comfy because they weren't all white.

CFC Parent

The experience of implementing culturally appropriate programs in WA CFCs has highlighted the range of challenges, and responses needed, to achieve culturally informed and culturally attuned services. Where trust between community and government is low, where English literacy is a barrier, and where climate presents its own challenges, engagement takes sustained effort, creativity and patience.

Community ownership and acceptance of the centre has been promoted through engagement of community members in the naming of a centre and in the appointment of local staff. When it came to engaging parents, strategies included tailored communications, for example, displaying service provider logos rather than government logos; directly inviting parent feedback on the types of support they would like to see available; establishing a highly convivial environment through a focus on food and meal times; and having an op-shop operating from the CFC.

The efforts of CFCs to provide culturally accessible services appears to have been broadly successful in the communities visited by the evaluation team. Having put the range of strategies in place, the task ahead is to continue to promote the CFCs as culturally safe places, in order to maintain a strong presence and increase utilisation by families.

8.3.1.4 BUILDING AND STRENGTHENING CAPACITY

The CFCs have developed and fostered a number of partnerships with local service providers and organisations to offer a wider range of services for the community and to allow for integrated provision of services. For example, the Halls Creek CFC has a MOU with the Yuri Yungi Aboriginal Medical Service who offer nutrition classes and provide general health information and child health nurse services to families accessing the CFCs.

A key challenge to developing and strengthening capacity is the recruitment and retention of committed staff. The barriers to this include workforce issues, such as the lack of suitably qualified staff, a lack of

appropriate accommodation for staff, and difficulty attracting staff due to uncertainty around continued funding of the CFCs.

Senior government officials observed challenges for staff moving from small, locally based childcare organisations to the CFC, where National Quality Standards needed to be met; and that more could have been done to smooth the transition process. To address this, CFCs are looking to tailor early childhood training to better meet the needs of local staff, which could be achieved by adapting the course content of the Certificate III in Children's Services to include local context, and to allow for flexibility around practical assessment.

A lack of housing was identified as a common barrier to recruiting staff in remote locations, and to address this, negotiations with WA State Government departments resulted in an agreement that staff would not be subject to the income threshold applied to public housing eligibility. Despite this, CFC managers and senior government officials reported that housing is still a significant barrier to employment of staff.

8.3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Establishing the CFCs involved significant community engagement and cooperation between state government departments and community representatives, prior to the handover of centres to the auspicing bodies. According to senior government officials the priority placed on consulting with communities contributed to delays in the implementation of the CFCs.

In terms of building design, CFC staff in Kununurra reported that the reference group was involved in the design of the building, and that they were now looking to this group for guidance on what the community needs. In one CFC the design of the building was not what the community had expressed during consultations.

Community engagement has also been achieved through community representation on governance bodies. In WA, CFCs have a reference group that has representation from members of the community although this is not the case in all areas, and has led to criticisms when a reference group is comprised of mainly non-Indigenous people who, while supportive of community objectives, may not yet have struck the right balance in membership. Management structures for the CFCs appear to be working effectively with local Aboriginal and Torres Strait Islander people managing their centre:

Indigenous faces are a major plus. It's great to have an Aboriginal manager.

CFC Staff Member

CFCs reported that ongoing opportunities for community engagement and participation are also provided through 'Family Fun Days' and NAIDOC Week activities; and that CFCs also seek feedback to improve service delivery from the child health nurse and parents involved in the PACE program. Some CFCs also communicate with the community through regular newsletters. However, some of the CFC staff said that more consultation was needed with the community to understand local issues.

8.3.1.6 DATA AND REPORTING

The three operating CFCs reported that they all collected client data for reporting purposes, but that there were differing degrees of sophistication in how the information was recorded. The Halls Creek CFC records weekly client and provider information on spreadsheets. The CFC staff indicated that they mainly kept track of attendance through sign-in sheets, and record appointments with allied health professionals in a book. They are yet to develop a database to analyse the collected data, and indicated they were not at the point where they could use data to inform program development. Data collected is mostly used for reporting purposes only. On the other hand, during its development phase, the Kununurra CFC developed templates to collect information from clients of the CFC. This data is entered electronically every month and used for quarterly and six-monthly reporting, as well as to identify gaps and inform continuous improvement. The centre is also considering developing a survey to ascertain what people want and whether they are meeting the community's needs. The Kununurra OVAHS enter data into their system, but acknowledge its limitations in providing insights to inform service planning. To remedy this they place a greater weight on anecdotal evidence and advice from their Community Board.

8.3.2 ELEMENT 2

WA will receive \$17.12m over six years for the implementation of Element 2 activities. WA has committed to delivering two state-wide programs and eight regional programs, the majority of which focus on maternal and child health outcomes, and two that focus on sexual health. Specifically, the programs aim to:

- provide evidence-based clinical advice, support and education to services delivering antenatal programs
- provide education and support to reduce harm associated with alcohol use during pregnancy
- increase the provision of antenatal care services targeted at young Aboriginal and Torres Strait Islander women
- increase the provision of sexual and reproductive health services to Aboriginal and Torres Strait Islander teenagers.

The two state-wide programs are the FASD program and the AMSSU program located at the King Edward Memorial Hospital.

The FASD component of Element 2 aims to provide workforce training and support for the FASD program across Metropolitan and Regional areas of WA. Among its initiatives, the AMSSU program aims to provide an ongoing professional development course for Aboriginal and Torres Strait Islander health professionals and ongoing development and provision of support for antenatal services throughout WA.

Regional programs aim to increase the capacity of programs providing clinical and outreach antenatal care services for Aboriginal and Torres Strait Islander women, as well as the ongoing provision and development of locally relevant health promotion activities and strategies for Aboriginal and Torres Strait Islander youth and pregnant women in all regions.

The implementation of these programs is supported by WA COAG Governance structures, committees and planning forums. During the implementation of Element 2, each program developed and maintained their own local and regional partnerships to strengthen the program quality, and to extend the reach of the projects or services they deliver.

8.3.2.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

Overall, there is some evidence to suggest that Element 2 programs are strengthening outcomes for individuals and families. In terms of antenatal and postnatal aspects of Element 2, senior government officers noted that many of the Element 2 activities relate to lower level outcomes (for example, awareness), but that these could contribute to long-term change, particularly in terms of antenatal and postnatal care. The number of antenatal and postnatal sessions delivered has continued to grow, with the number of women who received a service increasing from 295 in the period January–July 2013, to 579 in July–December 2013. The percentage of young women under 20 attending sessions, and the number of women attending their first antenatal session in the first trimester, has also increased over time. Senior government officers also stated that there has been an increase in the birth weight of babies and a decrease in teenage pregnancies.

In relation to sexual health under Element 2, while there is no specific data indicating whether Aboriginal and Torres Strait Islander teenagers are better informed and are making responsible, informed sexual and reproductive choices, all regions presented evidence to suggest that there has been an increase in the number of Aboriginal and Torres Strait Islander teenagers accessing sexual and reproductive health programs and services.

8.3.2.2 INCREASING SERVICE ACCESS AND UTILISATION

A large part of the approach of Element 2 activities has related to filling gaps in service access and utilisation. Using regional forums, every region developed a plan that incorporated a mapping of services and service gaps, which were reassessed at a later point to make sure programs and services were still meeting the needs of communities. The Premier of WA has also established an Aboriginal Affairs Subcommittee, which is looking at investments in Aboriginal and Torres Strait Islander programs with the aims of avoiding duplication, and making better connections between services.

Despite the difficulty in achieving full integration of services there was some evidence of cooperation between different programs and service providers. For example, the FASD program and child and maternal health nurses are working well together to ensure that if any concerns are identified when a pregnant woman presents at the Aboriginal Medical Service she is referred to the FASD program and to alcohol and drug counselling. The FASD program has also conducted annual awareness campaigns with advertisements broadcast state-wide, which reportedly received positive feedback from the community.

Transport remains a key challenge in terms of accessing services. WA reported that to address this issue, a number of services have provided transport to clients, enabling them attend services, and that this approach has received positive feedback from clients.

8.3.2.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

A large proportion of Element 2 activities involve delivering culturally accessible outreach services that means visiting people in their communities and homes.

However, a number of women need to leave their communities to give birth. AMSSU is conducting a review and audit of accommodation and transport mechanisms for women and their support person, to ensure leaving the experience of leaving community is as culturally safe as possible.

In relation to the FASD program, when it was first established in 2009, there was concern among community members in Kununurra about whether this was women's and or men's business. However, this concern has dissipated overtime and the community is reported to be highly supportive of the FASD program and its approach. An ongoing challenge for the FASD program, however, is that it is designed to be preventative, but women often only come to the program after children are born with FASD.

8.3.2.4 BUILDING AND STRENGTHENING CAPACITY

Element 2 programs have continued to employ a high percentage (49 per cent) of Aboriginal and Torres Strait Islander employees. Unlike other Elements (and in other jurisdictions), retention and recruitment have not been major issues for Element 2 programs in WA.

A number of professional development activities have been delivered to staff, which have included the rollout of a maternal and newborn health learning framework to support health workers, remote area nurses and family support workers; the delivery of a professional development course on maternal and infant health to Aboriginal Health Services and NGO representatives; FASD training workshops for staff; and implementation of cultural awareness initiatives for the Women's and Newborns Health Service antenatal program.

The focus on FASD prevention in WA forum

In May 2013 the FASD project team, in collaboration with TICHR and the Department of Health's child and youth health network, planned and presented the focus on FASD prevention in WA forum. This was a one-day forum that featured an opening speech from Ms Andrea Mitchell MLA, Parliamentary Secretary to the Minister for Mental Health, Disability Services and Child Protection, a FASD prevention workshop by Nancy Poole, Director of Research and Knowledge Translation, British Columbia Centre of Excellence for Women's Health; a presentation from TICHR and the Department of Health's health network and a panel session. The event was attended by 65 people and was well received by participants. The presentations have been made available on the TICHR alcohol and pregnancy and FASD website.

Partnerships have been developed in order to build and strengthen capacity under Element 2. For example, the AMSSU has developed key linkages with the ACCHS, the AHCWA and the Women's and Newborns Health Service. Within the Kimberley region, the RMCH has coordinated with Broome Midwifery to increase antenatal engagement. Several other examples of partnerships in service delivery were cited as examples in other regions. Analysis undertaken utilising the Partnerships Analysis Tool (Victorian Health Promotion Foundation), estimated that of the 71 per cent of service providers who reported on partnerships, 17 partnerships were collaborative, 22 were networking, seven were coordinating and 12 were cooperating partnerships. The most commonly identified outcomes from the development of partnerships were education and training opportunities, followed by increasing access to other agencies and the sharing of information and support.

8.3.2.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

The consultation process for Element 2 has been undertaken at a community, regional and state-wide level. Community members provide feedback on Element 2 programs and are given the opportunity to raise any health issues. For example, community members voiced their concerns about teenage sexual health and domestic violence and local women reiterated their desire for a low-risk birth centre in the Kimberley. WA has also worked with community representatives to support and develop community initiatives for the FASD project. In addition, AHWs have been able to identify and refer new clients to programs through yarning in the community.

WA reported that governance structures have supported the successful implementation and growth of Element 2 programs. It has been reported that the WA COAG governance structure is an effective mechanism for managing service implementation and regional planning. However, during consultations, senior government officials reported that the relationship between the Commonwealth Government and the state could be fragile. At an operational or officer level, things work well but WA has some unique challenges which can make it hard to deliver things on the ground. According to senior government officials these challenges are not always adequately understood by the Commonwealth Government. At a state level, the state-wide forum is regarded as an effective mechanism for facilitating information sharing and decision-making. The metropolitan and regional planning forums have also reportedly been effective for the sharing of information, regional planning, coordination, collaboration, and for providing peer review of programs.

8.3.2.6 DATA AND REPORTING

Under Element 2, data is assessed every six months to see if progress is satisfactory and then this assessment is fed back to funded organisations. However, senior government officials reported that integrated reporting is difficult, as the reporting requirements are for individual programs. In particular, senior government officials noted that reporting for Element 2 programs is difficult due to the small amount of money involved and that Element 2 activities are integrated into pre-existing programs within organisations. Senior government officials suggested that to address this, the Department of Health could explore organisational level reporting instead of program-specific funding.

Senior government officials also noted that while there is clinical data available, such as birth rate, immunisation and contract tracing, it is whole-of-service, making it difficult to drill down to ascertain what specific IECD funded programs are doing. Senior government officials suggested it would have been better to do benchmarking from the beginning of the implementation of Element 2, so that change over time could be monitored. There was now insufficient time to collect baseline data and in addition to this, organisations were only now working on data collection templates.

In relation to evaluation, program managers are in the process of consulting with service providers about the development and implementation of evaluation frameworks. Five service providers have developed an evaluation framework, or are in the process of preparing one. These include one state-wide program and four regional programs.

8.3.3 ELEMENT 3

WA provided funding of \$11.25 to deliver a range of regional and state-wide programs under Element 3 that include the:

- delivery of postnatal services and outreach programs with a focus on adolescent mothers
- provision of child health and development assessment including MBS-funded services
- provision of immunisation services throughout the community.

WA has expanded programs and implemented new programs under Element 3. Two new programs include the Child and Adolescent Community Health (CACH) state-wide services, which provides the Moorditj Yarning Kulunga Playgroups program, enabling access to occupational and speech therapy; and a Young Dads parent program that has been developed by the Great Southern Aboriginal Health Service. The aim of this program is to educate and stimulate discussion about parenting issues among young fathers (Initial Status Report, June 2012).

In terms of governance, the three-tier governance structure provides an effective mechanism for consulting and managing service implementation and regional planning. The state-wide forum provides information sharing and decision-making; and, as with Element 2, metropolitan and regional forums are also positive spaces for information sharing, regional planning, coordination, collaboration, as well as providing peer support for implementing programs.

8.3.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

Senior government officers reported that it is difficult to ascertain outcomes for Element 3 programs because the WA model is not very prescriptive. The outcomes are broad and aspirational, and as a result the reporting is also broad and not particularly evidence-based. Nevertheless there is some indication that increased access to services is leading to improved outcomes for individuals and their families. For example, in the Goldfields the rate of immunisation is reported to have increased through the New Directions services. Joint hospital rounds are now conducted with Ngunytyu Tjiti Pirini (NTP), which has resulted in positive outcomes for client care, especially for women from the Tjuntjuntjara community.

8.3.3.2 INCREASING SERVICE ACCESS AND UTILISATION

Programs are focused on the provision of culturally appropriate maternal and child healthcare to the community and include ongoing child health checks, immunisation, speech therapy sessions and parenting skill sessions. At the time of the last reporting period, January–June 2013, a total of 7273 clients were registered with the 14 service providers; and a significant number of child health checks (1589) were undertaken, the majority (1172) of which were for children under five years.

In terms of addressing gaps, senior government officers noted that although there are a number of S&RH programs across the state, there are not many available in the areas where CFCs are located. WA is seeking to address this shortfall in S&RH programs by facilitating pap smears, STI screening and sexual health education in local schools and communities.

Transport is also a barrier to the utilisation of services and the majority of service providers in WA transport clients who find it difficult to access private or public transport to attend health service appointments. Attention has also been given to referral pathways through schools, and an audiologist has been funded to provide ear health program sessions, and to receive referrals from children who require follow-up.

8.3.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

The provision of culturally appropriate services is an important focus of staff and senior government officials. However, there is little data on whether Aboriginal and Torres Strait Islander women are experiencing fewer barriers to accessing services. Community engagement and consultation with Element 3 service providers has raised the need to continue to improve the availability of culturally secure services and resources. Current activities include the provision of information on culturally appropriate tools and resources, which is provided through training under the Enhanced Aboriginal Child Health Schedule (EACHS). Cultural training was also included in some of the professional development sessions provided.

8.3.3.4 BUILDING AND STRENGTHENING CAPACITY

A number of training initiatives have been implemented under Element 3 activities in WA. These include training for Aboriginal child health workers throughout the state about the Universal Child Health Schedule and the EACHS. In total, 89 professional development sessions and training activities were provided under Element 3 in the six-month period January–June 2013. Of these, 44 per cent were mandatory internal training; 35 per cent were child and maternal health related training; nine per cent was cultural training; four per cent was health promotion training and 18 per cent was 'general' professional development training.

The EACHS program is currently piloting a regional Aboriginal Child Health upskilling course in partnership with Marr Mooditj, a training organisation. Approximately 82 participants attended four upskilling courses in the January–June 2013 period, and the EACHS service was a finalist in the WA Healthy Awards Category 8: Partnering for Better Outcomes in Aboriginal Health.

8.3.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

The AHU continues to provide comprehensive community engagement and consultation with Element 3 service providers; and staff reported there were strong and genuine working relationships between providers and their communities. Forty-three community consultations were undertaken in the period between January–June 2013, and included focus groups, informal gatherings and interactions with participants. In addition, a total of 250 partnership meetings were held and 12 new partnerships were established in January–June 2013. Key outcomes of partnerships included improved or increased collaboration and coordination that allowed the sharing of resources and an increased ability to develop and deliver programs and services.

8.3.3.6 DATA AND REPORTING

As for Element 2, senior government officials noted that reporting against Element 3 activities is difficult due to the small amount of money involved for each individual program. Element 3 programs have been working on developing service reporting tools to improve the capture of information from programs.

9 South Australia

9.1 SUMMARY OF ACHIEVEMENTS

Implementation of the NPA IECD in South Australia (SA) has been largely successful across all elements. Key observations include the following:

- CFCs have been operating for a relatively short time and information on their impact is limited, due in part to issues associated with data collection and evaluation consultations being undertaken before centres were fully established.
- Nevertheless, CFCs are important to each community. The range of services available at each site has expanded as staff and communities work together to identify services families with children need; and access by families has reportedly increased as familiarity with the services has increased, and relationships of trust develop over time.
- The programs established under elements 2 and 3 of the NPA IECD build on existing successful mainstream programs in SA. They have been successfully adapted after consultation with local communities and other stakeholders, and appear to be well regarded and well attended.

9.2 PROGRESS ON IECD ELEMENTS

Implementation of the NPA IECD in South Australia (SA) has been substantially completed.

Under the NPA IECD, SA was to establish three CFCs, but a decision was made to establish four. Construction of all centres was largely completed by June 2013 and while services were initially provided from interim premises, services in all CFCs were operating from permanent premises by mid-2013. SA has planned to implement an integrated model for early childhood services based on a number of core services, which are expected to be common to all centres, as well as additional services tailored to meet individual community needs. Most core services, including preschool education, occasional care, Learning Together, early intervention and prevention programs, and child and maternal health, are now being delivered in each of SA's CFCs.

Under Element 2, SA has expanded the Aboriginal Family Birthing Program (AFBP); is providing health screening and education on S&RH issues for Aboriginal and Torres Strait Islander young women and their partners; and is providing sexual health information for Aboriginal and Torres Strait Islander young people. This latter project consists of two parts: the Aboriginal Focus Schools Program (AFSP), which is targeted at school principals and teachers; and the Investing in Aboriginal Youth Project (IAYP), which is targeted at health, education and community workers, as well as young Aboriginal people.

The intensive Family Home Visiting (FHV) program for 'at risk' Aboriginal and Torres Strait Islander families of young infants in remote locations has been expanded under Element 3, as has the AFSP.

SA Health and the DECD are both very supportive of the model that brings the three elements of the NPA IECD together. SA Health has commented that 'the outputs of the three elements are all aiming to achieve better outcomes and reduce disadvantage for Indigenous young people and mothers, and there are regular meetings with the managers of the three elements to bring these together'.

9.3 PROGRESS AGAINST PERFORMANCE INDICATORS

Table 17 shows a snapshot of performance against the indicators agreed for the NPA IECD. It should be noted that in most instances, significant qualifications are attached to data items and these should be interpreted with caution.

TABLE 17 – SA PROGRESS REPORT CARD

PERFORMANCE INDICATOR	JURISDICTION RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	During the census period, 14% of all Aboriginal and Torres Strait Islander children who accessed services through CFCs in SA were fully immunised for their age. The number of Aboriginal and Torres Strait Islander children who had received the latest age-appropriate health checks for their age was not able to be determined.
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 902 SA Aboriginal and Torres Strait Islander children recorded as enrolled in (and 862 attending) preschool programs in the year before full time schooling, representing 5.4% of all enrolled (and 5.2% of attending) children. A total of 753 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 5.2% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	During the census period 27 May to 31 May 2013, 143 Aboriginal and Torres Strait Islander children and 45 Aboriginal and Torres Strait Islander families accessed services at or through CFCs in SA.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	The age-standardised rate of access by Aboriginal and Torres Strait Islander mothers in the first trimester was 57.5% in 2010. The age-standardised rate of access by Aboriginal and Torres Strait Islander mothers in the first trimester rose from 40.3% to 57.5% between 2007 and 2010, although this increase was not statistically significant (AIHW 2013b).
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	In 2010-12, the rate of notifications of chlamydia among Aboriginal and Torres Strait Islander teenagers aged 15 to 19 in SA was 3,079.7 per 100,000 population, compared to 1,174.7 among other teenagers, for gonorrhoea were 1,554.0 per 100,000 compared to 27.0, and for hepatitis C, 94.2 compared to 7.8.
7. Reduced proportion of Indigenous babies born with low birth weight each year	In the period 2008-2010, 11.8% of babies born to Aboriginal and Torres Strait Islander mothers in SA were of low birth weight, compared to 4.8% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers aged less than 20, the proportion of low birth weight babies is 10.0% compared to 7.2% among non-Indigenous mothers (AIHW 2013a).
8. Reduced mortality rate of Indigenous infants each year	Due to small numbers, state and territory specific trends were not calculated.
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	In 2010, the crude proportion of Aboriginal and Torres Strait Islander mothers in SA aged less than 20 who reported smoking during pregnancy was 47.9%, compared to 39.8% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers older than 20, the crude proportion who reported smoking during pregnancy was 60.6% compared to 15.5% of non-Indigenous mothers (AIHW 2014). Between 2007 and 2010, the rate of smoking during pregnancy fell by 4.1% for Aboriginal and Torres Strait Islander mothers, but this was not statistically significant. In 2008, the proportion of Aboriginal and Torres Strait Islander mothers in SA who reported drinking alcohol during pregnancy was 16.9%, while 9.1% reported using illicit substances. Both figures have a relative standard error of between 25% and 50% and should be used with caution.
10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	In the period 2009-10 to 2010-11, hospital separation rates for Aboriginal and Torres Strait Islander children in SA aged under 5 was 362.6 per 1000, compared to 248.5 per 1000 for non-Indigenous children (AIHW 2013a). Between 2004-2005 and 2010-2011, the rate of hospital separations for Aboriginal and Torres Strait Islander children in SA aged under 5 increased by 5.1%.

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by AHMAC.

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

9.3.1 ELEMENT 1

SA received \$25.22m in Commonwealth funding over six years for this element of the NPA IECD. The SA Implementation Plan included the following key components, to:

- identify sites and establish four CFCs by December 2011
- improve Aboriginal families' access to early childhood care, education, health and family support services by building up these services in the CFCs
- increase employment of Aboriginal people in early childhood development to offer culturally competent services
- ensure integration of early childhood services through CFCs
- engage Aboriginal women, men and community members in the design and delivery of early childhood services in CFCs.

SA's CFCs have been developed in a range of locations, including one in the Adelaide metropolitan area (Christie's Beach), one in a regional location (Whyalla) and two in remote parts of the state (Ceduna and Ernabella). Many of the core services envisaged by the SA model were being provided from all four centres at the time of the SA Report in 2012–13.

SA has established a range of governance structures for the CFCs, which bring together key stakeholders at the state level and also provide for engagement and involvement of local people at the community level. SA Health has established the Indigenous Early Childhood and Young People Working Group to coordinate these elements with the Department of Education and Child Development, Families SA, and children and family related programs through Closing the Gap.

Similar to other jurisdictions, the construction of CFCs in SA was delayed, with only one centre having been completed by the end of 2012; although by the time of the SA Report January–June 2013, all four CFCs had been largely finished. During this time services in three CFCs were operating from interim sites and one from a permanent location; and by mid-2013, services in all CFCs were operating from permanent premises.

SA CFCs were to feature core services based on the following:

- access to 15 hours per week of preschool education for 40 weeks of the year before children attend school
- occasional care, which is short-term child care for babies, toddlers and children under school age
- the Learning Together program, an early literacy program for families with children from birth to three years of age
- early intervention and prevention programs for children with additional needs
- adult learning opportunities so that parents can engage in supported study to attain a qualification or South Australian Certificate of Education to support employment opportunities
- child and maternal health including:
 - health promotion and support on parenting, hygiene, nutrition, safety and oral health
 - child health checks and immunisations
 - infant and maternal care
- family support to enable parents to guide and nurture their child's physical, social and emotional needs

- community development and capacity building opportunities through centre governance structures, parent information and support programs and targeted and universal playgroups.

Element 1 has been led by the Department of Education and Child Development (DECD), and implementation arrangements have drawn on approaches already employed in the development of non-Indigenous CFCs. This has led to a governance approach adopted for all CFCs that incorporates a specific partnership group engaging key service providers in the planning and provision of integrated strategies and directions to support achievement of CFC outcomes (Government of South Australia, 2013). In three of the SA CFCs there is a centre director, a community development coordinator and a family services coordinator. In the fourth centre (Ernabella), the school principal provides leadership to the CFC and supports the work of a community development manager.

In terms of services, most core services are being delivered in each of the CFCs, with tailoring to suit the needs of individual communities.

9.3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

There is currently no specific evidence available in relation to this outcome; however, SA reports that it does collect data on a regular basis through the Learning Together program and that this data will be available during 2014. Further DECD collects preschool enrolment data through the Early Years System. This system is currently being expanded to include collection of information relating to programs, services and participants and will provide more detailed data around the Children and Family Centres. Learning Together aims to provide early learning opportunities for children in the context of their families and also assists parents to support their children's early learning and development, as well as encouraging parents' own learning. Other programs that also involve individuals and parents, such as FaFT, Yarning Time sessions, Oral Health Promotion, Bringing Up Great Kids, and Circle of Security, are expected to support this outcome.

Anecdotal evidence suggests there is a high level of support for the SA CFCs and increased attendance at the centres' programs. For example, in Whyalla (Gabmididi Manoo CFC), it was reported that 'local families and the community generally are excited to be part of the new centre' (SA Report January–June 2013); and the DECD has reported that 'there has been a steady increase in the number of Indigenous women attending programs and services in the CFCs'. Evidence from consultation visits suggests that prior to the existence of CFCs, in some locations, Aboriginal families were disengaged from the health and community services system.

9.3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

The SA CFCs have been operating for a relatively short time and, as reported by a senior officer, the data that is available is limited and fragmented at this time. As discussed above, the expanded Early Years System will collect accurate and relevant data from the CFCs. Furthermore, some services, such as child support (counselling and disability services), were not operating at the time of the most recent report. In this context, the data provided for the census period 27 May–31 May 2013 may not provide a full picture; it does however, show that 143 Aboriginal and Torres Strait Islander children accessed a total of 41 early childhood services, including early childhood education, early learning activities, child care and 'other' services. In terms of family and parenting services, 45 families accessed 26 parenting and support services.

South Australia reports that since second term 2013, preschool enrolments have increased at two of the three newly constructed centres; and the number of programs offered at each site has also increased. In addition, the range of programs available at each site has increased as staff and the communities work together and discuss the services families and children need. South Australia also reports that each of the CFCs has reported increased enrolments and attendances at parenting programs and general support, enthusiasm and praise for the new centres, their staff and the support provided there.

Other anecdotal evidence, also suggests growing levels of access:

Access by Aboriginal families has increased over time, as families come to know more about the services and support offered; relationships and trust have developed over time. Parents and families appear to be more willing to engage, for example, through informal conversations as they drop kids off, picking up and taking away information, increasing take-up in groups for young mothers, participation in end of term celebrations.

CFC Leader

SA reports that across all the CFCs there is an aim to deliver services in a holistic or comprehensive manner by developing partnerships with a range of organisations, delivering services on site and at the CFC and as part of outreach and home visiting programs. Membership of regional advisory boards and local networks is also common across the CFCs. A senior officer indicated that 'CFCs should be a "connection point" for Indigenous people to services more broadly'.

CFC leaders reflected on the process of setting up partnerships with other organisations, saying that Families SA is an important player, while also noting close coordination with services such as local schools, health services, maternal health and Centacare, which delivers the C4C program. Coordination of services is assisted by local partnership forums; by mapping existing and complementary services; and joint-working arrangements including, sharing venues, and training and assistance provided to other agencies such as Centrelink. CFC leaders also commented on the importance of having a building that provided an early childhood focus, with links to other services, which allowed easier access to a range of programs.

9.3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Anecdotal evidence about the acceptance of the CFCs by Aboriginal families described earlier can be viewed as an indicator of the CFCs as culturally safe places. SA reports that informal discussions, through partnership groups and parent engagement groups, also demonstrate the value placed on them in each community.

CFC leaders also commented on the importance of leadership and governance that has a focus on cultural competency and appropriateness, for ensuring services are culturally secure. For example, leaders explained how assigning an Aboriginal name to centres is culturally symbolic and powerful; and that three centres have achieved this after extensive consultation with the community.

Also at the CFC leader level, DECD states that, to ensure there is a continued focus on the specific needs of Aboriginal and Torres Strait Islander children and families, CFC directors have participated in workshops, which have a focus on developing a 'joined up' approach that reflects a philosophy of acknowledgement, engagement and inclusion of Aboriginal history, culture and community. In addition to this, the services provided through the Ernabella CFC are an example of the way services have been tailored to reflect and suit the needs of the community. Programs include an arts education program; FaFT, which focuses on parenting skills and literacy through the use of art and craft activities; a breakfast program with food provided through the Red Cross; and an NPY (Ngaanyatjarra Pitjantjatjara Yankunytjatjara) Women's Council nutrition program. Additionally, a Child and Family Health Service permanent visiting program is also delivered and involves nursing visiting 1–3 days per fortnight, to deliver the Early Childhood Development Program under FHV.

At a staffing level, senior officers reported that staff are required to participate in cultural awareness training on an ongoing basis and that all services are expected to report against service agreement objectives for cultural competency. They provided a number of examples of the way services are adapted to the needs of Aboriginal and Torres Strait Islander families including recruitment of Aboriginal and Torres Strait Islander workers, and encouraging Aboriginal women to support other women and children attending appointments.

9.3.1.4 BUILDING AND STRENGTHENING CAPACITY

All SA CFCs have a mix of established and new partnerships in their communities that includes local schools, Families SA, Obesity Prevention and Lifestyle (OPAL), Housing, Aboriginal Family Support Services, Save the Children, Child and Family Health Service (CAFHS), and Centacare.

Capacity building is also developed through the recruitment of Aboriginal and Torres Strait Islander staff to CFCs, as well as in the professional development of staff. Senior officers reported that the recruitment and employment of Aboriginal and Torres Strait Islander workers across the initiatives were key outcomes for the NPA IECD. The CFCs have employed Aboriginal and Torres Strait Islander staff across all locations, including two directors, three coordinators, and three staff members at Whyalla. This reflects the importance of CFCs to work force development in a community, as well as providing a culturally safe place.

The location of the CFC appears to have a major impact on recruitment. As SA reports, in the metropolitan and regional locations including Christie's Beach and Whyalla, there are no significant issues related to recruitment and retention of staff. However, both remote centres, Ceduna and Ernabella, report

challenges in this area; and a strategy to address this issue is being developed in these locations, involving discussions with TAFE to support students interested in employment in early childhood services.

In terms of professional development, SA reports that all CFCs have an emphasis on further extending the skills of their employees. This is achieved through an onsite professional development program, and through specific training in areas such as Learning Together. For all CFCs leaders are encouraged to attend the Leadership Development Program in Adelaide, which focuses on a range of themes, including leadership, engagement and capacity building, and engaging parents.

9.3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

As indicated earlier, the governance model for SA CFCs is based on experience with non-Indigenous CFCs. It is designed to be consistent across each of the CFCs and includes the establishment of a partnership group that engages with key service providers. The DECD explains that each of the CFCs has been provided with information and training sessions around governance and that these have been open and offered to community members, local agencies and members of a governing council and the partnership group. Community members and centre families are invited to be on the governing council, partnership group and a parent engagement group, and are provided with information about the structure of their group, responsibilities and participation.

Engagement arrangements were to be adapted to meet individual community circumstances and it would appear that this has happened. CFC leaders acknowledge the critical importance of community engagement. One CFC leader reported they used the standard approach as a guide, but worked it through more specifically with the local community and in consultation with the DECD regional director. Senior officers reported community engagement as 'relatively informal' and that it may occur through parent engagement groups, between staff who are Aboriginal and Torres Strait Islanders, and through staff links and relationships within the community. 'Yarning Time', which is coordinated by a community development coordinator, is another example of more informal arrangements.

Some of their comments suggest there has been a lengthy process in finding the right formula and having to work hard to adapt the standard model. One CFC leader noted that:

This is particularly an issue in "divided" communities, where there may be a number of groups that need to be involved. The role, structure, protocols and processes of a governing council need to reflect the sensitivities across different groups and enable ongoing participation and inclusion. In one instance, this took several months to work through.

CFC Leader

CFC leaders also made a distinction between 'engagement in service design and planning' and 'engagement in service delivery'. With regard to the former, they reported 'mixed experiences of engagement in the design and planning phase', and explained that an initial investment was required to build Aboriginal and Torres Strait Islander voices into the process; and that this was required again, once construction commenced to ensure the process remained true to those requirements. Senior officers identified the design and construction of Taikurrendi CFC is an example of a consultation process that was collaborative, and created opportunities for community members.

In terms of engagement in service delivery, South Australia has reported a number of examples that show how CFCs have engaged with and been responsive to community needs. They include:

- a financial counselling service run by Centacare at Gabmididi Manoo (Whyalla) CFC. This initiative was instigated by staff after several families reported financial difficulties. The service is regularly attended and families have informed staff of the benefits
- family support and community development programs at Ceduna CFC that are being shaped by community need, and identified through consultation and local discussions undertaken by the community development coordinator and family services coordinator
- the delivery of targeted programs at Taikurrendi (Christies Beach) CFC for Aboriginal and Torres Strait Islander children and families, such as Starting Out Right, Rapped in Culture, Deadly Dads, Families Cooking Together, Aboriginal Meminis and Learning Together.

9.3.1.6 DATA AND REPORTING

SA reports that all CFCs collect data in accordance with the requirements of the NPA IECD and that this includes the ten performance indicators that must be reported against annually. CFC data is collected through the Learning Together and Allied Health Program as well as whole-of-centre data relating to preschool enrolments and attendance, occasional care attendance, attendance numbers at parenting programs, outcomes of programs, and the numbers accessing crèche.

There was a strong view among some CFC leaders however, that data collection does not capture the key activities that deliver outcomes for families and children. These include fundamental activities that centres undertake to offer inclusive and appropriate support and include community relationship building; capacity building; partnership development; relationship and skills development; referrals to specialists, or the number of visits by specialists; and possible outcomes linked to those referrals.

Both DECD and SA Health commented on the limited data available on the effectiveness of the program, particularly as data collection and consultations for the evaluation had occurred 'before centres had time to fully establish staff teams, develop programs and establish effective links and relationships with service providers and community members'. DECD is currently negotiating a new data collection system for all centres across SA.

9.3.2 ELEMENT 2

SA received \$5.35m in Commonwealth funding over six years for this element of the NPA IECD. The SA Implementation Plan for this element includes the following key components, to:

- improve the sexual health, wellbeing and safety of Aboriginal and Torres Strait Islander children and young people in targeted rural and remote communities in school grades 5–10 by:
 - increasing access to relationship and sexual health education programs
 - improving the sexual health literacy of Aboriginal and Torres Strait Islander students
- improve access to sexual health services for Aboriginal and Torres Strait Islander young women and their partners
- expand the current Country Health AFBP based in Port Augusta and Whyalla and to integrate the program with midwifery services across selected country and metropolitan sites.

SA Health has noted that the programs underpinning this element of the NPA IECD in SA are well regarded, evidence-based services. In particular, the Yarning On program was developed by Sexual Health Information Networking & Education SA (SHine SA) from the successful Focus Schools program that commenced in 2006; the expansion of the AFBP across additional country and metropolitan sites was based on the successful Anangu Bibi Birthing Program that commenced in Port Augusta in 2004.

Sexual health for Aboriginal and Torres Strait Islander young people projects are being run by SHine SA and has involved increasing school involvement the AFSP and IAYP. SA reported that as part of the AFSP, 17 nominated schools plus four additional schools were successfully engaged; and in relation to IAYP, 20 community groups were successfully involved in the project.

The second area of focus provides sexual health screening and education on sexual and reproductive health issues for Aboriginal and Torres Strait Islander young women and their partners, and is run by the AHC of SA (AHCSA). This program developed an STI and blood-borne virus handbook and rolled out the education program over a six-week period across ten Aboriginal community controlled health service sites for which an has been developed. All community controlled health organisations — except Nganampa, which has its own screening arrangements — now participate.

The third area under Element 2 involves the expansion of the AFBP, an antenatal care program that aims to increase early access to antenatal services, provide support to reduce risk factors such as smoking, drug and alcohol; and improve families' understanding of the importance of good nutrition and sexual health. SA explained that this was an innovative program because it involves implementing a whole new model of AHW-led antenatal care in hospitals.

9.3.2.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

There is limited data on outcomes for individuals and families under this element. Evidence about utilisation of the services under this element is included in the next section below.

9.3.2.2 INCREASING SERVICE ACCESS AND UTILISATION

Data available from SA shows a strong take-up of STI screening services. Between 29 April–7 June 2013, the Sexually Transmitted Infections Screening Program screened a total of 415 people during the six-week period, and of these, 252 people were within the 16–30 year age group targeted by this program. Thirty-nine people (15.5 per cent) were identified as having one or more STIs; and 16 cases of chlamydia, 8 cases of gonorrhoea and 15 cases of trichomoniasis were detected.

In terms of access to the AFBP, SA reported that all targets across country and metropolitan areas were exceeded during 2011–12 (Evaluation Interim Report, p53) and again in 2012–13. In 2012–13 there were 136 births across all country sites against a caseload target of 120; and 119 births across all metropolitan sites against a case load target of 90 (SA Report 2012–13). SA Health refers to research that shows only 42 per cent of women receiving mainstream public care described their antenatal care as 'very good' compared with 80 per cent of women receiving care from a metropolitan AFBP service and 57 per cent of women attending a regional service.

Fieldwork at Port Augusta confirms the effectiveness of the Anangu Bibi Birthing Program. Mothers consulted said that the program has had a positive impact on the Aboriginal community overall, and most families are aware of the program and how to access it. They indicated that access is gained quickly and referrals and appointments are confirmed within a week.

There was agreement that women were now accessing services when they would not have accessed any services before. It was anecdotally reported that before this program was introduced, it was common for Aboriginal women to have to go to Adelaide to give birth because they experienced a range of complications. Now it is generally only women with pre-existing complications, such as diabetes, who have to go to Adelaide, rather than a complication resulting from the pregnancy. It was suggested by two midwives that this was because more women were receiving care throughout their pregnancy by accessing the Anangu Bibi Birthing Program, and concerns were identified early on in the pregnancy.

This project has changed the lives of women birthing. There is much more antenatal contact, less premature deliveries, Aboriginal contact with the health services has increased tenfold...the statistics prove that the outcomes are great.

Midwife, Anangu Bibi Birthing Program, Port Augusta

Some mothers mentioned that there were many positive benefits to having the support of the program in Port Augusta: as well as healthier mothers and babies, mothers noted that it also addresses social issues including Centrelink, food vouchers, budgeting, maintaining scheduled appointments, and better self-care and awareness. There are links to other services, and mothers are trying out the playgroups and parenting programs, which they would not have accessed before being a part of the program.

Anangu bibi birthing program: consumer comments

'They were so supportive — I didn't want them to leave my side and they didn't.'

'It made my last two pregnancies so much easier — having someone pick me up and take me to appointments was a huge difference to me and they helped me pay my bills too. Having toddlers in the home is so much easier now because of their support because I have three kids under 5'.

9.3.2.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

There is no specific information available that goes to perceptions of cultural safety by service users. However, the way services have been established and their acceptance in communities is indicative of their cultural safety. The sexual health program implemented by SHine SA is an example. This program required the development of training materials into a format suitable for Aboriginal children, which SA reported has been well received by the target group. In a similar way, the acceptance of the AFBP, with satisfaction levels well above mainstream services, shows the way this program has been made relevant to Aboriginal communities. This reflects the design of the program to be culturally safe, including the

employment of Aboriginal and Torres Strait Islander workers, and support for them to complete midwifery qualifications.

9.3.2.4 BUILDING AND STRENGTHENING CAPACITY

Senior officers report that new partnerships have been established under this element, including the training partnerships under the AFBP; new health networks under the Women's and Children's Health Network; as well as new partnerships between non-government and community sector organisations, and partnerships to support outreach activities. Furthermore, SA Health has established the Indigenous Early Childhood and Young People Working Group to coordinate Elements 2 and 3 with DECD, Families SA, and children and family related programs through Closing the Gap.

SA has also established program-specific governance structures, for each program under this element, to assist in building community buy-in of the programs. In addition to the program-specific governance structures, SA reported that it has run regular internal meetings that cut across all of the national partnerships and other programs working with children. Another success is that relationships between the Aboriginal Health Service and the hospital have been strengthened. Having established these structures, South Australia has expressed concern that none of the programs would be sustainable when the NPA IECD funding ceases.

SA Health reports there is an increased supply of early childhood workers as part of the AFBP. The program has an emphasis on recruiting Aboriginal and Torres Strait Islander workers and training them so that the service delivery needs are met. The supply of workers has increased in so far as some women, who would not have worked at all before, are now working as AFBP workers. Mentoring is also an aspect of arrangements in SA. As part of the sexual health education program, experienced staff at SHine SA mentor new staff, and young people mentor other members of the community, to spread the word about sexual health.

9.3.2.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

South Australia reported that extensive community consultation has been undertaken with key stakeholders including ACCHOs. Examples of issues addressed include the involvement of local communities in the development of Aboriginal materials for the AFSP and the development of a local management structure and Aboriginal ownership for the AFBP.

This engagement is reported by SA to continue across all locations and that effective partnerships now exist between the Country Health SA Local Health Network, the AHCSA and the community controlled sector. Partnerships are supported by Memorandums of Administrative Arrangements. In metropolitan areas, collaborative partnerships are reported with Country Health SA Local Health Network, Nunkuwarrin Yunti, the AHCSA and the metropolitan local health networks. Referrals are occurring between the SHine SA sexual health program to ACCHS.

9.3.2.6 DATA AND REPORTING

All programs under this element are required by SA Health under the terms of their service agreements to deliver monthly activity reports, which became quarterly after April 2012; and quarterly financial reports that are then provided to the Portfolio Executive, SA Health. SA Health indicates that these reports are used to monitor program performance and to inform future policy and program development.

9.3.3 ELEMENT 3

SA provided funding of \$3.75m to support this element of the NPA IECD. The SA Implementation Plan for this element of the NPA IECD includes the following key components:

- expand the intensive home visiting program, FHV, which involves regular home visits by specially trained nurses, into remaining rural and remote areas of SA
- expand the AFSP into schools with a high proportion of Aboriginal and Torres Strait Islander students in attendance
- increase the incidence of smoke-free pregnancies among Aboriginal and Torres Strait Islander women and their families, and maintain postnatal smoking cessation, through the Smoke-Free Pregnancy Project, with a focus on services that provide antenatal care to Aboriginal and Torres Strait Islander women and their families.

SA has reported progress on projects and activities consistent with its Implementation Plan. An outline of progress in relation to these projects is as follows:

The intensive home visiting program, FHV, is a two-year preventative parenting program and the NPA IECD component provides a proportion of funding towards the expansion of the program. The program is offered to eligible families identified by child and family services nurses at the universal contact visit. It has been adapted from a mainstream program to provide an emphasis on working locally with remote Aboriginal communities.

Working in partnership with the Anangu community and with providers including Nganampa Health, the NPY Women's Council and the Pitjantjatjara Yankunytjatjara Education Committee (PYEC) has resulted in the development of the culturally appropriate early childhood development program for the APY Lands, which has a focus on infants aged 0–3 years and their families. The service commenced in Pukatja and Kenmore Park in February 2012, and is fortnightly.

SHine SA's AFSP aims to improve the sexual health, safety and wellbeing of young South Australians by supporting schools to develop a whole school approach to relationships and sexual health education. In 2011–12, the expansion of the program continued around curriculum development and provision of support and training to schools with a high proportion of Aboriginal and Torres Strait Islander young people. The program targeted eleven schools from the Limestone Coast region; and in 2012–13, expansion continued to include schools in the Limestone Coast, Murray and Mallee, Eyre and Western, and Far North regions.

9.3.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

There is little evidence currently available concerning the outcomes for individuals or families under this Element. However, the AFSP has extended its reach during 2012–13: a total of 360 teachers participated in the 15 hour professional education course; 472 teachers participated in updates and introductory sessions; and a further 465 teachers participated in other professional development sessions. In the FHV program, there is potential for families to increase their capacity to support their children. Through the program, families are linked into community services such as treatment and intervention programs, community support groups and parenting programs delivered by Playgroups SA, the Children's Centres and the non-government sector.

9.3.3.2 INCREASING SERVICE ACCESS AND UTILISATION

Senior officers reported that child and maternal health services were being accessed at higher levels by Aboriginal and Torres Strait Islander women and children, referring specifically to the FHV program and the Early Childhood Development Program on the APY Lands. ... The Early Childhood Development Program is the version of the FHV program designed for remote Aboriginal communities that commenced on the APY Lands in February 2012 with a team of four nurses. As at 30 June 2012, the overall FHV program state-wide had 1576 active clients, including 187 Aboriginal clients and as at 30 June 2013, the program overall had 1602 active clients, including 184 Aboriginal clients. Since commencement of the mainstream program in September 2004, 534 Aboriginal and Torres Strait Islander clients have successfully completed the two-year program.

9.3.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

As indicated earlier, the Early Childhood Development Program has been adapted from the mainstream FHV program to provide an emphasis on working locally with remote Aboriginal communities. Working in partnership with the Anangu community and with providers including Nganampa Health, the NPY Women's Council and the PYEC has resulted in the development of the culturally appropriate early childhood development program for the APY Lands. The service commenced in Pukatja and Kenmore Park in February 2012, is delivered each fortnight, and has a focus on infants aged 0–3 years and their families.

9.3.3.4 BUILDING AND STRENGTHENING CAPACITY

Working in partnership has been integral to the Early Childhood Development Program, the version of the FHV program designed for remote Aboriginal communities. The program was developed in partnership with the Anangu community and in consultation with Aboriginal organisations including Nganampa Health Service, the NPY Women's Council and the Pitjantjatjara Yankunytjatjara Education Committee. The program is delivered in partnership with local Anangu staff in local CFCs.

9.3.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

In relation to the AFSP, negotiations and discussions are reported to have occurred with targeted school communities via school leadership groups, school staff, governing councils and parent meetings. Engagement and partnership with local communities in relation to the Early Childhood Development Program (FHV) is described earlier.

9.3.3.6 DATA AND REPORTING

There are no additional observations about data and reporting to those already included earlier in relation to Elements 1 and 2.

10 Tasmania

10.1 SUMMARY OF ACHIEVEMENTS

Implementation in Tasmania has been largely successful across all elements, with key successes including:

- that information exchange and collaborative effort at the state-wide level has led to a cohesive set of service investments in Tasmania
- effective integration, where CFCs provide services funded through Element 2 (family planning and antenatal services) and Element 3 (Child Health and Parenting Services). While full integration of these services remains in the early stages, indications are that significant benefits are being derived from co-location *and* integration in these instances
- a focus on capacity building and a partnership approach to the rollout of a range of resources and professional training initiatives on sexual and reproductive health, including train-the-trainer approaches, is strengthening the broader workforce knowledge and skills in this area
- that there are positive early indications that rates of access by Aboriginal and Torres Strait Islander people to child and family services, family planning and antenatal services are trending upward, which reflects the work of CFCs to engage with the community to overcome access issues to the centres.

10.2 PROGRESS ON NPA IECD ELEMENTS

The implementation of the NPA IECD in Tasmania has been broadly successful. Two CFCs were funded through Element 1 and both have been delivering services since 2010. The construction of the Bridgewater CFC (Tagari Lia) has finished, with its formal opening occurring in July 2012; the refurbishment and construction projects at Geeveston CFC Wayraparattee were completed in June 2013. Both CFCs are now offering adjunct care, early learning and creating early linkages with local schools, child and maternal health services, health promotion and a number of child and parenting support activities, including a full-time psychologist at Wayraparattee and a speech pathologist at Tagari Lia.

Tasmania's Element 2 commitments have included the development and delivery of teenage sexual health education and promotion strategies, including through Family Planning Tasmania (FPT); smoking cessation initiatives; professional training in both cultural competency and sexual and reproductive health, which has included COL and Mooditj Leader Training; and the development of collaborative practices that strengthen links between Aboriginal and Torres Strait Islander organisations. Key services associated with these collaborative links have included antenatal and family planning services. A focus has also been on increasing the availability and uptake of community-based pregnancy and support services through the Aboriginal Midwifery Outreach Project (AMOP), which has seen an increase in young Aboriginal and Torres Strait Islander women accessing antenatal care.

Element 3 activities in Tasmania are coordinated through the Child Health and Parenting Services (CHaPS) within the Department of Health and Human Services (DHHS), in partnership with the Tasmanian Aboriginal Centre (TAC), South East Tasmanian Aboriginal Corporation (SETAC) and Community Gateway Services. The focus of efforts has been on providing a broad range of culturally appropriate services for families, such as the placement of CHaPS workers in Tasmanian Children and Family Centres (including the two IECD funded sites), TAC and SETAC sites. Services have evolved over time, and in March 2013 a new model of care was implemented, which includes emphasis on engaging vulnerable families that may have found it difficult to access CHaPS services in the past.

10.3 PROGRESS AGAINST PERFORMANCE INDICATORS

Table 18 provides a snapshot of performance against the indicators agreed for the NPA IECD. It should be noted that in most instances, significant qualifications are attached to data items and these should be interpreted with caution.

TABLE 18 – TASMANIA PROGRESS REPORT CARD

PERFORMANCE INDICATOR	JURISDICTION RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	During the census period 27 - 31 May 2013, 86.1% of all Aboriginal and Torres Strait Islander children who accessed services through CFCs were fully immunised for their age, 88.6% had received the latest age-appropriate health checks for their age and 87.3% were up to date in both immunisations and health checks.
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 563 Tasmanian Aboriginal and Torres Strait Islander children recorded as enrolled in (and 544 attending) preschool programs in the year before full time schooling, representing 8.4% of all enrolled (and 8.3% of attending) children. A total of 559 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 8.5% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	During the census period 27 - 31 May 2013, 95 Aboriginal and Torres Strait Islander children and 28 Aboriginal and Torres Strait Islander families accessed services at or through the two Indigenous CFCs in Tasmania.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	No data for Tasmania are available for this indicator.
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	In 2010-12, the rate of notifications of chlamydia infections among Aboriginal and Torres Strait Islander teenagers aged 15 to 19 in Tasmania was 758.3 per 100,000 population, compared to 2,286.1 other teenagers. The rate of notifications of gonorrhoea among Aboriginal and Torres Strait Islander teenagers aged 15 to 19 in Tasmania was 0.0 per 100,000 population, compared to 6.3 among other teenagers. No reliable time series data are available for these indicators.
7. Reduced proportion of Indigenous babies born with low birth weight each year	In the period 2008-2010, 8.2% of babies born to Aboriginal and Torres Strait Islander mothers in Tasmania were of low birth weight, compared to 5.2% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers aged less than 20, the proportion of low birth weight babies is 6.6% compared to 7.9% among non-Indigenous mothers (AIHW 2013a). No reliable state-level trend data are available for Tasmania.
8. Reduced mortality rate of Indigenous infants each year	Due to small numbers, state and territory specific trends were not calculated.
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	In 2010, the crude proportion of Aboriginal and Torres Strait Islander mothers in Tasmania aged less than 20 who reported smoking during pregnancy was 63.3%, compared to 45.5% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers older than 20, the crude proportion who reported smoking during pregnancy was 52.8% compared to 20.5% of non-Indigenous mothers (AIHW 2014). No reliable state-level trend data on smoking rates is available for Tasmania. In 2008, the proportion of Aboriginal and Torres Strait Islander mothers in Tasmania and the ACT (combined) who reported drinking alcohol during pregnancy was 19.1% (note this figure has a relative standard error of between 25% and 50% and should be used with caution) (AIHW 2013a).
10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	In the period 2009-10 to 2010-11, hospital separation rates for Aboriginal and Torres Strait Islander children in Tasmania aged under 5 was 128.1 per 1000, compared to 152.0 per 1000 for non-Indigenous children (AIHW 2013a). Between 2004-2005 and 2010-2011, the rate of hospital separations for Aboriginal and Torres Strait Islander children in Tasmania aged under 5 increased by 100.5%.

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by AHMAC.

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

10.3.1 ELEMENT 1

Tasmania received \$8.09m in Commonwealth funding over six years to establish two CFCs, which occurred in the context of Tasmanian state government investment in mainstream CFCs.¹⁴ The implementation and operation of CFCs in Tasmania has been led by the Department of Education. It is important to recognise that the two Indigenous CFCs are part of a network of 11 CFCs in Tasmania. This enables strategic planning and policy development to support delivery. The Tasmanian Early Years Foundation (TEYF) funded learning and development strategy (LaDS) teams to support the implementation of community development processes for Tasmanian CFC communities — including Geeveston and Bridgewater — from 2009 (Murdoch Children's Research Institute, 2013, p13).

During the developmental phase, local Aboriginal groups and the community were engaged in the first instance. This was followed by engagement with key stakeholders, including LEGs, local government and the DHHS, was supported through a CFC Development Project Team Support Group. Collaboration between government departments across the three Elements was also supported by an inter-agency group.

The construction of CFCs in Tasmania experienced early delays — as in most jurisdictions, but is now fully completed with both centres operating from new, or refurbished permanent premises. Key issues causing the delays in Tasmania related to an early decision to co-locate a state-funded Learning and Information Network Centre (LINC) with the CFC at Bridgewater, which slowed the planning process; and difficulties in finding a suitable site for the Geeveston CFC.

Tagar Lia wins architectural award

The CFC in Bridgewater won the Alan C Walker award for Public Architecture in 2013 (Australian Institute of Architects, 2013).

The Jury citation said that:

The Bridgewater LINC and Tagari Lia Child and Family Centre is exemplary in demonstrating the synergy possible when different facilities are drawn together under a single roof — in this instance, a library, Service Tasmania shopfront, and child and family centre. An exhaustive community consultation process has engendered local ownership, and the completed project has truly been a catalyst for social connectedness in what is a demographically disadvantaged municipality.

The service model employed in both Tasmanian Indigenous CFCs is a co-location model designed to be facilitative of integrated service delivery, particularly in relation to core programs offered by both the Department of Education and the DHHS, including services funded through Element 2 and 3. The service development approach began with community consultation, which is consistent with the Platforms model (Department of Education, 2010; Centre for Community Health, 2009), which focuses on the development of local community partnerships to lead the reconfiguration of services in response to identified local needs (Centre for Community Health, 2009).

10.3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

Both CFCs in Tasmania offer parenting and family support programs, which are reported to have been successful in engaging local Aboriginal and Torres Strait Islander families. The CFCs report an increasing uptake of key programs, and interviews from the field support the view that they are having a positive impact for participants, including equipping participants with new skills, and increasing their confidence to support the developmental needs of their children. The successful completion of parenting programs at one CFC has in some cases provided a pathway to undertaking further education at TasTAFE. A key enabler for parent participation in training appears to have been the provision of adjunct care that supports parents' continued engagement in the centre, which has led to parents becoming COL or Mooditj facilitators.

An example of an individual outcome includes the personal growth evident in a young Aboriginal mother, who has transitioned from being a volunteer at the Geeveston CFC, to being engaged to deliver parenting programs at the CFC, after facilitator training. This mother is one of three Aboriginal mothers, who were unemployed but are now employed by the centre.

¹⁴ At March 2014, there were eleven operating Child and Family Centres in Tasmania, including the two IECD-funded services. A twelfth CFC has also been funded but is not yet operating. (Department of Education, Children and Family Centres (web page), accessible at http://www.education.tas.gov.au/parents_carers/early_years/Programs-and-Initiatives/Pages/Child-and-Family-Centres.aspx (last accessed 3 March 2014).

Further evidence of the impacts of parenting and skills training is found in the observations made by parenting program facilitators:

Parents are celebrating the achievements made by the young mums when they didn't before. There was a lot of lateral violence. It is so much easier now that we have common things to talk about.

CFC Parenting Program Facilitator, Geeveston

One father said to me: this course did more for me than years of therapy I have been doing.

CFC Parenting Program Facilitator, Geeveston

The Bridgewater CFC, Tagari Lia, has also featured in the Prime Minister's 2013 *Closing the Gap Report* as an example of an investment that is 'making a real difference to the lives of children and their families' (Australian Government, 2013, p54).

10.3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

The number and the diversity of programs offered at each CFC, the partnerships and networks now in place, as well as the pathways for participation and the plans for further development, reflect dynamic environments that have been enthusiastically embraced by the community. The weekly program combines formalised parenting-oriented and adult education programs, informal participatory activities, and sessions delivered by other providers from the CFC. The clinics and programs run through the CFC have provided pathways for services to reach families in the target communities, with a clinic provider observing that:

We are so excited to be able to provide services in the [region] but especially so in [the CFC] because it goes further...It gives us an opportunity to talk to young mums about anything — like private parts and naming things correctly. It helps us talk to parents about how they can talk about these things with their children...

External Partner

The CFCs have been able to provide choices and opportunities that did not exist before, and this is driving growth in access to services and utilisation by Aboriginal and Torres Strait Islander families in the communities in which they are established. Strategies are in place to address local barriers to service access, including provision of community transport and adjunct care. Effort invested in understanding key relationships within the local community also appears to be important to enabling CFCs to engage influential members as 'advocates' for the service, who may then encourage others to attend.

A key enabler of the growth in service access is reported to include having an Aboriginal worker leading or attending and supporting programs. Where the worker could not attend, stakeholders reported that some parents became very uneasy, and sessions were not as productive. A challenge is to remove the dependency of the families on the workers.

Stakeholders in Geeveston reported that as a result of the CFC, more Aboriginal and Torres Strait Islander women and children are accessing Child Health and Parenting Services (CHaPS), and that some parents come to the CFC 'every day'. This is supported by unpublished data, which indicates an 80 per cent growth in the number of instances of families attending services at Geeveston CFC between March 2013 and October 2013.

Engaging dads

Workers at Wayraparattee participate in the newly established men's group and the parenting programs. They suggest to some of the men to go for a walk with them and meet the new parents in the parent program. Now the men go on their own which is a major change from pre-CFC.

We see more dads coming to the centre now who we [used to] only see in the street in the community. They are more confident and speak up more and spend more time with their children at the centre.

Tasmania also reported that during the first CFC census period, held in Tasmania between 27–31 May 2013, 24 types of services were being provided to children through CFCs and 21 services were being provided to families through the CFCs. Twenty-eight Aboriginal and Torres Strait Islander families, including 95 children, accessed services at, or through, the CFCs in Tasmania. During the census period,

86.1 per cent of children who accessed services through the CFCs were fully immunised for their age; 88.6 per cent had had all age-appropriate health checks; and 87.3 per cent had had both.

10.3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

The CFCs in Tasmania have developed a cultural identity that resonates with community members and makes services culturally safe places. Aboriginal Elders have had input into the development and establishment of both centres from the beginning including design, language, resources and programs. Stakeholder reports about the efforts taken by some Geeveston staff to learn about the town, its history and Aboriginal cultural issues provides evidence for the recognition of cultural respect, as a fundamental requirement for providing culturally accessible services.

The role of the centre as a point of cultural focus is also supported by observations from partnering services about the value of cultural awareness training in helping their workers understand and respond to the cultural needs of individuals. The success of the CFCs in providing a safe place to access services, including in-reach or visiting services was articulated by one mum:

The Centre doesn't discriminate. I don't feel like everyone is looking at me or the other mums. We feel welcomed and supported by the staff of visiting services, which didn't happen before.

Aboriginal Mother, Geeveston

The consistency of reported feedback and the evident commitment to processes that support culturally safe and appropriate services — such as engaging community in governance, employment of Aboriginal and Torres Strait Islander people, partnerships with local Aboriginal and Torres Strait Islander service organisations — indicate that Tasmanian CFCs are delivering culturally accessible services that are valued in their communities.

10.3.1.4 BUILDING AND STRENGTHENING CAPACITY

Through a range of integrated partnerships and relationships, Tasmanian CFCs are enjoying some success in building local capacity in both Aboriginal and Torres Strait Islander organisations and non-Indigenous organisations. Tasmanian reporting supports the contention that CFCs are strengthening individual, service and community capacity. CFCs are directly training, employing and providing volunteer opportunities for Aboriginal and Torres Strait Islander people, as well as partnering with SETAC and TAC.

The Tasmanian CFCs also appear to be strengthening capacity in the non-Indigenous sector to work effectively with Aboriginal and Torres Strait Islander Families. CFCs are reported to be working closely with non- or quasi-government organisations such as FPT, Tasmania Medicare Local, and with 'mainstream' areas of local and state government agencies to provide integrated or co-located services. A key example is evident in state reporting and stakeholder feedback that points to strong linkages between the DHHS

Working together agreements

The development of a 'working together agreement' at Wayraparattee is the result of community members and service providers brainstorming the ways services could most effectively engage with and provide services to the community.

The agreement is signed by each service providing a program from the CFC, and sets out mutually agreed expectations. As a new service commences work from the centre, a community member leads their induction, with the conversation including "this is how we want you to work with us".

CHaPS program and both Geeveston and Bridgewater CFCs. CHaPS nurses work on-site at the CFCs offering opportunistic child health assessments, parenting information and referrals to other services.

Tasmanian senior officials point to the influence of the LaDS, an initiative supported by TEYF and funded by the Tasmanian Government since 2009, to lead change by building capacity in partnership arrangements. The LaDS is a planned professional development program for staff and community members who are involved in the establishment and operation of CFCs (Department of Education, 2013, p9). It has an explicit focus on the Family Partnership Model developed by the Centre for Parent and Child Support in the United Kingdom (Davis & Day 2010) and uses the Platforms model for community engagement (Centre for Community Child Health, 2009).

The importance of the physical infrastructure to the success of service integration and partnerships is underscored by feedback from community stakeholders: construction of the CFC has made it easy for people to have incidental meetings, for service providers to get to know each other and to personally introduce clients for referrals. It also means that some service providers, which previously may not have been approached, are now familiar to the service users. For example, at Geeveston, one stakeholder described how community stigma associated with seeking mental health support has diminished. The stakeholder noted that many Aboriginal and Torres Strait Islander clients of the CFC 'would sooner fly to the moon than see a psychologist...', but that since psychological services have been positioned within the CFC, the psychologist has a waiting list and is very popular amongst the local community.

10.3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

While CFCs in Tasmania are government-operated, state-level reporting and stakeholder feedback secured during field consultation indicates that the development and implementation of Tasmanian CFCs has been characterised by a high level of community engagement and participation in service planning, development and now, operation.

As noted above, both Tasmanian CFCs were developed using the Platforms model, which emphasises local community engagement in planning and reconfiguring early childhood services. While CFCs are government-operated in Tasmania, they have been led locally by LEGs established to support their development and implementation. The LEG at Geeveston convened for two years, with the support of a recognised Aboriginal leader, before being replaced by the Wayraparattee Advisory Group (wAG) in November 2012, while the Bridgewater LEG, which is chaired by an Aboriginal Elder, continues to operate and is supported by an Aboriginal Advisory Group.

The wAG also appears to act as a conduit for community members and staff to participate in service development. It was reported that prior to each wAG meeting a notice is sent to both the community and staff about the meeting and that this provides an opportunity for them to identify any issues to be discussed.

Community engagement extends beyond the formal structures of centre governance. The partnership with the two Tasmanian Aboriginal corporations has been crucial in this engagement with a senior CFC stakeholder reporting that it has 'allowed for access to culture' for many community members who have been isolated from their cultural identity.

In terms of the programs on offer, there is open dialogue about what the community wants from the CFC, including changes to existing programs or new programs they would like to do in the future. Evidence of meaningful influence being exerted by the community is supported by anecdotal reports including engagement of a pregnancy support worker at Geeveston CFC in response to community feedback that such a role would help with engagement around other services within the CFC.

10.3.1.6 DATA AND REPORTING

Tasmanian reporting indicates that there is an active focus on service and policy development through the use of key data, including the results of the AEDI, which indicate Tasmanian Aboriginal and Torres Strait Islander children continue to be vulnerable against a number of indicators. The AEDI results are reported by senior CFC stakeholders in Tasmania to have triggered a focused response from the CFCs to refresh ways of engaging with individuals and ways of responding, as part of a network of early-years' services.

For example, Geeveston CFC is taking a systematic approach to engaging identified families through multiple home visits to consult each family about their preferences and needs. In Bridgewater the response to the AEDI results is being planned together with community-based early-years partners. Practical action includes closer engagement with Centrelink case coordinators to proactively identify vulnerable families and refer them into the CFC programs.

10.3.2 ELEMENT 2

Tasmania received \$3.21m over six years for implementation of Element 2 activities. The Tasmanian *Implementation Plan* articulates a broad suite of actions to support achievement of the Element 2 objectives. These included:

- distribution of key resources to Aboriginal services and other NGOs

- delivering sexual health and relationships education and health promotion strategies
- delivering sexual health training to workers working with young Aboriginal people
- providing Aboriginal cultural competency training to mainstream services that provide sexual health and relationships education to young people, including young Aboriginal people
- developing collaborative practices between Aboriginal and Torres Strait Islander and mainstream services that provide antenatal care
- delivering Aboriginal Cultural Competency training to mainstream services that provide antenatal care
- exploring options to increase community-based pregnancy support to young Aboriginal women in the north, north-west and south of the state
- increasing capacity for new, or innovative, models of service delivery by hospital antenatal services, and ensuring that opportunistic screening and referrals for smoking, alcohol and other risk factors are part of antenatal visits
- providing brief intervention training in smoking cessation, alcohol and drug minimisation for workers in antenatal care settings, children and family Services, NGOs and youth health services
- ensuring provisions for antenatal and postnatal care are included in planning for CFCs.

Implementation was supported by a project team within DHHS and informed by a consultation strategy that encompassed the views of sector stakeholders including Aboriginal and Torres Strait Islander organisations and other organisations, as well as young Aboriginal and Torres Strait Islander people. The strategy also focused on ensuring collaboration with areas responsible for implementing Elements 1 and 2 of the NPA IECD.

10.3.2.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

At this stage, progress toward strengthening longer-term outcomes for Tasmanian individuals and families through Element 2 funded activities can only be assessed by examining intermediate outputs that are focused on activities expected to result in improvement over time. The focus has been on antenatal care, smoking cessation and health promotion activities related to sexual and reproductive health.

In terms of antenatal care, all AMOP midwives are reported to be working well within the participating Aboriginal organisations state-wide. Quarterly statistics from community-based midwives, particularly in the north and north-west, indicate that Aboriginal women are continuing to access more antenatal care, and that home visits are also on the increase.

In relation to smoking, while very high rates of delivery of smoking cessation brief interventions are reported, AMOP midwives working within participating Aboriginal organisations continue to report unacceptably high rates of young Aboriginal women smoking during pregnancy.

A range of health promotion activities have focused on providing sexual and reproductive health education and information. Resources including condoms, contraception kits, pregnancy tests and hygiene packs have also been distributed to young people in Tasmania. These efforts have utilised a number of distribution channels to increase accessibility, including direct provision and through funded agencies. While levels of actual use by Aboriginal and Torres Strait Islander young people are unknown, increasing accessibility and availability of information and resources is likely to enable young people to better manage and preserve their own sexual health.

10.3.2.2 INCREASING SERVICE ACCESS AND UTILISATION

A key indicator of success of Element 2 funded efforts is the greater number of Aboriginal and Torres Strait Islander people now reported to be accessing antenatal services in Tasmania. Women are accessing more antenatal care and home visits are increasing, particularly in the north and north-west of the state. There are also encouraging results in the reported decrease in the gap between the number of Aboriginal and Torres Strait Islander and non-Indigenous mothers accessing antenatal care earlier in pregnancy, regardless of age group.

For example, it was reported that in the first six months of 2013, 82 per cent of young Aboriginal women under 20 had more than eight antenatal visits during their pregnancy, compared 61.9 per cent in the previous year.¹⁵ This result is reported to be largely attributable to the IECD funded AMOP positions, which work with participating Aboriginal organisations state-wide.

Broad data on access to sexual and reproductive health services is not readily available although there are signs of increased access. FPT has implemented measures to increase access to clinic services including the provision of two outreach clinics, one of which is an Element 2-funded fortnightly clinic at Geeveston CFC.

The number of Aboriginal and Torres Strait Islander clients accessing FPT services is also reported to have increased substantially over the period of the NPA IECD. A key contributor to the gains made, identified by senior stakeholders in Tasmania, is the continuing development of FPT's engagement with the Aboriginal and Torres Strait Islander community in Tasmania. Through this genuine engagement, services are reaching new groups of clients.

There has also been significant investment in the delivery of sexual health promotion and education to Tasmanian school students and their parents, with a focus on schools with proportionally high Aboriginal and Torres Strait Islander populations, as well as through other organisations. Programs are delivered through a mix of direct provision or train-the-trainer models, and have included Relationships and Sexual Health (RASH), COL, Mooditj and others.

Engaging on sexual health matters

The FPT clinics have given out 7,000 condoms to young people, who text FPT for them, and which are then mailed out every Thursday for the weekend.

FPT have ensured consistency in staff across the clinic they run through the local cfc and the nurse delivering school-based information sessions. As a result, young people see a familiar face, and have provided positive feedback about this.

Information stalls also provide creative ways of engaging young people to stop and have a chat, utilising 'games' that reduce stigma. One example is the fishing game, where the young person hooks a question about STIs from a bucket and poses the question to the health professional.

Widespread distribution of 22,000 copies of the resource *Talk Soon Talk Often: A Guide for Parents Talking to Their Kids About Sex* (Walsh 2011) is also reported to have been well received. The Tasmanian project team adapted the Western Australian version of this resource, ensuring it was Tasmanian specific. The impact of this resource has not been formally evaluated.

10.3.2.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES, PROGRAMS AND RESOURCES

Strategies employed in Tasmania to ensure culturally accessible services have included the provision of cultural competency training to mainstream agencies and services, to increase their capacity to engage and work effectively with Aboriginal and Torres Strait Islander people. A positive indicator of reducing barriers is the earlier uptake of antenatal care by Aboriginal and Torres Strait Islander women. Tasmania reports that the gap in mean gestation between Aboriginal and Torres Strait Islander and non-Indigenous women at first antenatal visit is closing.

Stakeholders involved in sexual health and antenatal services that have co-located with CFCs have also indicated that integration with the centre was important to their ability to engage with community members:

We are ever grateful to have had the CFC opportunity and to deliver locally because I have lived in [region] for 19 years and it is a tight knit area, so it is a real privilege for community organisations to invite you in and even better when the clients say, "go and see our workers" — this is where we get that rapport.

FPT Worker

¹⁵It should be noted that these data carry the qualification (as reported within Tasmania's Annual Report) that '[s]ervice usage numbers for Aboriginal women aged under 20 years giving birth in Tasmania are very small. These numbers are too small to be used as a reliable benchmark on which to determine future changes and cannot be reported as trend data.

Implementation of Element 2 in Tasmania has included the roll out of the Mooditj program, a sexual health and positive life skills program for Aboriginal young people aged 10–14 years. While the program has not been formally evaluated in the Tasmanian setting, an earlier evaluation of its implementation in Western Australia found beneficial knowledge and behavioural outcomes that were likely to support better sexual health for its participants (Powell 2008). Participation by sexual health staff, educators and nurses in Mooditj Leader Training was also reported to be beneficial in equipping providers with skills for engaging young Aboriginal people to discuss sexual and reproductive health issues.

While many of the resources distributed in Tasmania through IECD funding have been mainstream resources, rather than being adapted or designed specifically for an Aboriginal and Torres Strait Islander audience, stakeholders in Tasmania indicated that this approach was appropriate in the Tasmanian setting. The project explored the development of Tasmanian Aboriginal specific sexual health resources with participating Aboriginal organisations but given the smaller, dispersed population in Tasman this approach was not cost effective. Early consultations with Aboriginal youth indicated a preference for accessing the same sexual and reproductive health information as all youth.

10.3.2.4 BUILDING AND STRENGTHENING CAPACITY

Capacity building has occurred in both mainstream services, including DHHS, and Aboriginal and Torres Strait Islander community organisations in Tasmania, with the recognition that capacity gaps have existed in both settings. The view articulated by senior stakeholders in Tasmania has been that a focus on building intra- and inter-organisational capacity through workforce development and partnership building, will place gains made by Element 2 investment on a more sustainable footing.

The capacity within Aboriginal and Torres Strait Islander organisations and communities to support service delivery has benefited from investment in collaborative out-reach or partnership models, such as the pregnancy support workers situated in Geeveston CFC, and the AMOP project. More broadly, strengthening and deepening capacity within schools, communities and Aboriginal organisations has also included a focus on the provision of professional training, often under a train-the-trainer model. For example, FPT was engaged to deliver specific services and training to Aboriginal organisations; and YFER was engaged to train facilitators in the COL education package, and then support them to deliver education sessions to young people aged 14–17 years, in both community and school settings.

On the mainstream side, cultural competency training was one focus of Element 2 investment and was made available to providers of both sexual and reproductive healthcare and antenatal care, as well as to all CFCs in the state, including the non-IECD funded centres. State reporting suggests that cultural competency training has delivered benefits to non-Indigenous workers in that they reported increased confidence working with Aboriginal organisations. The DHHS also reports having recently completed development of an Aboriginal cultural competence e-learning module for all DHHS staff.

While this strengthens skills for specific program delivery, Tasmanian stakeholders report that Aboriginal and Torres Strait Islander workers who completed training also have a more generalised increased confidence and skills in talking about family planning matters with their community and clients.

There is an evident and continuing commitment to bringing and adapting successful programs to Tasmania and in developing a workforce capable of delivering them. These programs include COL, Mooditj and Sex and Ethics training, which have been developed by the New South Wales Rape Crisis Centre. More recently, the *SafeLanding* program developed by Family Planning Victoria will commence delivery state wide from June 2014. *SafeLanding* aims to 'address the barriers that schools face in delivering sexuality education' (Family Planning Victoria, 2013), and incorporates professional training and supporting resources.

An example is IECD funded COL facilitator training, which has been delivered across a range of professional groups from different services that are in contact with young Aboriginal and Torres Strait Islander people, including teachers, youth workers, social workers and midwives. FPT also continues to develop key relationships with AEOs and AEWs, including completing a residential cultural exchange, during which it delivered most components of its two-day, teenage sexuality, contraception and STIs training.

10.3.2.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Implementation of the Element 2 funded programs in Tasmania has been enabled through close engagement with Aboriginal and Torres Strait Islander organisations. Early engagement occurred with

TAC and SETAC during the planning and development stages of the programs, as well as with the Tasmanian Aboriginal Health Forum and Tasmanian Aboriginal Health Reference Group. Community consultations also occurred regularly and specific consultation was undertaken with young people.

It was reported that there is ongoing flexibility in the delivery of programs in order to meet the needs of local Aboriginal and Torres Strait Islander organisations. This has been a factor in successful engagement, as have open lines of communication with the IECD project team in DHHS. The Aboriginal and Torres Strait Islander organisations have demonstrated a significant commitment to develop the capacity of their staff, as evidenced by very good training participation rates, in order to improve young people's access to sexual and reproductive health services. Organisations have also been supported to engage with their communities through the distribution of a range of resources.

The history of implementation provides consistent examples of partnerships and collaboration across a number of projects, suggesting that program-level management has been effective in engaging with the sector and the Aboriginal community. A key example has included the partnership established by FPT with SETAC to facilitate a weekly sexual and reproductive health clinic for the Huon Valley district, encompassing the Geeveston CFC. FPT also formed a relationship with the TAC, which included FPT staff undergoing cultural competency training facilitated by TAC.

FPT have been proactively building relationships with Aboriginal organisations, which has resulted in FPT being invited and attending events run by the Aboriginal organisations. Notwithstanding the positive engagement and emerging partnerships, there are areas where engagement has not been as successful.

10.3.2.6 DATA AND REPORTING

Data collection and reporting frameworks are established for key indicators related to Element 2 initiatives in Tasmania, including throughput data collected via the DHHS Obstetrix data capture system; some outcomes data by AMOP; and six-monthly reporting by FPT. Additional data on health professionals training and cultural competency completions is also gathered. Challenges remain in terms of the quality of data and detecting significant change given the smaller, dispersed population in Tasmania.

The collection of data supports program monitoring but is also likely to facilitate evaluative activity, which is underway for Element 2.

10.3.3 ELEMENT 3

Tasmania committed \$2.5m to Element 3 activities over six years under the NPA IECD. The Tasmanian Implementation Plan indicates that Element 3 strategies were expected to include:

- provision of Child Health and Parenting Services to the Aboriginal Community
- provision of multipurpose parent and child group sessions, including those targeted at vulnerable parents, to promote health and wellbeing outcomes
- development of culturally appropriate service models for proposed new services, including participation in the 'right@home' trial, a multi-state sustained nurse home visiting randomised controlled trial designed to promote family wellbeing and child development¹⁶
- increased access and participation of Aboriginal young women to the teenage pregnancy home visiting program, known as 'cu@home'.

10.3.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

Information about specific outcomes attributable to Element 3 investment is not yet available — most available information relates to changes in levels of access. However, anecdotal indications are that increasing access to, and engagement with, evidence-based child and maternal health services is likely to positively influence longer-term outcomes.

¹⁶ The trial is being coordinated by the Australian Research Alliance for Children and Youth, and is based on the Maternal Early Childhood Sustained Home-Visiting program (Kemp & Harris 2012). More information is available at: www.aracy.org.au/projects/righthome/righthome

10.3.3.2 INCREASING SERVICE ACCESS AND UTILISATION

A key focus of Element 3 investment in Tasmania has been on increasing timely access to CHaPS. Early data, from 2011–12, suggests that rates of engagement have increased. These gains are supported by positive reports of the effectiveness of the state-wide and local relationships between CHaPS and CFCs across Tasmania, which support CHaPS nurses working closely with other family support services, in turn enabling families to access a broad range of multi-disciplinary services under the one roof.

In Geeveston, the Child and Family Health (CFH) nurses visit the CFC twice a week and have seen some great outcomes for children who may have previously 'slipped through the gaps'. They report that being based at the CFC has encouraged more parents and children to drop in and have a chat with the nurses. This is a significant change. CHaPS nurses are also situated within TAC and SETAC services to provide universal assessments, professional advice, support and information for Aboriginal and Torres Strait Islander families; and this approach is reported to both strengthen access, and provide a pathway for building trust within the community.

Partnering with a CFC

CHaPS staff reflected on the benefits of the program's engagement through the CFCs, noting that some of the disadvantaged families who struggle to meet their scheduled appointment times are now able to meet with the nurses because the CFC is open all day.

Families are actively welcomed at the CFC, and they can see their child/ren playing games and with toys rather than sitting in a waiting room in a general service setting. They are also engaged at the CFC doing other things and can opportunistically drop in on CHaP services. Staff noted an improvement in the efficacy of their work:

I am so impressed to be here – it has made my job a lot easier and nicer and I feel like I am really doing something good for the community.

[CFH nurse]

Similarly, investment in an Enhanced Child Health team within the CHaPS is focused on offering intensive assistance to families who may require it in the early years of parenting; and the *cu@home* and *right@home* initiatives target specific and vulnerable groups who may otherwise not readily access child and family services.

A key problem regularly highlighted in Tasmanian reporting is the ongoing complex issues in Tasmania which relate to the recognition of Tasmanian Aboriginality, and which are reported to have made it difficult for some families to access Aboriginal and Torres Strait Islander-specific services. The CFC is providing a pathway to needed services, in a setting that also supports people's cultural identity journey.

10.3.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

There is no specific data available that goes to the perceptions of cultural security by users of the CHaPS services. However, there are strategies in place that are likely to contribute to this outcome. For example, an operating framework for family support providers has been established. This incorporates a requirement that services will either refer Aboriginal identifying clients to dedicated Aboriginal Child and Family Support Services for culturally sensitive services; or closely consult the Aboriginal community at a local and service level, if no funded service is available in the region (DHHS 2012, p 19).

On a more practical level, some of the key reported gains in engagement made through Element 3 initiatives have been through integration or collaboration of CHaPS services with key Aboriginal and Torres Strait Islander community organisations or Children and Family Centres. This points to the importance of providing programs and services in a culturally safe space. An illustration of the impact is that when the *Launching into Learning* program moved from the local primary school in 2012 to operate from the Geeveston CFC, there were two families enrolled. There are now 13 families engaged with the program, most of who have been referred in by other families, reflecting confidence and comfort by the participants.

10.3.3.4 BUILDING AND STRENGTHENING CAPACITY

Element 3 initiatives in Tasmania have enabled the expansion of CHaPS and increased on-ground engagement with the Aboriginal and Torres Strait Islander organisations — particularly TAC and SETAC, where CHaPS nurses are placed, as well as the two Indigenous CFCs. This approach strengthens the capacity of those organisations to provide child health and parenting services to children and families in their communities. The new model of care established for the CHaPS also specifically seeks to enhance

collaborative practice, provide more flexible services and increase access opportunities for vulnerable families (Tasmanian Government, 2013).

The CHaPS also continues to work toward strengthening linkages with TAC to build awareness and recognition of the importance of the early-years, positive family functioning and parenting skills, within the Aboriginal and Torres Strait Islander community. If these objectives are realised it would likely support a strengthening of community capacity to support children's developmental outcomes in the longer-term.

10.3.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Advisory groups comprised of family support services and other organisations, including Aboriginal and Torres Strait Islander organisations, were established at area level to provide input into service coordination and program delivery. Engagement with communities at the local or ground level has reportedly been complicated by the relatively low rates of identification and the non-homogenous nature of the Aboriginal and Torres Strait Islander population.

One particular strategy, which is anecdotally reported to have yielded some success, has been for CFH nurses to connect with Aboriginal and Torres Strait Islander mothers through playgroups, e.g. playgroups run by TAC and SETAC and the Baby Chat Café at Geeveston CFC. The engagement benefits of these types of linkages are recognised in the new model of care established for CHaPS that recommends and supports the increased participation of CHaPs within CFCs and other children's services.

10.3.3.6 DATA AND REPORTING

An ongoing issue for data collection for Aboriginal and Torres Strait Islander programs in Tasmania has been the differences in data definitions used by Aboriginal Community Organisations, the Office of Aboriginal Affairs and the Australian Bureau of Statistics.

A new database within CHaPS is expected to support the reliable capture of a wider range of data and is expected to assist in improving the identification of Aboriginal families across the service system. Tasmania also reports that efforts to improve data linkages between CHaPS, TAC and SETAC, will enable Aboriginal families to be better identified across a range of services.

11 Australian Capital Territory

11.1 SUMMARY OF ACHIEVEMENTS

The ACT has successfully implemented all elements of the NPA IECD in accordance with its implementation plans. Key findings are:

- the West Belconnen CFC (WBCFC) at West Belconnen was among the earliest to be built and have services operating
- the WBCFC has developed strong partnerships with key stakeholder organisations in the ACT and has established an integrated model made up of centre-based services, outreach services provided at the centre by partner organisations and brokered services (child care)
- the WBCFC is strongly supported by users, and has improved access for Indigenous families to a range of new and existing services
- services funded under Element 2 of the NPA IECD have produced a range of innovative responses, aimed particularly at building capacity among both users and service workers
- Element 3 funding has allowed the Winnunga Nimmityjah Aboriginal Health Service to continue to deliver the successful Aboriginal Midwifery Access Program (AMAP).

11.2 PROGRESS ON NPA IECD ELEMENTS

Implementation of the NPA IECD in the ACT has been successfully completed.

Under Element 1, the ACT was funded to establish one CFC, which was among the first to be implemented nationally and has, since that time, become well established. The approach to service delivery at the WBCFC is based on an integrated model made up of centre-based services, outreach services provided at the centre by partner organisations and brokered services (child care).

Under Element 2, the ACT established a steering committee of key stakeholders to guide the development and implementation of a single, integrated project called the Antenatal Care, Pre-pregnancy and Teenage Sexual and Reproductive Health project (APTSRH). The APTSRH includes the 'Street Beat' Youth Outreach Program, operated by the Gugan Gulwan Youth Aboriginal Corporation, which provides sexual health services and health promotion information to young people. A further project under the APTSRH is the Teenage and Young People's Sexual Health Outreach (TYP SHO) project, which is supported by the Canberra Sexual Health Centre (CSHC). The APTSRH has also funded several innovative information resources, including electronic information kiosks.

Element 3 funding has been used to continue and strengthen an existing service, the AMAP at Winnunga Nimmityjah Aboriginal Health Service. This service provides antenatal and postnatal care, community at home support, baby health checks, breastfeeding support, immunisations, and a range of women's health services. A new funding agreement between ACT Health and Winnunga, for the period 2013–16, was implemented in October 2013.

11.3 PROGRESS AGAINST PERFORMANCE INDICATORS

Table 19 provides a snapshot of performance against the indicators agreed for the NPA IECD. It should be noted that in most instances, significant qualifications are attached to data items and these should be interpreted with caution.

TABLE 19 – ACT PROGRESS REPORT CARD

PERFORMANCE INDICATOR	JURISDICTION RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	During the census period of 29 July to 2 August 2013, 89% of all Aboriginal and Torres Strait Islander children who accessed services through the CFC in ACT were fully immunised for their age, 74% had received all age-appropriate health checks, and 74% had were up to date in both immunisations and health checks.
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 129 ACT Aboriginal and Torres Strait Islander children recorded as enrolled in (and 132 attending) preschool programs in the year before full time schooling, representing 2.4% of all enrolled (and 2.5% of attending) children. A total of 131 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 2.6% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	During the census period 29 July-2 August 2013, 19 Aboriginal and Torres Strait Islander children and 22 Aboriginal and Torres Strait Islander families accessed services at or through the CFC in the ACT.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	The age-standardised rate of access by Aboriginal and Torres Strait Islander mothers in the first trimester was 57.1% in 2010. Earlier time points enabling trend data are not available for the ACT (AIHW 2013b)
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	No reliable territory-level data are available for this indicator.
7. Reduced proportion of Indigenous babies born with low birth weight each year	In the period 2008-2010, 12.1% of babies born to Aboriginal and Torres Strait Islander mothers in the ACT were of low birth weight, compared to 3.9% of non-Indigenous mothers (AIHW 2013a). No reliable territory-level trend data are available for the ACT.
8. Reduced mortality rate of Indigenous infants each year	Due to small numbers, state and territory specific trends were not calculated.
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	In 2010, the crude proportion of Aboriginal and Torres Strait Islander mothers in the ACT aged less than 20 who reported smoking during pregnancy was 80.0%, compared to 51.2% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers older than 20, the crude proportion who reported smoking during pregnancy was 55.6% compared to 9.2% of non-Indigenous mothers (AIHW 2014). In 2008, the proportion of Aboriginal and Torres Strait Islander mothers in Tasmania and the ACT (combined) who reported drinking alcohol during pregnancy was 19.1% (note this figure has a relative standard error of between 25% and 50% and should be used with caution) (AIHW 2013a).
10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	In the period 2009-10 to 2010-11, hospital separation rates for Aboriginal and Torres Strait Islander children in the ACT aged under 5 was 217.9 per 1000, compared to 139.2 per 1000 for non-Indigenous children (AIHW 2013a). Between 2004-2005 and 2010-2011, the rate of hospital separations for Aboriginal and Torres Strait Islander children in the ACT aged under 5 increased by 154.4%.

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by AHMAC.

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

11.3.1 ELEMENT 1

The ACT received \$8.09m in Commonwealth funding over six years for this element of the NPA IECD. The ACT's Implementation Plan for this element included the following key components:

- identify a site and establish one CFC by January 2011
- deliver a range of universal and targeted services to families, particularly Aboriginal and Torres Strait Islander families, in the West Belconnen area, commencing in January 2011
- deliver a range of early learning programs and improve access to childcare for children with identified vulnerabilities, particularly Aboriginal and Torres Strait Islander children; access to childcare will come in various forms, at, or through, the centre
- staff the CFC with qualified and culturally competent staff
- deliver services in partnership with the ACT Government and the wider community sector.

Implementation and operation of the WBCFC has been led by the ACT Government's Community Services Directorate. Community engagement has been achieved through consultation during the developmental phase and continues through ongoing dialogue with users. At the time of the *Evaluation Interim Report*, the CFC was described as fully operational.

The service delivery approach at the WBCFC builds on existing ACT Child and Family Centres and has aimed to establish an integrated model of service delivery. In the *Evaluation Interim Report*, this is referred to as 'the model of the emergency recovery centre for the bushfires in 2003, [which is a] co-location of government and community service providers'. A key characteristic of this model is its 'one-stop-shop' integration of both targeted and universal services.

The WBCFC offers a broad range of service types ranging from the provision of individual to group and community development services. Community development is undertaken through a range of platforms, including the Growing Healthy Families program which aims to engage, support and link Aboriginal and Torres Strait Islander children and their families to services within, and separate from, the CFC. The WBCFC has also established strong links with local child care centres to enable increased and supported access to child care by Aboriginal and Torres Strait Islander children and families (ACT Report, July–December 2012).

Underpinning the integrated model are 'strong partnerships with other services to facilitate the provision of coordinated services for children and their families' (ACT Report, July–December 2012). These partnerships have been developed with a range of government and community organisations that provide outreach at the centre. They include the ACT Women's Health Service (WHS), MACH services, the YWCA, ACT Mental Health, Care and Protection Services, local schools, church-based providers of community services, a local domestic violence service and Relationships Australia.

11.3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

The ACT has reported that programs offered at the WBCFC, such as Growing Healthy Families have produced positive outcomes for Aboriginal women. For example, the Yurwang Bullarn Strong Women's group component of this program offers a range of activities that are based on client-identified needs and issues. Activities include group activities focused on nutrition, selfcare, parenting, culture, art and craft. A senior officer also observed that the case management offered to all clients of the Centre, has led to increased engagement with parenting services and supports, and has increased the parenting capacity of participants. Voluntary case management has been taken up more by Aboriginal parents than anticipated, and the key worker, who acts as advocate, referrer and, at times, as adviser, has helped parents to resolve a range of complex issues.

Staff at the WBCFC speak positively about the impacts the program has had on individuals and families; and this is reflected in the fieldwork consultations with service users, who found that the type of programs available through the WBCFC have helped them develop capacity to meet their children's developmental needs. One parent explained that as a result of the referral services at the WBCFC, she was able to have her son diagnosed with autism, and she was able to seek relevant support for him and herself. Other users said the CFC has provided a location for women to gather together and make friends with other

parents. From this, they were able to share stories and frustrations they experience as parents. The opportunity to build networks that the group provided was identified as particularly important for sole parents and people who are socially isolated.

11.3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

The ACT has used the centre to improve the accessibility of programs in the region. For example, prior to the establishment of the WBCFC, MACH services were offered in three locations across the ACT. Through the integration of programs at the centre, these services have been consolidated in one place and now include services delivered five days a week from the CFC, as well as two clinics a day, booked appointments, drop-ins, a new parent group, home visits and an immunisation service. This means that a full suite of maternal health services are provided at, or through, the WBCFC. They include antenatal and postnatal care, prenatal, perinatal and postnatal support, breastfeeding support, women's health, doctors, nurses and specialists.

In addition to this, the Women's Health Service has begun attracting Aboriginal clients (Evaluation Interim Report, p41). Until a review of its program delivery, the ACT WHS had concentrated its business in the city centre. The review highlighted the need to engage with women with a significant disability, women who experienced barriers to accessing the services and women who experienced violence. The WHS approached the CFC and now runs services from the centre and 'for the first time has Indigenous clients'.

The ACT reports that there is now a full range of family services accessed at, or through, the CFC in the ACT, including the child and maternal health described above, and parenting and family support services. While child care is not offered as part of the CFC, it works to establish links with childcare centres to increase access for Aboriginal and Torres Strait Islander families. Furthermore, the CFC provides brokerage for child care to vulnerable Aboriginal and Torres Strait Islander families, although the precise number of families receiving this support was not reported.

Casework support for individuals and families provided by the WBCFC links people into programs and services through one case manager. When an Aboriginal or Torres Strait Islander person is first linked with the CFC, staff ensure that he or she is introduced to the Growing Healthy Families program. During the reporting period, 40 families received services from the centre. Thirty-two of these families received case management or attended CFC programs. Eighty-one children received a service from the centre; 30 children under five years; 36 children aged between 5–12 and 18 young people aged between 13–18 years (ACT Report July–December 2012).

11.3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Considerable effort has been made at the WBCFC to ensure services are culturally accessible. Consultation with the community before, and during, CFC development was undertaken and opportunistic consultation with service users continues on an ongoing basis.

The CFC staff report a range of strategies in their approach to working with Aboriginal families. They are flexible in service delivery arrangements and will not only meet by appointment, but will talk with people when they drop-in, or will meet where a parent feels most comfortable. Staff also work at the parents' pace, allowing longer times than in other settings for engagement with a family to build a trusting relationship. Staff noted that families may not trust a service until they have had a chance to get to know the workers and the 'feel' of the centre, and their practice reflected the importance of this process.

According to CFC staff, the emphasis in the centre is around building relationships and this, 'in turn assists families to feel comfortable in the centre, so they are more likely to come to us if they need any help'. The CFC operates using a combination of both case management support and community activities that include community celebrations, community-led groups and events. The WBCFC also has a casual, 'open door' approach. One CFC worker noted that families, particularly children, 'will walk into the centre and treat it like their lounge room — and that is fantastic'.

A project is also being undertaken across service provider agencies that is aimed at developing an understanding of what would be required to 'build an effective, sustainable partnership between the five key agencies in the Belconnen area to address the needs of the Belconnen Aboriginal and Torres Strait Islander community'.

Indigenous service users from the centre's women's groups said services are meeting their needs. Transport was mentioned as being extremely important in helping them access the services there. They

also reported learning and developing new skills, which they have been encouraged to translate into workplace skills. One client explained that she learnt a traditional craft through a centre program and enjoyed it so much that she decided to start her own business, and she has been supported in practical and other ways in the start up phase of the business.

Service users say they value the services offered at WBCFC:

[Having the CFC] makes a big difference to my life, it's somewhere to go and get out of the house; somewhere to belong and somewhere to connect to other women and children.

Service User, WBCFC

11.3.1.4 BUILDING AND STRENGTHENING CAPACITY

The delivery of services through government and non-government partnerships, either as referrals from the WBCFC, or from within the centre, is seen as a core feature. For example, ACT Health and Relationships Australia both have a strong presence at the CFC and also provide outreach services. The CFC also has strong partnerships with local schools, and through these is able to assess the needs of Aboriginal and Torres Strait Islander children and deliver school outreach programs to meet their needs. A senior officer reports that both formal and informal partnerships with services in the area are functioning well, and good referral pathways are reported to be in place. Backing these partnerships is a 'will to collaborate' among partners to ensure that referrals flow easily for the services and the individual. Fieldwork interviews with a range of CFC partners confirmed that there are strong relationships in place, and there was an anticipation that over time more Aboriginal and Torres Strait Islander clients would take up the supports available.

Staffing is an important element of capacity building. Staff recruitment at the WBCFC operates within a wider ACT staffing framework provided by the Community Services Directorate Reconciliation Action Plan and the Aboriginal and Torres Strait Islander Employment Action Plan. The staffing model currently utilised by the WBCFC has been further informed by community consultation. This model highlights the importance of suitably qualified staff, Aboriginal and Torres Strait Islander workers, cultural supervision and Aboriginal and Torres Strait Islander staff in positions of influence and leadership.

Engaging Our Mob

Engaging Our Mob is a training day developed through the WBCFC'S growing healthy families program. It is designed for teachers, child and family centre workers and other education professionals and focuses on ways to engage appropriately and sensitively with Aboriginal and Torres Strait Islander clients. Engaging our mob explores the attributes, skills and beliefs of experienced people working successfully with Aboriginal and Torres Strait Islander families and communities. It has been delivered in the ACT on several occasions at WBCFC, one being at the request of local principals.

The Australian National University has also utilised Engaging Our Mob to increase cultural competency in relation to Aboriginal and Torres Strait Islander issues at the university.

All workers at the Centre have access to training and development opportunities and professional supervision. Examples of training activities that relate to Aboriginal and Torres Strait Islander issues include Engaging Our Mob, the Murray Chapman Reconciliation Speakers Series and COL. A senior officer observed that staff at the WBCFC are strongly culturally attuned and are working effectively with all community members. The skill of the team is considered to underpin the achievements of the centre, and reflects a commitment for all staff to work with all community members, rather than having a model where Aboriginal workers are focused on Aboriginal families.

In terms of Indigenous staffing, there are two Aboriginal staff employed at the centre: the Centre Manager and a worker funded through other Commonwealth sources.

11.3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

The implementation phase of the CFC has involved strong community consultation, with a steering committee established to guide this process. The WBCFC is seen as being consultative, flexible, develops trust, is willing to compromise, doesn't threaten turf and has a collaborative approach.

Now that the CFC is established, consultation is conducted through a community development framework, which involves feedback from groups, feedback about programs, as well as formal consultations and community events. The ACT reports that the West Belconnen Aboriginal and Torres Strait Islander community has been enthusiastic in their engagement with the centre, and that Growing Healthy Families events and programs are well attended. Input from the community has shaped the direction of the programs and services offered, and has contributed to the development of the Strong Women's Group, the Koori Kids group and a cultural school holiday program.

CFC workers provide a similar view, saying that, compared to the formal consultations undertaken with the local Aboriginal communities when the centre first opened, ongoing consultations are less formal. A senior officer also reported that consultation on program ideas and general perspectives on the centre are now gathered from people using the centre. This is said to maintain a positive environment and a strong sense of belonging among community members. Service users say they feel comfortable talking to the CFC Manager about the programs and services, including giving suggestions for improvements, or new programs and services that they would like to access.

11.3.1.6 DATA AND REPORTING

The ACT Community Services Directorate is reported to be building on the existing data collection system and reporting framework that is already in place for existing ACT CFCs. ACT Health is also continuing to undertake data improvement activities, through its work with the Aboriginal and Torres Strait Islander Data Improvement Group. Activities include the development of a new ACT health client registration policy, which will incorporate information in relation to Aboriginal and Torres Strait Islander identification.

11.3.2 ELEMENT 2

The ACT received \$1.07m in Commonwealth funding over five years for this element of the NPA IECD. The ACT's *Implementation Plan* for this element includes the following key components:

- establish a collaborative project offering antenatal, pre-pregnancy, sexual and reproductive healthcare through the provision of:
 - targeted STI testing
 - education and promotion of sexual and reproductive health
 - family planning advice and support
 - antenatal care.
- establish an antenatal care, pre-pregnancy and teenage sexual and reproductive health steering committee to inform the design and coordinate implementation of the project. The design is to include definition of the roles and responsibilities of project partners.

The planned project — the APTSRH — has become well established and has involved the participation of several schools, colleges and community organisations (Evaluation Interim Report, p48).

One component of the APTSRH project is the Street Beat Youth Outreach Program, operated by the Gugan Gulwan Youth Aboriginal Corporation that provides sexual health services and health promotion information to young people. The ACT reported that Gugan Gulwan staff have also been working in partnership with the ACT Government Health Directorate to implement the Beyond Today smoking cessation and healthy lifestyle campaign, which has a particular focus on young people and smoking in pregnancy. In terms of other resources, the ACT has developed a booklet, *Health in Pregnancy*, and a breastfeeding DVD for young mothers.

Parenting and pregnancy education, delivered through the COL program commenced in February 2012. COL was initially designed for mainstream young people in Victoria and has since been introduced to other states and territories. The program has been tailored to be locally and culturally relevant to Aboriginal people in the ACT and is delivered through sessions within schools, and as well as the non-government sector.

Sexual and reproductive health education activities are also delivered through the TYP SHO, which is supported by the CSHC. This program aims to increase the number of community organisations engaging in sexual health education and training opportunities offered by the CSHC. Resources and education materials have been developed and revised to suit the needs of individual organisations.

11.3.2.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

Information about specific outcomes attributable to the APTSRH project is not available, although an evaluation scoping paper for the project has been developed and an external evaluator will be contracted in early 2014. All components of the project are now well established and indications are that services are well attended, as indicated by usage information in the section below.

11.3.2.2 INCREASING SERVICE ACCESS AND UTILISATION

Services established under the APTSRH project are being widely used in the ACT. The successful Street Beat Youth Outreach Program has provided services including night patrols, advice and support to young people, and distributed condoms along with information and referral packs.

An interactive kiosk has also been introduced to extend the program's accessibility. The kiosk provides interactive, culturally appropriate content and resources with a health promotion focus for low literacy audiences. In the January–June 2012 period there were 530 users of the kiosk. The kiosk has been so successful that a second kiosk was installed at the Junction Youth Health Centre in late December 2013 and installation of a kiosk at Bimberi Youth Justice Centre is planned for March 2014. Data provided from January–June 2013 indicates there have been 145 'meaningful sessions' recorded on the kiosks with sexual health, hepatitis C and smoking being the most popular topics.

In an effort to boost the numbers of Aboriginal and Torres Strait Islander young people using the CSHC, from August 2012 a sexual health information, education and clinical screening project was delivered in partnership with community organisations. A part-time sexual health nurse with a youth focus was employed and as a result, the number Aboriginal and Torres Strait Islander clients accessing CSHC services has increased. In 2012, 15 Aboriginal and Torres Strait Islanders accessed the CSHC, and in 2013 this number increased to 33, with 67 per cent of Aboriginal and Torres Strait Islander clients also being aged less than 25 years.

The Gugan Gulwan youth aboriginal corporation 'street beat'

A night outreach service for under-18 year olds that aims to reduce young people entering the justice system; binge drinking rates in the ACT Aboriginal and Torres Strait Islander community; and to promote sexual and reproductive health, and smoking cessation. The program's youth workers provide through-care to the team leader, ensuring appropriate diversionary interventions are put in place to deter clients from continuing to make poor choices.

As part of the TYP SHO project, nine sexual health outreach sessions were provided during the July–December 2013 period. This included 129 participants aged 15–25 years, with the majority being in the 15–17 age group; and a total of 16 youth workers or staff. Nine young people also engaged in opportunistic sexual health screening with two positive Chlamydia results, and one positive Gonorrhoea result plus one non-immune Hepatitis B result. Approximately ten young people were referred to services.

COL is a 'hands-on' pregnancy and parenting program for teens. COL comprises teams of presenters including midwives, and other youth, health, education and community representatives delivering an education program about the journey to becoming a parent. The program utilises slide images, video, discussion and role play to portray real life. COL also offers a train the trainer program to equip community members to deliver the education program in partnership with a health professional.

During the reporting period, demand for COL sessions within schools and in the non-government sector continued to grow. From 1 July–31 December 2013, 26 sessions were provided, with a total of 369 participants across these sessions. Participating organisations included Kingsford Smith High School, Erindale College, Ted Noffs day and residential programs, Stromlo High School, the Social Inclusion Company, and Melba Copeland College.

In addition, a two-day workshop to train new facilitators was held in October 2013. This workshop was facilitated by the newly qualified instructors and was attended by 13 participants from across the ACT and

Queanbeyan region. Newly-trained facilitators will be mentored by the instructors, to deliver the program at various locations in 2014.

11.3.2.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

The APTSRH project is managed by the ACT Health Directorate through the Aboriginal and Torres Strait Islander Health Unit. A steering committee of stakeholders has also been established and its membership includes the CSHC, Sexual Health and Sexual Health and Family Planning ACT (SHFPACT), Winnunga Nimmityjah Aboriginal Health Service, Gudan Gulwan Youth Service, and Anglicare's Junction Youth Health Service. The steering committee allows a direct engagement of key Indigenous organisations to ensure the design and implementation of the project is culturally appropriate.

A number of components of the APTSRH project, such as the outreach program, Street Beat, have been designed specifically for Aboriginal and Torres Strait Islander users, as have a number of resources. These include health in pregnancy and sexual health booklets, a breastfeeding DVD for young mothers and a documentary style DVD for young Aboriginal and Torres Strait Islander parents and parents-to-be. The breastfeeding DVD features young Aboriginal and Torres Strait Islander mothers and has been requested by other jurisdictions. The DVD was presented at the National Maternal and Child Health Conference in Canberra in May 2013 and received positive feedback.

One of the issues facing the implementation of the APTSRH project is the small Aboriginal and Torres Strait Islander population in the ACT and the diversity of settings and social networks in which these young people interact. While some components of the project have been designed specifically for Aboriginal and Torres Strait Islander users, other components of the project are mainstream ones that have required a level of modification to ensure their cultural appropriateness. For example, the CSHC engaged a part-time sexual health nurse with a sexual health youth focus to work with young members of the community. In a similar way, while the COL program is not presented to Aboriginal and Torres Strait Islander young people exclusively, it has been delivered in settings where they are known to be overrepresented; and these sessions have been adjusted to be culturally relevant.

11.3.2.4 BUILDING AND STRENGTHENING CAPACITY

It is apparent that the APTSRH project has strong partnerships with community agencies including Gudan Gulwan Youth Aboriginal Corporation, the Junction Youth Health Service, SHFPACT and other community based organisations. Relationships with branches within ACT Health are also reported to be well established.

Partnerships have been built on a strong foundation of positive relationships and good will across sectors and departments in a small jurisdiction. Partnerships have been strengthened by the formation of the steering committee for the project. Partnerships have been further consolidated through the specific components of the project; for example, the COL program and the TYPCHO project have established strong working relationships with organisations such as Bimberi Youth Justice Centre, Canberra College Cares and the Indigenous Social Inclusion Company. Linkages have also been established with other ACT Government Directorates including Community Services, Education and Training and Justice and Community Safety.

The quality of partnership arrangements is also acknowledged. A senior officer said that formal and informal partnerships with services in the area were functioning well, and good referral pathways were reported to be in place. Backing these partnerships is a 'will to collaborate' among partners that ensures referrals flow easily for the services and the individual.

Capacity building has also occurred through staff training activities. SHFPACT developed a sexual health training needs analysis to inform the development of a pilot training program for Aboriginal or Torres Strait Islander community and health workers, which was delivered in March–April 2012. Ten Aboriginal participants completed the pilot program and the feedback was very positive, with workers reporting increased knowledge. A number of Gudan Gulwan staff also participated in sexual health information sessions. Participant feedback indicated that workers felt more confident to provide basic sexual health information and appropriate referral for clients. The ACT has reported that SHFPACT has just approved a project with the CSHC to trial, with other community agencies, to deliver a program aimed at disengaged youth in selected locations.

Additionally, a COL facilitators' workshop was held in March 2012. This workshop increased the number of trained facilitators in the ACT to 38. Approximately 40 per cent of participants were Aboriginal or Torres

Strait Islander and the majority of participants work with Aboriginal or Torres Strait Islander people. The ACT also introduced a model of paid facilitators, which includes midwives and Aboriginal community members, and is reportedly working well. These training sessions for facilitators continue to be offered in the ACT.

The training component of the APTSRH project provides a platform for the program's sustainability. However, the ACT says that, without further funding, all APTSRH project activities will cease at 30 June 2014.

11.3.2.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Community input into the APTSRH project is provided through broad representation on the APTSRH steering committee, which is now an advisory group, and the partnerships that have been established during the project. APTSRH was also informed by consultations led by a project coordinator.

A senior officer reported that implementation of the project faced early challenges, including securing the right personnel, and the need for engagement from Aboriginal organisations. The latter challenge reflects the sensitivities surrounding sexual health for some members of the community, as well as the existing priorities and demands on services. Overtime this has resolved, and COL training is seen to have played a part because there are now several trained facilitators able to address issues concerning pregnancy and parenting programs for teens, and sessions have been delivered successfully.

Consultations for the development of resource materials for the APTSRH project with the Aboriginal and Torres Strait Islander communities in the ACT continue to be held on a regular basis. Opportunities to inform the community on the project, including the COL and smoking cessation components are planned for community events such as NAIDOC Week, which attracts significant numbers.

11.3.2.6 DATA AND REPORTING

While there are data quality issues arising from the small sample sizes and data integrity problems with identifying Aboriginality, a more complete understanding of the project is expected as a result of an external evaluation to be undertaken in 2014.

11.3.3 ELEMENT 3

The ACT provided funding of \$0.5m to support this element of the NPA. The ACT's Implementation Plan for this element aims to increase the regularity of service provision including antenatal care; infant and child health and development checks; and immunisation rates through the provision of additional funding to the Winnunga Nimmityjah Aboriginal Health Service (Winnunga), to expand the AMAP.

A funding agreement for 2010–13 was entered into with Winnunga to continue to deliver the AMAP. While the AMAP has been running for some time within Winnunga, funding provided under Element 3 by the ACT Government Health Directorate has enabled the program to be strengthened. Comprehensive antenatal, postnatal, maternal and child health support are provided to women and their families by a team of general practitioners, midwives, and MACH nurses supported by the general health and wellness team.

More recently, the antenatal classes provided at Winnunga have included COL sessions, which represent an extension of the COL program provided to schools and the non-government sector under Element 2. Women who attend Winnunga for pregnancy services are able to access a range of supportive primary care and health promotion interventions such as smoking cessation, nutrition advice and allied health services such as physiotherapy and podiatry. Women who want to stop smoking during pregnancy are encouraged to participate in the 'No more Boondah' smoking cessation program.

A new funding agreement between ACT Health and Winnunga, for the period 2013–16, was implemented in October 2013.

11.3.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

While there is no specific data that covers this outcome, Winnunga offers an established range of antenatal and postnatal care, community at home support, baby health checks, breastfeeding support, immunisations, and a range of women's health services. Antenatal classes seek to build parental capacity

and incorporate COL concepts to promote healthy lifestyles for young Aboriginal and Torres Strait Islander women.

11.3.3.2 INCREASING SERVICE ACCESS AND UTILISATION

Funding under this element has enabled the AMAP to continue to provide services at Winnunga. During the reporting period January–June 2013, services were provided on a total of 1,201 occasions; 44 women were registered and received antenatal care and 35 women received postnatal care. In terms of the first point of visitation for antenatal care, 15 per cent visited in the first trimester, 51 per cent in the second trimester, and 34 per cent visited in their third trimester. Of the women attending, 15 were between 20 and 35 years; ten were over 35; and five were under 20 years old. The reported proportion of women smoking in pregnancy was 45 per cent; the proportion using alcohol in pregnancy was seven per cent, and the population using other drugs in pregnancy was 17 per cent.

The data represents a significant number of Aboriginal women using services at Winnunga, as well as an improvement in the rate of substance use, and the proportion of first point of visitation over the course of the NPA IECD. This showed that, for the January–June 2012 period, 22 per cent of mothers were attending antenatal care in the first trimester; 52 per cent of mothers were smoking during pregnancy and 18 per cent of mothers were using alcohol during pregnancy.

11.3.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Winnunga's AMAP is designed specifically for Aboriginal and Torres Strait Islanders. Consisting of a community midwifery team of three midwives and one Aboriginal access worker, it aims to provide antenatal and postnatal care, community at home support, baby health checks, breastfeeding support, immunisations, and a range of women's health services in 'an environment of understanding and respect'. Winnunga also provides referral to, and support in accessing, mainstream and specialist services; and the also provides information on mainstream services.

11.3.3.4 BUILDING AND STRENGTHENING CAPACITY

The ACT is a small jurisdiction and Winnunga already had well developed partnership arrangements with other service providers. In this context, the ACT reports that Winnunga has established links with ACT Health, Gudan Gulwan Youth Aboriginal Corporation and the ACT Health CFCs as well as the COL project officer, who is employed under Element 2 of the NPA IECD (ACT Report 2012–13).

11.3.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

As indicated earlier, Winnunga's AMAP existed before receiving additional funding under the NPA IECD. It already had a strong relationship with other service providers in the ACT and the ACT reports that it continues to engage with key stakeholders. Recently, Winnunga was one of a number of stakeholders in the Aboriginal and Torres Strait Islander community that had input to the ACT Health's social marketing campaign 'Beyond Today...It's up to You'. The program promotes tobacco cessation and healthy lifestyle behaviours, including information on the effects of smoking in pregnancy and in families.

11.3.3.6 DATA AND REPORTING

Winnunga has adopted the same Birthing Outcomes System as the Canberra Hospital.

12 Northern Territory

12.1 SUMMARY OF ACHIEVEMENTS

The Northern Territory (NT) has made substantial progress in implementing all three elements of the NPA IECD in a challenging environment that has resulted in construction and service delivery delays. Construction of the five CFCs is now expected to be completed by mid 2014, although four of the CFCs are providing services from interim premises. Site locations in the NT include Yuendumu, Maningrida, Ngukurr, Gunbalanya and one urban location, Palmerston. Elements 2 and 3 have largely been implemented. The key observations about the implementation are that:

- the range and design of services have been developed in close consultation with local communities, and there appears to be a high level of engagement at the community level
- access to a wide range of services in early childhood, sexual and reproductive health, and maternal and child health has greatly increased as result of the NPA IECD funding
- recruitment and retention of staff across all the program elements is a challenge in the NT.

12.2 PROGRESS ON NPA IECD ELEMENTS

The implementation of Element 1 of the NPA IECD in the NT has been undertaken in a challenging environment with the construction of the five CFCs and associated levels of service delivery delayed. At the time of this report four CFCs are providing services from interim premises across the five sites. Services are a mix of programs, covering child care (except in two communities); early childhood education and learning activities; child and maternal health; health promotion; parenting and family support; and child support services and activities.

Under Element 2 of the NPA IECD, the NT has implemented a range of projects that include capacity building through training and professional development; the recruitment of specialist Adolescent Sexual Health (ASH) promotion officer positions; and nine remote area midwives. The NT has also funded expansion of the MGP working from Darwin and Alice Springs, extended the Strong Women, Strong Babies, Strong Culture (SWSBSC) program, and has established partnerships with existing providers to deliver a range of training, parenting information, childbirth and postnatal support services.

Under Element 3, the NT has expanded the MGP and has continued to expand the coverage of universal early childhood programs, along with recruitment of additional remote community-based child health workers.

Uncertainty about ongoing funding for services that have been established, or expanded, under the NPA IECD is a significant issue. This is reported to have negatively impacted on recruitment in the final months of funding. It is also impacting on the planning and structure of services into the future; and influences the level of commitment of other organisations in planning collaboratively.

12.3 PROGRESS AGAINST PERFORMANCE INDICATORS

Table 20 provides a snapshot of performance against the indicators agreed for the NPA IECD. It should be noted that in most instances, significant qualifications are attached to data items and these should be interpreted with caution.

TABLE 20 – NT PROGRESS REPORT CARD

PERFORMANCE INDICATOR	JURISDICTION RESULT*
1. Increased proportion of Indigenous children attending the CFCs who have had all age-appropriate health checks and vaccinations	During the census period 7 May to 8 June 2012, 73.3% of children accessing services through CFCs in the NT were fully immunised for their age, 56.7% had received all age-appropriate health checks, and 56.7% had were up to date in both immunisations and health checks.
2. Increased proportion of Indigenous three and four year olds participating in quality early childhood education and development and child care services	In 2013, there were 1,286 NT Aboriginal and Torres Strait Islander children recorded as enrolled in (and 993 attending) preschool programs in the year before full time schooling, representing 38.1% of all enrolled (and 35.0% of attending) children. A total of 1311 Aboriginal and Torres Strait Islander children were recorded as enrolled preschool for 15 hours or more per week in 2013 (ABS 2014). This represented 41.6% of the total number of children recorded as enrolled for 15 hours or more per week in 2013. Trend data is not yet available as these data are not comparable to previous collection cycles due to changes in collection coverage, data development activities and collection methodologies.
3. Increased proportion of Indigenous children attending the CFCs who go on to attend school regularly	No data are available for this Indicator.
4. Increased proportion of Indigenous children and families accessing a range of services offered at or through CFCs including but not limited to child care, early learning, child and maternal health, and parent and family support services	During the census period 7 May to 8 June 2012, 49 Aboriginal and Torres Strait Islander children and 89 Aboriginal and Torres Strait Islander families accessed services at or through CFCs in the NT. These figures are likely to represent an over-estimate as individuals accessing multiple services were counted more than once.
5. Increased proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy in each year	The age-standardised rate of access by Aboriginal and Torres Strait Islander mothers in the first trimester was 53.1% in 2010. The age standardised rate rose from 50.8% to 53.2% between 2007 and 2010, although this increase was not statistically significant. (AIHW 2013b).
6. Increased proportion of Indigenous teenagers accessing sexual and reproductive health programs and services**	In 2010-12, the rate of notifications of chlamydia among Aboriginal and Torres Strait Islander teenagers aged 15 to 19 in the NT was 6,510.3 per 100,000 population, compared to 2,791.5 among other teenagers, for gonorrhoea were 6,641.4 per 100,000 compared to 362.1, for syphilis, 65.5 compared to 39.8, and for hepatitis B, 65.5 compared to 126.7.
7. Reduced proportion of Indigenous babies born with low birth weight each year	In the period 2008-2010, 12.9% of babies born to Aboriginal and Torres Strait Islander mothers in the NT were of low birth weight, compared to 4.5% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers aged less than 20, the proportion of low birth weight babies is 13.6% compared to 5.7% among non-Indigenous mothers (AIHW 2013a). No reliable state-level trend data are available for the NT.
8. Reduced mortality rate of Indigenous infants each year	Due to small numbers, state and territory specific trends were not calculated.
9. Reduce proportion of Indigenous women who use substance (tobacco, alcohol, illicit drugs) during pregnancy each year**	In 2010, the crude proportion of Aboriginal and Torres Strait Islander mothers in the NT aged less than 20 who reported smoking during pregnancy was 49.6%, compared to 25.6% of non-Indigenous mothers (AIHW 2013a). For Aboriginal and Torres Strait Islander mothers older than 20, the crude proportion who reported smoking during pregnancy was 54.3% compared to 13.2% of non-Indigenous mothers (AIHW 2014). Between 2007 and 2010, the rate of smoking during pregnancy increased by 6.6% for Aboriginal and Torres Strait Islander mothers, but this was not statistically significant. In 2008, the proportion of Aboriginal and Torres Strait Islander mothers in the NT who reported drinking alcohol during pregnancy was 14.9%. This figure has a relative standard error of between 25% and 50% and should be used with caution.
10. Reduced proportion of hospital admissions of Indigenous children 0-4 years	In the period 2009-10 to 2010-11, hospital separation rates for Aboriginal and Torres Strait Islander children in the NT aged under 5 was 472.5 per 1000, compared to 181.4 per 1000 for non-Indigenous children (AIHW 2013a). Between 2004-2005 and 2010-2011, the rate of hospital separations for Aboriginal and Torres Strait Islander children in the NT aged under 5 increased by 10.9%.

* The 2nd Annual Data Report prepared by the AIHW and on which this report card draws has been endorsed by the NPA IECD Steering Committee but has yet to be endorsed by AHMAC.

** These indicators cannot be measured directly from existing national data collections; the AIHW reports interim measures for these indicators (AIHW 2013a, p 3).

12.3.1 ELEMENT 1

The NT received \$42.35m in Commonwealth funding over six years for this element of the NPA IECD. The NT Implementation Plan for this element included the following key components, to:

- identify sites and establish five CFCs by December 2012
- integrate existing services and provide additional services, including child care, early learning, parent and family support, antenatal care for young women, teenage sexual and reproductive health services, MACH services
- develop governance structure at cross-agency and community level
- build capacity for the local workforce
- build community governance capacity
- establish a seamless service system for children and families
- improve community access to, and take-up of, existing and new services.

Construction of five purpose-built CFCs has taken longer than the anticipated December 2012 completion date. Delays are due to the time taken to negotiate land use arrangements with traditional owners in remote communities; site selection and agreement with stakeholders; and delays in the tender processes. The NT Report of January–June 2013 indicated however, that physical sites had been selected for all five centres and construction has commenced at most; and construction of the five NT CFCs is expected to be completed by June 2014. Arrangements have been put in place to expedite the design phase at Palmerston by using the same design developed for the CFC at Gunbalanya.

Although construction of CFCs has been delayed, planning and provision of services from interim premises has progressed. The model planned for NT sites is based on an integrated approach and includes the following elements: child care, early childhood learning and education, health services and parent and family support. In addition, it was expected that the integration of services would be facilitated by a child and family leader, a community-based position that 'has the goal of improving service delivery through coordinating the integration of universal and targeted child and family services (pre-birth to 8 years of age) provided by the government and non-government sector'.

Early progress was made with the appointment of child and family leaders in Ngukurr and Gunbalanya, and existing staff also undertook training to increase their capacity to provide quality services, although at the time of the December 2012 NT Report, three locations were not yet able to provide any services and two had not begun developing linkages and partnerships. By the time of the NT Report in January–June 2013, service delivery had commenced in interim premises in four remote communities.

The services being provided at interim premises are tailored to individual locations. For example, at Yuendumu the integration of early childhood services is facilitated by the child and family team, which is comprised of a child and family leader and two child and family engagement officers. Yuendumu has a well-established early childhood service system that is operating from a number of locations, by different auspice agencies.

In locations where interim services are being delivered, workers have been recruited and training has been provided. However, it is reported that:

Staff recruitment and retention is a challenge across all sectors in the NT. There is a shortage of staff in many areas and in particular health, education and other specialist support services for children and families. Reasons impacting on the difficulty in recruitment include high staff turnover, difficulty of access and remoteness

NT E1 Report January–June 2013.

This issue is highlighted by child and family leader vacancies reported in three of the five communities in the NT Report January–June 2013.

12.3.1.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

It is apparent that a key to strengthening outcomes for families and individuals is the FaFT program. The FaFT program builds family knowledge of early learning through active engagement of parents in early childhood education programs. A number of programs are delivered through the FaFT model in the NT. In Maningrida, for example, the Abecedarian Early Learning¹⁷ program is being developed and delivered via the FaFT team. The health clinic nurses attend the FaFT program regularly to provide assistance to mothers and babies around developmental growth and baby health; healthy cooking programs are run alongside adult learning activities, such as computer learning; and families are also access other health services such as oral health, anti-smoking, alcohol and drug management, and trachoma support.

The significant numbers of parents participating in FaFT suggests a contribution will be made to increasing the capacity for parents to meet their children's developmental needs. In the January-June 2013 period alone, 446 parents were reported to have participated across four NT communities.

12.3.1.2 INCREASING SERVICE ACCESS AND UTILISATION

The most recent data, from the census period 7 May–8 June 2012 reflects an early stage of service provision, but this early evidence supports the integrated early childhood service model being utilised in the NT. The CFCs and FaFT are reported to have worked 'hand in hand' to engage with families, and thereby maximise access to health and parenting support. There are also reported to be examples of FaFT and CFCs working together to address core issues of food supply and nourishment. Drawing the SWSBSC program into CFCs alongside community-based staff has also been remarked on as a positive collaboration.

Leadership was also viewed as key with capable local leadership acknowledged as being important to being able to 'harness the potential of the myriad programs and resources 'going through' communities'. NT reporting confirms that CFCs in the NT appear to have engaged with service providers through existing or new forums to bring together key local stakeholders across a range of early childhood services. A key enabler is the child and family leader role in each CFC. By way of contrast, education and health professionals in Wadeye, a community where a child and family leader roles has *not* been established, reported there is a lack of systematic integration between the range of programs. They indicated that more could be achieved through increased knowledge sharing, collaboration and coordination of resources.

Another barrier to integration highlighted by a senior officer relates to the child and family leader position. Because integrating and coordinating services can challenge how things have been done in small communities, the person appointed as a child and family leader to promote integrated services may be viewed suspiciously as encroaching on 'turf', but that this may not be visible to an external party. This situation can also affect the recruitment and engagement of workers, who risk being seen as unsettling established patterns of service operation.

12.3.1.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

The NT services have been developed with a strong emphasis on underpinning cultural values. Priorities have been identified in each location through a community reference group, and are similar across the communities: culture, healthy children and families, and local jobs for local people. The language CFCs use reflects these priorities, which helps to build trust, and promotes the use of common language about goals and the activities that relate to these goals. The development of the logo for the Maningrida CFC was offered by a Senior Officer as an example of community protocols being observed: the logo design process began with a story offered by men of the community; women then drew the meaning for women and children from the story; and from there a logo with cultural meaning was developed, and reportedly embraced by community.

The NT services have also recruited local Aboriginal and Torres Strait Islander staff in a range of positions delivering services to children and families. This includes child and family engagement officers, play group leaders, childcare workers, AHWs and FaFT playgroup leaders. Training provided is also delivered in culturally appropriate and flexible learning styles to students in a number of workplaces. An example is the Building the Remote Early Childhood Workforce Pilot that is being delivered in four communities. In addition to this, all Department of Health staff undertake cultural awareness training and

¹⁷ <http://evidencebasedprograms.org/1366-2/abecedarian-project>

are supported by Aboriginal community workers, Aboriginal health practitioners and SWSBSC workers within remote settings. The Department of Education has established an Indigenous Parenting Reference Group to oversee the cultural relevance and appropriates of programs and resources.

12.3.1.4 BUILDING AND STRENGTHENING CAPACITY

NT Reports indicate that both Aboriginal and Torres Strait Islander and non-Indigenous organisations in the early childhood sector have been engaged in all sites. All operating CFCs reported that the development of strong partnerships was a key component of their implementation.

Staff recruitment is an established challenge across the NT; and recruiting staff and developing their capacity to deliver services is an ongoing investment. Some CFCs have experienced significant challenges filling roles, and consequently at the time of reporting, some positions were still vacant. The NT reports eight strategies to minimise the high staff turnover rate, including:

- building the local workforce capacity
- assistance with airfares on a regular basis, for employees and their recognised dependents
- an allowance to assist with the cost of freight for foodstuffs that employees purchase outside the remote locality
- special study leave provisions
- an accommodation allowance in conjunction with fares out of an isolated locality
- partial reimbursement of household contents insurance premiums if higher costs are incurred.

A particular feature of workforce capacity building in the NT has been the Building the Remote Early Childhood Workforce Pilot.¹⁸ This project aims to build the capacity of local early-years workers to obtain certified qualifications to be employed in existing early-years services; and is reported to have made a substantial contribution towards increasing the supply of early childhood workers in remote communities. Additionally, a qualified trainer lives on site at each community and delivers culturally appropriate training and flexible learning to small groups of students in workplaces in the community. The tutorial work has provided opportunities for Aboriginal and Torres Strait Islander staff from across agencies to share knowledge and increase awareness of early-years services in each of the CFCs.

12.3.1.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

Approaches to engaging community have varied across CFC locations in the NT but, in general, appear to have been strong, incorporating both formal and informal structures and consultative mechanisms. In Gunbalanya, for example, the community requested that existing groups be utilised to engage in design and development of the CFC, rather than establishing a new advisory group. A different approach has been taken in Palmerston, where development has been overseen by a representative steering committee, and more recently a project development group. A key strategy for development of the local model, and for facilitating community engagement has been to utilise local people, two-thirds of who are Aboriginal and Torres Strait Islanders, as 'community linkers', to lead consultation.

The role of child and family engagement officers has been commended by senior officers; in particular their role engaging with communities to understand priorities and preferences. This approach is reported to have generated a high level of engagement in the design of CFCs, the internal layout and the program design.

12.3.1.6 DATA AND REPORTING

NPA IECD reporting requirements are detailed and the material generated by these reports has informed national level review and evaluation activity, but the extent to which these data collections usefully inform program and policy development in the NT is not known. A senior officer has commented that, given the

¹⁸Building the Remote Early Childhood Workforce Pilot is a Northern Territory Department of Education and Training initiative that has been developed in partnership with the Batchelor Institute of Indigenous Tertiary Education. Further information is available at: <http://www.ecdprofession.sa.gov.au/wp-content/uploads/2012/06/NT-Building-the-remote-workforce.pdf>

timing of service commencements and the interim nature of premises, evidence of increased access to services is not readily available at this time. This officer also has suggested the milestone structure of the jurisdictional reporting format means that they do not capture evidence of success in the form of stories and achievements.

12.3.2 ELEMENT 2

The NT received \$18.19m in Commonwealth funding over six years for this element of the NPA IECD. The NT Implementation Plan for this element included the following components, to:

- undertake research into the social and contextual influences on behaviours of NT adolescents
- establish a consistent and coordinated approach to sexual and reproductive health through training and health promotion resources
- provide adolescent sexual and reproductive health information through the recruitment of additional health promotion workers
- increase access to antenatal lifestyle and parenting education to young adults, delivered through COL and Anglicare Pandanus
- improve access to antenatal care for Aboriginal and Torres Strait Islander women under 20 years of age through remote area midwives.

The NT has reported progress on a number of projects. The Northern Territory reports that it has undertaken research to gather evidence to inform future program development. During 2011–12, a PhD student completed two three-month field placements within a Top End remote community, and disseminated preliminary results to senior researchers. Results from research conducted in Alice Springs were presented at a national sexual health conference in September 2011.

The NT's training and professional development strategy comprised two key streams: ongoing training and professional development for staff and health workers; and facilitator training to equip professionals and community leaders with the capacity to deliver training to their communities.

In relation to facilitator training, the NT reports that the Adolescent Sexuality Education Project (ASEP) has trained 90 men and 131 women in communities across the NT to deliver school and community-based sexuality education. The NT has also recognised that its existing Central Australian Aboriginal Congress (CAAC) sexuality education package was inappropriate for out-of-school settings and, as a result, a peer-based model of sexuality education for out-of-school youth has been developed. Youth-focused resources on sexual and reproductive health, the 'Choosin' Right' DVD and workbooks are being developed. Training continues to be provided according to an annual training calendar.

A project manager and seven ASH promotion officer positions are intended to support the community-based training in sexual and reproductive health described above. While the training program is progressing, recruitment and retention of staff is challenging, with positions vacant in West Arnhem and Tiwi at the time of the NT Report for July–December 2013.

Successful partnerships have been established with YFER, which runs the COL program and Anglicare's Pandanus Childbirth Education and Postnatal Support project. These projects provide a range of services including training, parenting information and support, childbirth education, community awareness forums, and confidential pre and postnatal support.

Further expansion of the NT MGP aims to provide holistic maternity care for women from remote communities. In particular, this project provides capacity for the Darwin MGP to coordinate and integrate with the Royal Darwin Hospital birth suite, the birth centre and community midwives located remotely; and for the Alice Springs Hospital MGP to employ AHWs and additional midwives to increase access for Aboriginal and Torres Strait Islander women from remote communities.

A total of nine remote area midwives were employed across the NT during the period July–December 2013. Their role is essentially to provide advice on clinical maternal issues to non-midwives in Health

Service Centres and work with other programs and organisations such as the Child Health Program and the FaFT program.

NPA IECD funding enabled the expansion of the Strong Women, Strong Babies, Strong Culture program, which relies on, and supports, senior women in participating communities to provide direct support to pregnant women and their families. Funding has allowed the development of health promotion resources and employment of an additional worker in both the Top End and Central Australia.

This project has funded a four-day health promotion short course, various workshops and the development of resources, training modules and presentations.

12.3.2.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

NT Reports suggest that Aboriginal and Torres Strait Islander teenagers are accessing sexual and reproductive health services and that these services are having an impact. Some 1800 adolescents have received sexuality education through COL sessions alone. And, according to a training provider, before COL was delivered in the NT it was rare for Aboriginal and Torres Strait Islander women to receive pregnancy and parenting education. Sexual and reproductive health education also wasn't provided to young women. Anecdotal evidence suggests that young people who have attended sessions have retained knowledge and are more aware of the need to access antenatal care when pregnant. A Wadeye educator said that COL provides young women with the message that they have options, and that these messages must be delivered at a pace tailored to the community:

Not overwhelming them...these are the choices you can make...little steps...one girl at a time; they then tell their sisters.

Wadeye COL Educator

It has also been reported that those involved with the SWSBSC program are more likely to access midwifery services in remote areas, visit clinics, and be aware of the benefits of breast feeding and good nutrition. In terms of smoking cessation, targeted reduction or cessation of smoking for expectant mothers has resulted in a modest uptake of the use of patches.

A senior officer suggested that this is starting from a very low base of pre-existing knowledge and that any impact on rates of sexually transmitted infections, for example, is a longer-term prospect. The Department of Health has indicated that Health Outcomes International is currently conducting a NT-wide evaluation of the impact of the ASEP and that this report is expected to be completed by early to mid-April 2014.

There are also barriers to achieving successful outcomes with this initiative. There is reported to be some, though diminishing, reluctance on the part of schools to release teachers for sexuality education training. In addition, sexual and reproductive health education challenges many parents who question why their daughters should not follow the established pathway, or leaving school and having babies at a young age. Peer pressure can see girls and young women withdraw from school and miss out on programs like COL; this is reportedly evident when young women partner with young men in their community, and priorities shift away from school attendance.

12.3.2.2 INCREASING SERVICE ACCESS AND UTILISATION

As well as those attending COL, there is evidence of increased attendance at midwifery and child health clinics. These programs are also said to be based on best practice evidence. The NT has said that its sexuality education packages have been favourably reviewed by UNESCO and that the 'Choosin' Right' youth sexuality education resource was presented at the 13th IUSTI World Congress conference in Melbourne in late 2012. COL is also reported to be an evidence-based program and SWSBSC has been operating for some 20 years. A particular feature that underpins the success of these programs is said by a senior officer to be the recruitment of staff within communities and the collaboration between community controlled and mainstream services.

12.3.2.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

Sexual and reproductive health programs have been designed to be culturally accessible. This is evident in their design, including the development of culturally appropriate materials such as 'Choosin' Right' recruitment of facilitators from within communities. It is also observed that by bringing parents and community leaders into the COL program, 'the stigma and shyness is reduced'. Their presence indicates to young women that it is okay to be doing the program.

The MGP has found that, for younger couples, there is an emerging trend for fathers to want to attend antenatal appointments and the birth. This reflects social change in communities, and at the same time, is challenging traditional divisions of men's and women's business. A changing expectation and meaning of cultural safety to different generations is worked through by health workers with Elders. This is critical to retaining Elders' support, while supporting the preference of the pregnant woman and her partner.

The increased involvement of fathers in antenatal appointments, and ultrasound scans in particular was observed by health workers to hold specific potential: a reduction in violence against the pregnant woman through her partner seeing the foetus via the scan, and engaging in the reality of the baby at an earlier than usual point in time.

Outreach services at Wadeye

By bringing services to the home, the 'verandah' model addresses the fear of leaving other children at home while taking a newborn to the clinic; the fear of a baby getting sick by being with sick people at the clinic; and the fear of who might be seen at the clinic if there's conflict between families. If a client is picked up they are dropped home; if there is an additional issue for the family, support for that is also discussed.

Guided by strong women workers and community workers, nurses are achieving a high level of reach into families: 'we have to do 95 per cent of our work out in the community — it's the only way to make a difference in a population like this'.

In the Healthy Under 5 Kids Program, engagement with grandmothers is proving important. In some instances, starting 'higher up', by teaching the grandmothers of children who are underfed, is more effective than working directly with the mothers.

Grandma knows we have the baby health knowledge, even though we are two young nurses. They can then influence the daughters.

Healthy Under 5 Kids Program Nurse

The success of the Healthy Under 5 Kids Program in Wadeye is also attributed to a service model that works around barriers to access within the community. This is an outreach model with a truck equipped to provide the service on the 'verandah', or at the back of the truck.

12.3.2.4 BUILDING AND STRENGTHENING CAPACITY

Funding for Element 2 of the NPA IECD has allowed the NT to continue to develop its early childhood workforce. This has been achieved by providing a range of ongoing professional development activities for staff; recruitment of seven ASH promotion officers; support for nurses and midwives to gain qualifications for professional development in group facilitation; health education and best practice antenatal care for young Aboriginal and Torres Strait Islander women and expansion of the MGP.

Capacity building has also been achieved by providing training to a community workforce. For example, in the July–December 2013 period, the ASEP team worked with the CAAC community health education program to complete a men's package and review a women's package. Over the last 12 months, it is reported that the project has trained 90 men and 131 women in communities across the NT to deliver school and community-based sexuality education. A concurrent peer-based model has been undertaken by the ASEP team to meet the needs of out-of-school youth.

Developing strong partnerships with NGOs is a further pathway to capacity building. As an example, the NT has collaborated with the YFER organisation which is said to have a core working practice aimed at collaboration and creating partnerships with communities and organisations.

Challenges however, remain, as observed by a senior officer who indicated that duplication and the absence of coordinated efforts continue to be features in some operating environments. The absence of

coordination is reported to occur between Commonwealth, territory and not-for-profit levels of investment. The view is that while these issues remain, it is unlikely that parents, young people and children will experience a fully integrated and coordinated pathway of education, care and support. Further to this, a worker on one community said there appears to be a lack of overall coordination of activities coming under the NPA IECD at the community level.

The NT also experiences challenges relating to recruitment and retention of staff although under Element 2. After experiencing close to 50 per cent turnover of project staff in late 2012, the ASEP, as of mid-2013, is at full strength. The SWSBSC program has also experienced recruitment and retention challenges in some areas for a variety of reasons, including conflict between local families. It has also been reported that retention of staff may be linked to transition issues in the NT, including a lack of pay structure or pay pathway, and intersection with Centrelink payments.

12.3.2.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

NT Reports indicate that a community development approach to ongoing community consultation has been used. NT Reports also indicate that the YFER organisation that delivers COL programs has promoted a cross-cultural and cross-generational community participation approach, by including youth, Elders and other community figures. An educator at Wadeye confirms the approach taken, reporting that COL has engaged effectively with community leaders to gain entry to their communities. The inclusion of Elders and mothers in the planning and the delivery of the program achieves both access to the young women and access to older women for whom the sexual and reproductive health information may be new. Older women sharing their stories are just one way community members participate in the training.

12.3.2.6 DATA AND REPORTING

NT provides six-monthly reports although a senior officer suggests that these reports don't capture the richness of what people believe is being achieved. Other data collection arrangements go outside these standard reports. For example, the Department of Health has indicated that Health Outcomes International is currently conducting a NT-wide evaluation of the impact of the ASEP. The YFER organisation generates its own data to evaluate COL facilitators and students, with a view to using this data to strengthen the training program.

12.3.3 ELEMENT 3

The NT provided funding of \$9.75m to support this element of the NPA IECD. The NT *Implementation Plan* for Element 3 includes the following components:

- increase access to antenatal care by Aboriginal and Torres Strait Islander women by:
 - establishing outreach midwife positions in remote areas
 - establishing a group midwifery practice to support continuity of care for women who transfer to Darwin or Alice Springs
- increase access in remote areas to early childhood health and wellbeing services by employing additional remote area community based child health workers
- maintain linkages with other services through the NT Closing the Gap coordination meetings
- involve communities through a specific maternity services community consultation process.

The NT has reported progress on projects and activities consistent with its *Implementation Plan*. An outline of progress in relation to these projects is as follows.

- Establish group midwifery practice continuity of care for remote women who transfer to Darwin and Alice Springs to give birth
 - The MGP in Darwin and Alice Springs has been expanded to provide additional capacity for antenatal, birth and postnatal care for Aboriginal and Torres Strait Islander women from remote communities. These services are operating at, or near capacity. In Darwin, an Aboriginal health practitioner commenced employment in August 2013 and two Aboriginal and Torres Strait

Islander Bachelor of Midwifery students from Charles Darwin University have undertaken placements. In Alice Springs, efforts to employ an AHW have been unsuccessful and an Aboriginal liaison officer has been appointed instead. This is said to have been beneficial to both the midwives and the women who access the service, as well as other services they have been linked to.

- Employ additional remote community-based child health workers.
 - The NT is continuing to expand the coverage of universal early childhood programs, including the Healthy Under 5 Kids package¹⁹ that has been developed in partnership between the Department of Health and Charles Darwin University, to better support practitioners working in remote areas to deliver preventative child healthcare. In the July–December 2013 period, two additional remote workers were recruited to Alpururulam and a range of training and educational activities, including SWSBSC were delivered at Papunya and Docker River.

12.3.3.1 STRENGTHENING OUTCOMES FOR INDIVIDUALS AND FAMILIES

The expanded MGP in Darwin and Alice Springs is widely used by women in remote communities. Midwives work closely with all services that are already being utilised with each individual woman and there is regular contact with remote health clinics. The NT reports that the program is at capacity and suggests that high levels of uptake indicate that women value the service and that existing barriers to access have been reduced.

The Department of Health indicates early childhood health services outside urban centres in the NT have been framed around the Healthy Under 5 Kids Program, which is based on a schedule of key, age-based reviews of young children. At the core of the key contact schedule is the surveillance of 'well child' growth and development, parenting education and support, and health promotion across the domains of child and family health and wellbeing. Anticipatory guidance and support to the child's caregivers is also provided. The program is complemented by support by the clinical staff based on their clinical judgement, in response to parental concerns and clinical observations. The NT reports that the numbers accessing maternal and child services have increased since these programs have commenced and pregnant women are presenting earlier for their first antenatal visit.

The NT also reports that workers who hold AHW qualifications are providing clinical care such as measuring height and weight in children under five years, and participating in health education and surveillance through the Healthy School Age Kids program. AHWs also provide the opportunity for individual and group education regarding parenting, feeding and nutrition. These workers link in with other health staff, both visiting and community-based.

12.3.3.2 INCREASING SERVICE ACCESS AND UTILISATION

The number of women from remote communities using the MGP in Darwin and Alice Springs shows the progress achieved in making this service culturally safe and accessible. In Darwin, the practice has provided antenatal, birth and postnatal care for 79 Aboriginal and Torres Strait Islander women from remote communities, who have given birth from July–December 2013. There are currently 87 women enrolled with the practice.

In Alice Springs, a total of 147 births were delivered through the MGP during the July–December 2013 period. Of these births, 61 involved Aboriginal and Torres Strait Islander women residing in remote communities. This represents 41.5 per cent of total births and is above the practice target of 33 per cent.

12.3.3.3 PROVIDING CULTURALLY ACCESSIBLE SERVICES

The NT reports that recruitment of Aboriginal and Torres Strait Islander people, and consultation with community, is a feature of program implementation, something relevant to both the Midwifery Group Practice and employment of remote community-based health workers. As noted earlier, the high uptake rate of the Midwifery Group Practice service is said to be indicative of its acceptance within remote communities.

¹⁹More information about the Healthy Under 5 Kids Package can be found at:
http://www.health.nt.gov.au/Child_and_Youth_Health/Healthy_Under_5_Kids/index.aspx

12.3.3.4 BUILDING AND STRENGTHENING CAPACITY

The NT reports that the recruitment of Aboriginal and Torres Strait Islander people, as well as consultation with community, are key features of program implementation for the MGP and the employment of remote community-based health workers.

As noted under the other NPA IECD elements, there is also concern in this area about the recruitment and retention of staff. A senior officer commented on the need for a long-term commitment, 'sticking to it as long as you can see there are some positives'. It was pointed out that the loss of continuity of effort with stop-start funding arrangements continues to frustrate solid outcomes being achieved.

12.3.3.5 COMMUNITY ENGAGEMENT AND PARTICIPATION

The Department of Health reports that, in the majority of communities there is involvement of local health reference groups. Consultation is also said to be an important part of the recruitment process for remote workers.

12.3.3.6 DATA AND REPORTING

A range of projects is underway to improve the quality and depth of data for MACH services. Project officers have been participating in the Perinatal Information Management Group to review and improve the perinatal data collection. In addition, it was reported that officers are participating in the advanced electronic shared care health information project, which involves reviewing data items and definitions for the pregnancy care record. The Department of Health also reported that work is progressing on the development of an NT Child Health Information Management System, which will include ongoing and regular monitoring of the delivery of key early childhood health services across the NT.

Bibliography

ABS: See Australian Bureau of Statistics.

AIHW: see Australian Institute of Health and Welfare.

ANAO: see Australian National Audit Office.

Anderson, I. (2007). Understanding the process. In B. Carson, T. Dunbar, R.D. Chenhall, & R. Bailie (Eds), *Social Determinants of Indigenous Health*. Sydney: Allen & Unwin.

Australian Bureau of Statistics (2002). *2002 National Aboriginal and Torres Strait Islander Social Survey*. Canberra, Australia: ABS.

Australian Bureau of Statistics (2009). *2008 National Aboriginal and Torres Strait Islander Social Survey*. Canberra, Australia: ABS.

Australian Bureau of Statistics (2012). *Preschool Education, Australia 2012*. Canberra, Australia: ABS.

Australian Bureau of Statistics (2013). *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011*. Canberra: Author.

Australian Government (2013). *Closing the Gap: Prime Minister's Report 2013*. Canberra. Author.

Australian Government. (2013a). *A Snapshot of Early Childhood Development in Australia 2012 - AEDI National Report*. Canberra, Australia: Australian Government.

Australian Government. (2013b). *Closing the Gap: Prime Minister's Report 2013*. Canberra, Australia: Australian Government.

Australian Human Rights Commission (2011), *Social Justice Report 2011: Aboriginal and Torres Strait Islander Social Justice Commissioner*. Sydney, Author.

Australian Institute of Architects (2013). *Community centre takes out top Public Architecture Award in Tasmanian Architecture Awards* (web page). Accessed at wp.architecture.com.au/news-media/community-centre-takes-out-top-public-architecture-award-in-tasmanian-architecture-awards/#sthash.Zvvldej.dpuf (Accessed 7 March 2014).

Australian Institute of Health and Welfare (2012). *Indigenous Early Childhood Development National Partnership Agreement (NPA IECD). First annual report on health performance indicators*, Cat. No. PHE 144. Canberra, Australia: AIHW.

Australian Institute of Health and Welfare (2012). *Indigenous Early Childhood Development National Partnership Agreement (NPA IECD). First annual report on health performance indicators*. Cat. no. PHE 144. Canberra, Australia: AIHW.

Australian Institute of Health and Welfare (2013). *Indigenous Early Childhood Development National Partnership Agreement (NPA IECD). Second annual report on health performance indicators*. (unpublished).

Australian Institute of Health and Welfare. (2013a). *National Partnership Agreement on Indigenous Early Childhood Development Second annual data report on health performance indicators*. Pre-publication draft.

Australian Institute of Health and Welfare. (2013b). *Impact of improvements to Indigenous identification in hospital data on patterns of hospitalised injury*. Canberra: Author.

Australian National Audit Office. (2012). *Indigenous Early Childhood Development. New Directions: Mothers and Babies*. Canberra, Australia: ANAO.

- Australian National Audit Office. (2013). *Indigenous Early Childhood Development: Children and Family Centres*. Canberra, Australia: ANAO.
- Australian National Audit Office. (2013). *Indigenous Early Childhood Development: Children and Family Centres*. Canberra, Australia: ANAO.
- Australian Social Inclusion Board (2008). *Principles for Social Inclusion - everyone's job*. Canberra, Australia: Australian Social Inclusion Board.
- Bowes, R and Grace, R (2014). *Review of early childhood parenting, education and health intervention programs for Indigenous children and families in Australia. Issues paper no. 8 produced for the Closing the Gap Clearinghouse*. Canberra: Australian Institute of Health and Welfare.
- Centre for Community Child Health (2009). *Guide to Planning, Implementing and Evaluating a Community Initiative*. Melbourne, Australia: The Royal Children's Hospital.
- Centre for Community Child Health and Telethon Institute for Child Health Research. (2009). *A Snapshot of Early Childhood Development in Australia – AEDI National Report 2009*. Canberra, Australia: Australian Government.
- Centre for Community Child Health. (2009). *Guide to Planning, Implementing and Evaluating a Community Initiative*. Melbourne, Australia: The Royal Children's Hospital.
- Centre for Epidemiology and Evidence (2012). *The health of Aboriginal people of NSW: Report of the Chief Health Officer, 2012*. Sydney: NSW Ministry of Health.
- CIRCA: see Cultural and Indigenous Research Centre of Australia
- COAG: See Council of Australian Governments
- Council of Australian Governments (COAG), 2006, Communiqué, Viewed February 2012, <http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/coag140706.pdf>
- Council of Australian Governments (COAG), 2007, Communiqué, Viewed February 2012, <http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/index.cfm>
- Council of Australian Governments (COAG), 2008a, Communiqué [July], Viewed February 2012, <http://www.coag.gov.au/coag_meeting_outcomes/2008-07-03/docs/communique20080703.pdf>
- Council of Australian Governments (COAG), 2008b, Communiqué [October], Viewed February 2012, <http://www.coag.gov.au/coag_meeting_outcomes/2008-10-02/docs/communique20081002.pdf>
- Council of Australian Governments (COAG), 2008c, Communiqué [November], Viewed March 2012, <http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/docs/communique_20081129.pdf>
- Council of Australian Governments (COAG), 2008d, National Partnership Agreement on Preventative Health, Viewed March 2012, <http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.pdf>
- Council of Australian Governments (COAG), 2009a, Intergovernmental Agreement on Federal Financial Relations, Viewed February 2012, <http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/IGA_federal_financial_relations.pdf>
- Council of Australian Governments (COAG), 2009b, National Early Childhood Development Strategy, Viewed February 2012, <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/national_ECD_strategy.pdf> [February 2012]

- Council of Australian Governments (COAG), 2009c, National Education Agreement, Viewed February 2012,
<http://www.federalfinancialrelations.gov.au/content/national_agreements/education/education_agreement.pdf>
- Council of Australian Governments (COAG), 2009d, Protecting Children is Everyone's Business - National Framework for Protecting Australia's Children 2009-2020, Viewed February 2012,
<http://www.fahcsia.gov.au/sa/families/pubs/framework_protecting_children/Documents/child_protection_framework.pdf>
- Council of Australian Governments (COAG), 2009e, National Partnership Agreement Early Childhood Education, Viewed February 2012
<http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_early_childhood_education.pdf>
- Council of Australian Governments (COAG), 2009f, National Partnership Agreement on Indigenous Early Childhood Development, Viewed February 2012, <
http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf>
- Council of Australian Governments (COAG), 2009g, National Partnership Agreement on Low Status Socio-Economic School Communities, Viewed March 2012, <
http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_for_low_socio-economic_school_communities.pdf>
- Council of Australian Governments (COAG), 2009h, National Partnership Agreement on the National Quality Agenda for Early Childhood and Care, Viewed February 2012,
<http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/education/quality_agenda_early_childhood/national_partnership.pdf>
- Council of Australian Governments (COAG), 2009i, National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, Viewed March 2012, <
http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/indigenous/closing_the_gap_health_outcomes/national_partnership.pdf>
- Council of Australian Governments (COAG), 2009j, National Plan to Reduce Violence Against Women and Their Children, Viewed February 2012,
<http://www.fahcsia.gov.au/sa/women/progserv/violence/nationalplan/Documents/national_plan.pdf>
- Council of Australian Governments (COAG), 2011a, Intergovernmental Agreement on Federal Financial Relations [webpage], Viewed February, 2012, <
http://www.coag.gov.au/intergov_agreements/federal_financial_relations/index.cfm>
- Council of Australian Governments (COAG), 2011b, National Healthcare Agreement 2011, Viewed February 2012,
<http://www.federalfinancialrelations.gov.au/content/national_agreements/healthcare/Healthcare_Agreement.pdf>
- Council of Australian Governments (COAG), 2011c, National Indigenous Reform Agreement, Viewed February 2012, <
http://www.federalfinancialrelations.gov.au/content/national_agreements/indigenous_reform/National_Indigenous_Reform_Agreement_from_13_Feb_11.pdf>
- Cultural and Indigenous Research Centre of Australia (2013). *Evaluation of Aboriginal Child and Family Centres in New South Wales. Interim State-wide Report. October 2013*. Unpublished.
- Davis, H. and Day, C. (2010). *Working in Partnership with Parents*. 2nd Edition. London, Pearson.
- DEEWR: See Department of Education, Employment and Workplace Relations.

- Department of Education (2010). *Development of a Local Outcomes Framework*. Hobart, Australia: Author.
- Department of Education (2013). *An Overview of Child and Family Centres* (Version 2.0). Available from <https://www.education.tas.gov.au/documentcentre/Documents/Overview-of-Child-and-Family-Centres.pdf> (Accessed 7 March 2014).
- Department of Education, Employment and Workplace Relations. (2010). *National ECEC Workforce Census*. Canberra, Australia: Author.
- Department of Education. (2010). *Development of a Local Outcomes Framework*. Hobart, Australia: Author.
- Department of Health and Ageing (2012). *Element three. 2010/11 Annual Report. Indigenous Early Childhood Development National Partnership*. Unpublished.
- Department of Health and Ageing. (2012). *2011-12 Department of Health and Ageing Annual Report*. Canberra, Australia: Author.
- Department of Health and Human Services (2012). *Family Support Services Operational Framework*. Hobart: Author.
- Department of Health. (2014). *Descriptive Analysis of New Directions Mothers and Babies Services Program. Final Report*. Prepared by KBC for the Department of Health and Ageing, Canberra. Available online at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/F1F11C046DD3BC8ACA257BF0001A8D33/\\$File/Final%20Report%20-%20New%20Directions%20-%20Mothers%20and%20Babies%20Services%20Program%20Descriptive%20Analysis.PDF](http://www.health.gov.au/internet/main/publishing.nsf/Content/F1F11C046DD3BC8ACA257BF0001A8D33/$File/Final%20Report%20-%20New%20Directions%20-%20Mothers%20and%20Babies%20Services%20Program%20Descriptive%20Analysis.PDF)
- DH: see Department of Health
- DHHS: See Department of Health and Human Services
- DoHA: See Department of Health and Ageing
- Eckermann, A, Dowd, T, Chong, E, Nixon, L, Gray, R & Johnson, S 2010, *Binan Goonj : bridging cultures in Aboriginal health*. Sydney, Churchill Livingstone.
- Family Planning Victoria. (2013). *SafeLanding. Addressing barriers to teaching sexuality education in schools*. Available online at http://www.fpv.org.au/assets/SLlaunchbrochurewebAugust2013_2.pdf (accessed 11 March 2014).
- Government of South Australia. (2013). *Children and Family Centres, Governance Arrangements*. Retrieved 2 September 2013 from <http://www.childrenscentres.sa.gov.au/pages/CC/>.
- Herceg, A (2005). *Improving health in Aboriginal and Torres Strait Islander mothers, babies and young children: A literature review*. Canberra, Department of Health and Ageing.
- Hunt, J (2006). *Trying to make a difference: A critical analysis of health care during pregnancy for Aboriginal and Torres Strait Islander women*. Australian Aboriginal Studies, 2006/2, pp 47-56.
- Kemp, L. & Harris, E. (2012). "The challenges of establishing and researching a sustained nurse home visiting programme within the universal child and family health service system". *Journal of Research in Nursing* 2012;17(2):127-38.
- Murdoch Childrens Research Institute (2013). *The Tasmanian Child and Family Centre Action Research Project: Phase Two Report*. Melbourne, Author.

- National Aboriginal and Torres Strait Islander Health Worker Association. (2012). *The Aboriginal and Torres Strait Islander Health Worker Professional Practice Framework*.
- National Centre in HIV Epidemiology & Clinical Research (2010). *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: surveillance and evaluation report 2010*. Sydney, NSW: National Centre in HIV Epidemiology & Clinical Research, University of New South Wales
- NATSIHWA: see National Aboriginal and Torres Strait Islander Health Worker Association.
- NNDSS Writing Group (2011) Australia's notifiable diseases status, 2009: annual report of the National Notifiable Diseases Surveillance System. *Communicable Diseases Intelligence*; 35(2): 61-131.
- Powell, F. (2008). *Mooditj Impact Evaluation February 2008 – August 2008. Report to FPWA Sexual Health Services*. Perth, Family Planning Western Australia.
- Secretariat of National Aboriginal and Islander Child Care. (2012). *Caring for our Children and Families. Profiling the set up of Aboriginal and Torres Strait Islander Children and Family Centres*. North Fitzroy, Australia: Author.
- SNAICC: see Secretariat of National Aboriginal and Islander Child Care
- Strobe, NA and Ward, J (2012). *Education programs for Indigenous Australians about sexually transmitted infections and bloodborne viruses. Resource sheet no. 14 for the Closing the Gap Clearinghouse*. Canberra: Australian Institute of Health and Welfare.
- Tasmanian Government (2013), Child Health and Parenting Service Model of Care. Available online at http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0020/129242/CHaPSModel_of_Care_-_Mar_2013_Logo_.pdf (Accessed 13 March 2014).
- Walsh, J. (2011). *Talk soon. Talk often: a guide for parents talking to their kids about sex* [adapted by the Tasmanian Department of Health and Human Services]. Hobart, Tasmania Department of Health and Human Services.
- Willis, J., Anderson, I., & Morris, K. (2005). *Sexual Health Promotion for Aboriginal and Torres Strait Islander People*. Melbourne, Australia: Australian Research Centre in Sex, Health and Society.

Appendix A

Evaluation framework and program logic

A.1 EVALUATION FRAMEWORK

A framework has been developed to guide the evaluation of the NPA IECD, focused on those outcomes and outputs that are within the evaluation scope. Each outcome and output is logically associated with the key evaluation questions, indicators of progress, sources of data and timing of data availability.

FIGURE 5 – NPA IECD EVALUATION FRAMEWORK

Outcome Hierarchy	Evaluation Questions	Data Indicators	Data and Research Sources	Data Collection
Early results (2013)				
E1. Services provided through CFCs are integrated and coordinated	<ul style="list-style-type: none"> To what extent are services provided through CFCs integrated and coordinated? 	Self-reported CFC service integration and coordination	<ul style="list-style-type: none"> Consultation with state/territory officers Consultation with selected service providers Consultation with Indigenous families and communities at selected locations Case studies 	Annually Baseline 2012
		Self-reported integration status	<ul style="list-style-type: none"> CFC leader survey 	2013, 2014
	<ul style="list-style-type: none"> What factors have contributed to improved integration and coordination? 	Self-reported factors that contribute to improved CFC service integration and coordination	<ul style="list-style-type: none"> Consultation with state/territory officers Consultation with selected service providers Partnership and integration survey 	2012, 2013, 2014
	<ul style="list-style-type: none"> What are the challenges to integration and coordination? How can these challenges be addressed? 	Self-reported challenges and strategies to address challenges	<ul style="list-style-type: none"> Consultation with state/territory officers Consultation with selected service providers 	2012, 2013, 2014
E2. More Indigenous teenagers are accessing sexual and reproductive health programs and services	<ul style="list-style-type: none"> What evidence is there that more Indigenous teenagers are accessing sexual and reproductive health programs services? 	Proportion of Indigenous teenagers accessing sexual and reproductive health programs and services (PI 6)	<ul style="list-style-type: none"> State/Territory annual reports Aggregated state/territory level service data 	Annually Baseline 2010–2011
	<ul style="list-style-type: none"> What are the ongoing challenges to increasing access to sexual and reproductive health programs services for Indigenous teenagers? How can these challenges be addressed? 	Self-reported challenges and strategies to address challenges	<ul style="list-style-type: none"> Consultation with state/territory officers Consultation with selected service providers STI notifications data 	2012, 2013, 2014
E3. More Indigenous women and children are accessing maternal and child health services	<ul style="list-style-type: none"> What evidence is there that more Indigenous women and children are accessing maternal and child health services? 	Proportion of Indigenous women and children accessing maternal and child health services	<ul style="list-style-type: none"> Perinatal National Minimum dataset (as reflected in PIs report) 	Annual
	<ul style="list-style-type: none"> What are the ongoing challenges to increasing access to maternal and child health services? How can these challenges be addressed? 	Self-reported challenges and strategies to address challenges	<ul style="list-style-type: none"> Consultation with state/territory officers Consultation with selected service providers 	
E4. Management and governance structures are effective in supporting the	<ul style="list-style-type: none"> To what extent are established management and governance structures effective in supporting the implementation of the NPA IECD? 	Self-reported effectiveness of established management and governance structures	<ul style="list-style-type: none"> Consultation with state/territory officers Consultation with selected service providers 	2012, 2013, 2014

Outcome Hierarchy	Evaluation Questions	Data Indicators	Data and Research Sources	Data Collection
implementation of the NPA IECD	<ul style="list-style-type: none"> What factors have contributed to effective management and governance structures? 	Self-reported factors that contribute to effective management and governance structures	<ul style="list-style-type: none"> Consultation with selected service providers 	2012, 2013, 2014
	<ul style="list-style-type: none"> What are the challenges to effective management and governance structures? How can these challenges be addressed? 	Self-reported challenges, and strategies to address challenges, associated with effective management and governance structures	<ul style="list-style-type: none"> Consultation with selected service providers 	2012, 2013, 2014
E5. There are demonstrated effective partnerships between Indigenous and non-Indigenous early childhood and related service providers	<ul style="list-style-type: none"> What evidence is there of effective partnerships between Indigenous and non-Indigenous early childhood and related service providers? 	Self-reported effectiveness of effective partnerships	<ul style="list-style-type: none"> Consultation with Commonwealth and state/territory officers Consultation with peak bodies Consultation with selected service providers and partners Case studies 	2012, 2013, 2014
	<ul style="list-style-type: none"> What factors have contributed to effective partnerships? 	Self-reported factors that contribute to effective partnerships		2012, 2013, 2014
	<ul style="list-style-type: none"> What are the challenges to effective partnerships? How can these challenges be addressed? 	Self-reported challenges, and strategies to address challenges, associated with establishing effective partnerships		2012, 2013, 2014
E6. There is an increased supply of early childhood and health workers	<ul style="list-style-type: none"> To what extent has the supply of early childhood workers increased? 	Number and type of early childhood and health workers	<ul style="list-style-type: none"> National Early Childhood Education and Care Workforce Census 	Frequency of data collection: TBC Baseline 2010
			<ul style="list-style-type: none"> ABS Census of Population and Housing 	Five-yearly Baseline 2006
	<ul style="list-style-type: none"> What factors contributed to increasing the supply of early childhood workers? 	Self-reported factors contributing to increased supply of early childhood workers	<ul style="list-style-type: none"> Consultation with state/territory officers 	2012, 2013, 2014
	<ul style="list-style-type: none"> What are the challenges to increasing the supply of early childhood workers? 	Self-reported challenges, and strategies to address challenges, to increasing supply of early childhood workers	<ul style="list-style-type: none"> Consultation with state/territory officers 	2012, 2013, 2014
E7. Early childhood services are perceived to be culturally secure	<ul style="list-style-type: none"> To what extent are early childhood services perceived to be culturally secure? 	Self-reported cultural security of early childhood services	<ul style="list-style-type: none"> Consultation with selected service providers Consultation with Indigenous families and communities at selected locations 	Annually 2012, 2013, 2014
		Number of early childhood workers with cultural competence training	<ul style="list-style-type: none"> State/territory annual reports Aggregated state/territory level service data 	
	<ul style="list-style-type: none"> What are the ongoing challenges to ensuring that services are culturally secure? How can these challenges be addressed? 	Self-reported challenges, and strategies to address challenges	<ul style="list-style-type: none"> Consultation with selected service providers Consultation with Indigenous families and communities at selected locations 	

Outcome Hierarchy	Evaluation Questions	Data Indicators	Data and Research Sources	Data Collection
E8. The local community is engaged in the design and delivery of services	<ul style="list-style-type: none"> To what extent is the local community is engaged in the design and delivery of services? 	<p>Evidence that community input has been used to inform the design and delivery of services</p> <p>Self-reported satisfaction with the community engagement process</p>	<ul style="list-style-type: none"> Consultation with Commonwealth and state/territory officers Consultation with peak bodies Consultation with selected service providers Consultation with Indigenous communities at selected locations 	2012, 2013
	<ul style="list-style-type: none"> What factors contributed to positive community engagement? 	Self-reported factors that contribute to positive community engagement		2012, 2013
	<ul style="list-style-type: none"> What are ongoing challenges to community engagement? How can these challenges be addressed? 	Self-reported challenges and strategies to address challenges		2012, 2013
E9. Indigenous women report fewer barriers to accessing services	<ul style="list-style-type: none"> What evidence is there that Indigenous women perceive fewer barriers to accessing services? 	Women report fewer barriers to services access over time	<ul style="list-style-type: none"> Consultation with Indigenous women at selected communities NATSIHS/NATSISS data 	2004-05 NATSIHS, 2008 NATSISS, 2012-13 NATSIHS and 2014 NATSISS.
E10. Established data monitoring and reporting systems provide accurate and timely data to inform program and policy development and implementation	<ul style="list-style-type: none"> To what extent do data monitoring and reporting systems provide accurate and timely data to inform program and policy development and implementation? 	<p>Self-reported accuracy and timeliness of data to inform program and policy development and implementation</p> <p>Alignment of reporting requirements with activities undertaken</p>	<ul style="list-style-type: none"> Consultation with Commonwealth and state/territory officers Consultation with selected service providers 	Annually Baseline 2012
Outputs (2010 and ongoing)				
O1. CFCs are progressively established and operational	<ul style="list-style-type: none"> To what extent are CFCs established and operational as intended? 	Documented and self-reported status of CFCs	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and State/territory officers Consultation with selected service providers 	Annually Baseline 2010–2011
	<ul style="list-style-type: none"> What factors influenced the progress of establishing CFCs? 	Self-reported factors affecting the progress of establishing CFCs		
O2. Evidence-based and innovative strategies are developed and implemented to increase access to sexual and reproductive health services for Indigenous teenagers	<ul style="list-style-type: none"> To what extent have evidence-based and innovative strategies been developed and implemented? 	Documented and self-reported status of the development and implementation of strategies to increase access to sexual and reproductive health services	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and State/territory officers Consultation with selected service providers Case studies 	Annually Baseline 2010–2011
	<ul style="list-style-type: none"> What are the ongoing challenges to increasing access to sexual and reproductive health services for Indigenous people? How can these challenges be addressed? 	Self-reported ongoing challenges and strategies for addressing challenges		
O3. Evidence-based and innovative strategies are developed and implemented to increase access to maternal and	<ul style="list-style-type: none"> To what extent have evidence-based and innovative strategies been developed and implemented? 	Documented and self-reported status of the development and implementation of strategies to increase access to maternal and child health services	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and state/territory officers Consultation with selected service providers 	Annually Baseline 2010–2011

Outcome Hierarchy	Evaluation Questions	Data Indicators	Data and Research Sources	Data Collection
child health services for Indigenous women and children	<ul style="list-style-type: none"> What are the ongoing challenges to increasing access to maternal and child health services for Indigenous women and children? How can these challenges be addressed? 	Self-reported ongoing challenges and strategies for addressing challenges	<ul style="list-style-type: none"> Case studies 	
O4. Management and governance structures to support the implementation of the NPA IECD are established and maintained	<ul style="list-style-type: none"> To what extent have management and governance structures been established to support the implementation of the NPA IECD? What mechanisms are in place to maintain these structures? 	Documented and self-reported status and activities of NPA IECD management and governance structures	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and State/territory officers Consultation with selected service providers 	Annually Baseline 2010–2011
	<ul style="list-style-type: none"> What are the barriers to establishing and maintaining management and governance structures for the NPA IECD? How can these barriers be addressed? 	Self-reported barriers and strategies for addressing barriers		
O5. Links and referral pathways with existing mainstream and Indigenous service providers are established and maintained	<ul style="list-style-type: none"> To what extent have links and referral pathways been established and maintained with existing mainstream and Indigenous service providers? 	Documented and self-reported status of established links and referral pathways	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and State/territory officers Consultation with selected service providers 	Annually Baseline 2010–2011
	<ul style="list-style-type: none"> What are the challenges to establishing and maintaining links and referral pathways? How can these challenges be addressed? 	Self-reported challenges and strategies for addressing challenges		
O6. Workforce strategies to support the NPA IECD are developed and implemented	<ul style="list-style-type: none"> To what extent have workforce strategies to support the NPA IECD been developed and implemented? 	Documented and self-reported status of the development and implementation of workforce strategies	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and State/territory officers Consultation with selected service providers 	Annually Baseline 2010–2011
	<ul style="list-style-type: none"> What are the challenges to enhancing the early childhood workforce to support the NPA IECD? 	Self-reported challenges and strategies for addressing challenges		
O7. Processes for community engagement are established and implemented	<ul style="list-style-type: none"> To what extent have processes for community engagement been established and implemented? 	Documented and self-reported status of community engagement processes	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and State/territory officers Consultation with selected service providers 	Annually Baseline 2010–2011
	<ul style="list-style-type: none"> What are the ongoing challenges to community engagement? How can these challenges be addressed? 	Self-reported challenges and strategies for addressing challenges		
O8. There are data monitoring and reporting systems to inform implementation progress	<ul style="list-style-type: none"> To what extent are there data monitoring and reporting systems to inform implementation progress and outcomes? 	Documented and self-reported use of data monitoring and reporting systems to inform implementation progress and outcomes	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and State/territory officers 	Annually Baseline 2010–2011

Outcome Hierarchy	Evaluation Questions	Data Indicators	Data and Research Sources	Data Collection
and outcomes	<ul style="list-style-type: none"> What are the challenges to monitoring implementation progress and outcomes? How can these challenges be addressed? 	Self-reported challenges and strategies for addressing challenges	<ul style="list-style-type: none"> Consultation with selected service providers 	
O9. Risks to the implementation of the NPA IECD are identified, monitored and managed	<ul style="list-style-type: none"> To what extent are risks identified, monitored and managed? What mitigation strategies or mechanisms are in place? 	Documented and self-reported risks and monitoring and management of risks	<ul style="list-style-type: none"> State/territory annual reports Consultation with Commonwealth and state/territory officers Consultation with selected service providers 	Annually Baseline 2010–2011

A.2 NPA IECD PROGRAM LOGIC MODEL

The program logic model for the NPA IECD is shown in Figure 6; outcomes and results that are beyond the scope and timeframe of this evaluation are shaded.

FIGURE 6 – NPA IECD PROGRAM LOGIC

Ultimate outcomes: closing the gap	<ul style="list-style-type: none"> The gap in life expectancy between indigenous and non-indigenous Australians is closed within a generation The gap in mortality rates for indigenous children under five is halved within a decade All indigenous four year olds in remote communities have access to early childhood education within five years The gap in reading, writing and numeracy achievements for indigenous children is halved within a decade The gap for indigenous students in year 12 attainment or equivalent attainment rates is halved by 2020 The gap in employment outcomes between indigenous and non-indigenous Australians is halved within a decade 		
Long-term outcomes (10+ years)	<ul style="list-style-type: none"> Indigenous children are born and remain healthy Indigenous children have the same health outcomes as non-Indigenous children 	<ul style="list-style-type: none"> Indigenous children acquire the basic skills for life and learning 	<ul style="list-style-type: none"> Indigenous children families are confident, connected to their community and its services, and equipped to support children's development
Late medium-term (2015 and beyond)	<ul style="list-style-type: none"> Indigenous children are physically well Indigenous mothers have healthier pregnancies Indigenous teenagers have the knowledge to make informed decisions about their sexual and reproductive health 	<ul style="list-style-type: none"> Indigenous children have social, emotional, literacy and numeracy skills appropriate for their age 	<ul style="list-style-type: none"> Indigenous families have ready access to suitable and culturally inclusive early childhood and family support services
– Early medium-term (by 2014)	<ul style="list-style-type: none"> There is evidence that Indigenous families access the full range of early childhood services, including early learning, child care and parent and family support services, and maternal and child health services There is evidence that Indigenous teenagers are better informed and are making responsible and informed sexual and reproductive choices There is evidence that Indigenous parents have increased capacity to meet their children's developmental needs Indigenous families and communities value the enhanced services, which are perceived to be appropriate for their needs There is evidence that Indigenous communities are actively engaged in appropriate service design and planning There are adequate numbers of appropriately qualified workers to meet service delivery needs Early childhood service models for Indigenous families are effective and evidence-based 		
– Early results (by 2013)	<ul style="list-style-type: none"> Services provided through CFCs are integrated and coordinated More Indigenous teenagers are accessing sexual and reproductive health programs and services More Indigenous women and children are accessing maternal and child health services Management and governance structures are effective in supporting the implementation of the NPA IECD 		

	<ul style="list-style-type: none"> ▪ There are demonstrated effective partnerships between Indigenous and non-Indigenous early childhood and related service providers ▪ There is an increased supply of early childhood and health workers ▪ Early childhood services are perceived to be culturally secure ▪ The local community is engaged in the design and delivery of services ▪ Indigenous women report fewer barriers to accessing services ▪ Established data monitoring and reporting systems provide accurate and timely data to inform program and policy development and implementation
<p>– Outputs (2010 and ongoing)</p>	<ul style="list-style-type: none"> ▪ CFCs are progressively established and operational ▪ Evidence-based and innovative strategies are developed and implemented to increase access to sexual and reproductive health services for Indigenous teenagers ▪ Evidence-based and innovative strategies are developed and implemented to increase access to maternal and child health services for Indigenous women and children ▪ Management and governance structures to support the implementation of the NPA IECD are established and maintained ▪ Links and referral pathways with existing mainstream and Indigenous service providers are established and maintained ▪ Workforce strategies to support the NPA IECD are developed and implemented ▪ Processes for community engagement are established and implemented ▪ There are data monitoring and reporting systems to inform implementation progress and outcomes ▪ Risks to the implementation of the NPA IECD are identified, monitored and managed
<p>Implementation activities (2009 and ongoing)</p>	<ul style="list-style-type: none"> ▪ Establish CFCs at selected locations ▪ Map existing early childhood services, analyse service needs and identify service gaps ▪ Develop and implement evidenced-based and innovative strategies to enhance teenage sexual and reproductive health services, and maternal and child health services ▪ Establish local management and governance structures to support the implementation of the NPA IECD ▪ Establish links with existing mainstream and Aboriginal and Torres Strait Islander services ▪ Develop and implement workforce strategies to support the implementation of the NPA IECD ▪ Develop and implement community engagement strategies ▪ Develop and implement systems for data monitoring and reporting ▪ Identify risks and develop risk management strategies for the implementation of the NPA IECD
<p>– Aims</p>	<ul style="list-style-type: none"> ▪ To improve developmental outcomes for Indigenous children and achieve key targets as agreed by COAG ▪ To achieve sustained improvements in pregnancy and birth outcomes for Indigenous women and infants ▪ To improve Indigenous families' use of the early childhood development services they need to optimise the development of their children ▪ To implement the NPA IECD in a way that also contributes to COAG's social inclusion, early childhood development, education, health, housing and safety agendas, by identifying reforms and models of service delivery that will improve outcomes for Indigenous children

Appendix B

2014 CFC leaders survey highlights report

B.1 INTRODUCTION

As part of the final round of data collection for the NPA IECD evaluation, a voluntary survey of operating CFCs was conducted in March and April 2014. All CFCs providing services were approached directly, except in the case of the NT, where the approach was via the NT Department of Education. Of the 35 operating CFCs, 17 agreed to participate. One respondent CFC did not complete the entire survey.

The survey comprised two components: a self-completion worksheet intended to be completed by leadership groups at each participating CFC, and a follow up interview conducted with a centre leader.

B.2 RESPONDENT PROFILE

Of the 17 CFCs which agreed to participate, most were from NSW (five) and Queensland (five), with three from WA, two from SA, one each from the ACT and Tasmania. There were no respondents from either Victoria or the Northern Territory.

Two thirds (63 per cent) of respondents identified themselves as centre managers at interview. Other respondents included a Director, General Manager, and 'other'. About two thirds (63 per cent) had been involved with the CFC for at least a year, and only one respondent (six per cent) less than six months.

Participating organisations identified themselves as ACCOs in 13 per cent of cases, and 25 per cent said they were part of a government agency. The majority (63 per cent) indicated that CFC management was contracted to an organisation or consortium.

B.3 IMPACTS AND OUTCOMES

When asked about what was different for the community compared to before the CFC was open, many a clear theme was the availability of coordinated services delivered in a culturally appropriate way. The integration of health and other aspects of early childhood development was also commonly highlighted as a key change and a benefit. Several respondents reported that the CFCs had become a 'hub' or a 'safe place' for community members to engage with services and each other.

When asked to identify the most significant outcomes for their local communities, CFCs frequently cited increased access to a range of services and an associated increase in utilisation of early childhood services. Parenting programs and training and employment opportunities were also reported to be delivering benefits to community. The successes of the centres in engaging with communities were also highlighted in a number of responses.

Children and Family Centres were asked to provide an illustrative example of a success story for their CFC – these consistently focused on highly complex, challenging scenarios often involving child protection services and the justice system. The CFCs' capacity to draw in multiple services and provide a tailored, intensive response to an individual or family's complex needs was reported in each instance to have had a significant and positive impact on people who had previously been disengaged and often felt disenfranchised by the mainstream system.

B.4 PARTNERSHIPS MAKING A DIFFERENCE

All organisations agreed or strongly agreed that the CFC established formal or informal partnerships with children and families, parent and family support services, child and maternal health services, and Aboriginal and Torres Strait Islander organisations, and that these "were making a real difference to children and families". Ninety three per cent agreed the CFC has established partnerships (formal or informal) with early childhood education services that are making a real difference to children and families.

Factors which were identified to be supportive of effective partnerships included co-location, consistent and honest communication, commitment to a common purpose, community engagement and leadership, commitment to 'following through' complex or challenging cases and shared program development.

Factors thought to hinder effective partnerships included perceptions that funding arrangements (including competitive tendering) created tensions, rigid organisational boundaries, lack of knowledge or

empathy about the client group among potential partner organisations and staff turnover (at CFC and in partners) requiring relationships to be re-built.

B.5 REFERRAL PATHWAYS

Respondents were also asked about how well they thought referral pathways were operating, and were generally very positive. Factors which were seen to support effective referral pathways included integrated service planning, memoranda of understanding, and other features of organisation-level relationships that supported operational relationships to be developed.

Co-location was identified as a clear enabler of effective referral, both from a provider and client perspective. Effective referral pathways were also thought to be underpinned by accessibility and flexibility in service delivery, enabled in some cases by in-reach capability allowing clients to access services in a familiar environment.

Strategies to improve communication and to streamline processes for both providers and families (for example, reducing how often they needed to 're-tell their story') were also commonly highlighted as enabling of effective referral pathways.

Some respondents offered insights into strengthening referral pathways for clients of CFCs, many of which focused on the importance of local networking and relationship development between source and destination organisations.

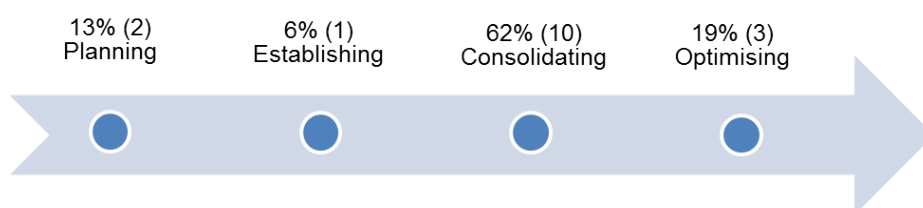
B.6 ORGANISATIONAL MATURITY

Respondents were asked to reflect on where they felt their CFC was on a four stage continuum of organisational maturity:

- Planning (no services being delivered)
- Establishing (some core services in place, focus on service development and expansion)
- Consolidating (most services in place, focus on service refinement)
- Optimising (most services well established, focus on performance and quality improvement)

Sixty two per cent reported that they were at consolidating stage (see Figure 7), while 19 per cent indicated that they had achieved a level of organisational maturity where their focus was on optimising their operations.

FIGURE 7 – CFC SELF-REPORTED ORGANISATIONAL MATURITY



B.7 DEGREE OF INTEGRATION IN SERVICE PROVISION

CFCs were asked to assess the model of integration they used in delivery of the range of different services offered at or through CFCs, and where asked to select the description that best fit their model those set out in Table 21.

TABLE 21 – CFC INTEGRATION CONTINUUM (AND SCORING KEY)

SERVICE MODEL	DESCRIPTION	SCORE
Direct provision	CFC staff directly deliver services with no external involvement	– 0
Co-location	CFC shares physical space with provider agency(ies) but services operate autonomously	– 1
Co-operation	CFC and provider agency (ies) share information, but otherwise operate autonomously	– 2
Co-ordination	CFC and provider agency(ies) undertake joint planning and coordination for a particular time-limited service or project	– 3
Collaboration	CFC and provider agency(ies) share resources and jointly plan and deliver particular services	– 4
Integration	CFC and other provider agency(ies) have merged to form a new entity, including virtual service integration	– 5

To determine a 'level of integration' each response was scored from 0 to 5 where 0 represents direct service provision with no external involvement, and 5 being full service integration (see Table 21). These scores were averaged over the range of services offered (excluding service not provided) and enabled an estimated integration level for each organisation, and also for each category of service. Where organisations reported using more than one integration model, the highest score was applied. There was a correlation between a CFC's self-reported level of organisational maturity and their mean integration score, as indicated in Table 22).

TABLE 22 – CFC MATURITY AND MEAN INTEGRATION SCORE

ORGANISATIONAL MATURITY	MEAN INTEGRATION SCORE
Optimising	3.5
Consolidating	2.7
Establishing	1.7
Planning	1.6

TABLE 23 – CFC MODELS OF INTEGRATION (SERVICE AREAS)

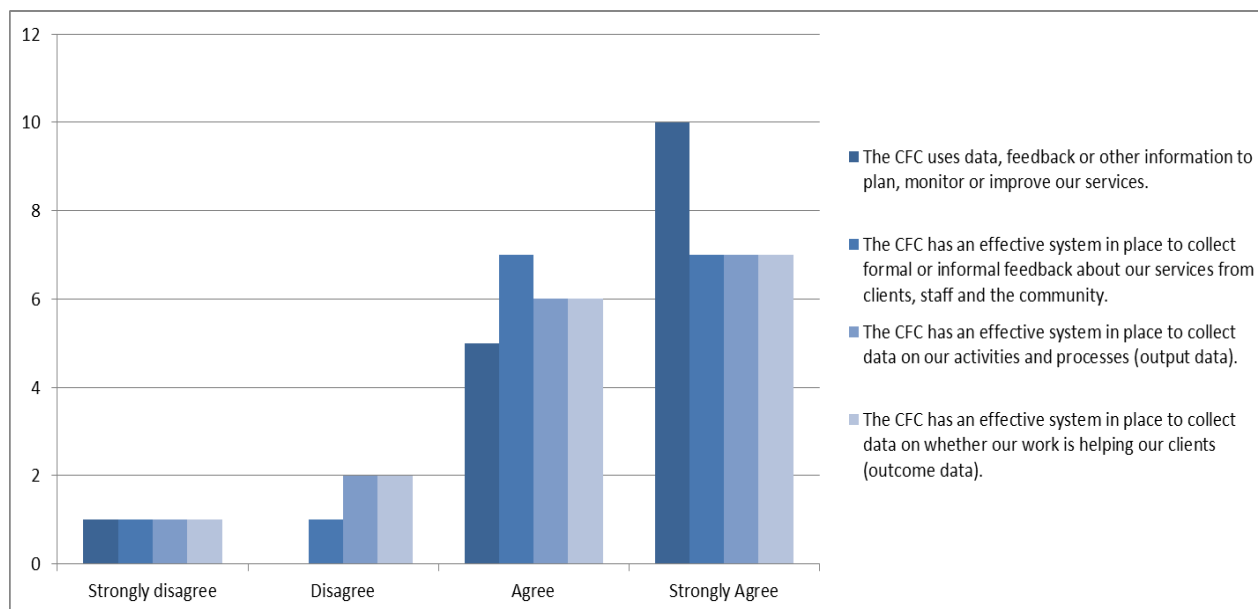
SERVICE AREA	RANGE	MEAN SCORE	SD
Maternal health services (e.g. antenatal and postnatal care/services, prenatal, perinatal and postnatal support programs, breastfeeding support/infant feeding, women's health clinics)	1-5	3.3	1.0
Health promotion (e.g. healthy eating workshops, nutrition courses, cooking programs, health and wellbeing activities, teenage sexual health programs)	0-5	3.2	1.6
Other (e.g. disability services, cultural programs, community events, non-parenting support (e.g. Centrelink), skills development to support employment, a place to study/learn, a community meeting place).	0-5	3.2	1.6
Parenting and support services (e.g. information and resources, advice, parenting and family skills development, group activities, counselling services)	0-5	3.1	1.7
Child support services (e.g. counselling, disability services)	0-5	3.0	1.7
Child support activities (e.g. playgroups, paint and play, school holiday programs/activities, story time/library services, toy library)	0-5	2.8	1.8
Child health services (e.g. child health checks, immunisations, early childhood allied health)	0-5	2.7	1.5
Early learning activities (e.g. early literacy/numeracy programs, transition to school programs, early learning programs provided by schools)	0-4	2.1	1.7
Early childhood education programs (e.g. preschool or kindergarten)	0-4	1.8	1.8
Childcare services (e.g. crèche, occasional care, long day care, mobile care, after hours school care, adjunct care)	0-4	1.5	1.7
Average across all service types	0-4	1.5	1.7

The mean integration score was highest for maternal health services, health promotion services and parenting and support services, with a mean score higher than 3. Early learning, early childhood and childcare services were reported to be less likely to be provided in a collaborative ways, with lower mean integration scores evident.

B.8 PLANNING AND IMPROVEMENT

Ninety four per cent of CFCs agreed that their organisations used data, feedback or other information to improve planning, while 88 per cent agree or strongly agree that they have effective systems to collect formal and informal feedback from clients, staff and community. Eighty two per cent agreed that they had effective systems for collecting data on activities and processes, and that they were collecting client outcome data (see Figure 8).

FIGURE 8 – CFC SELF-REPORTED USE OF DATA TO PLAN, INFORM AND IMPROVE SYSTEMS



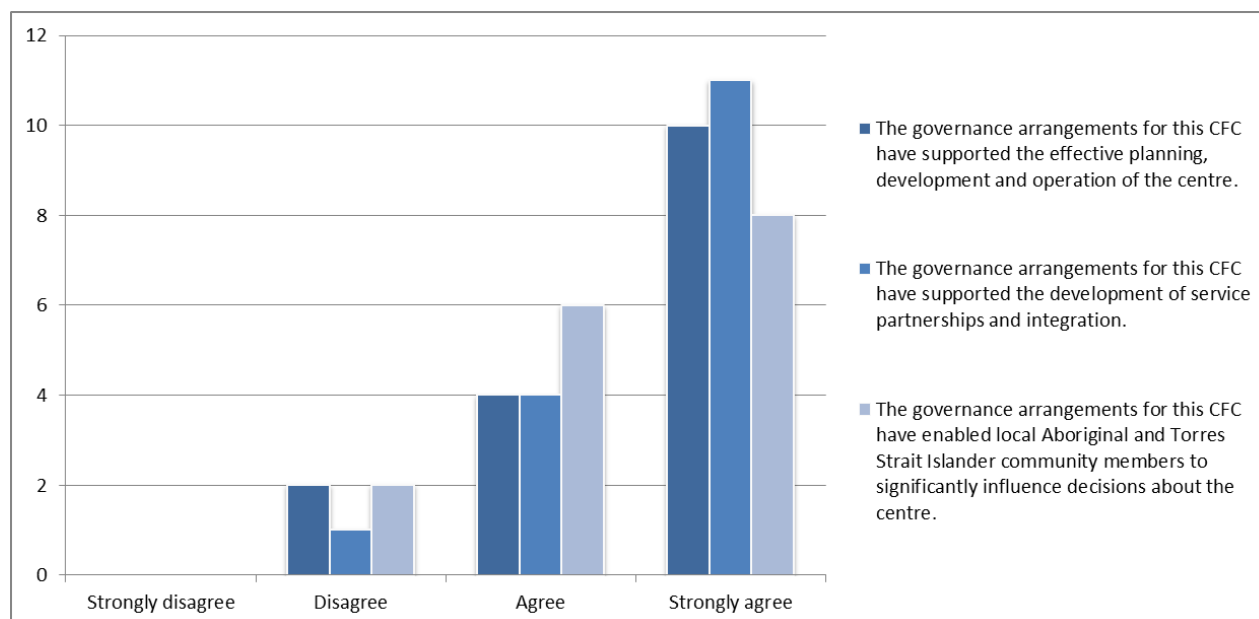
Most respondents provided information about strategies they employed to gather relevant data on client feedback and often highlighted the importance of collecting information from community members and family members in a less formal way.

Other strategies which were emphasised in responses to a question about ways in which CFCs sought to plan, monitor or improve their services included organisational planning and strategy development, continuous quality improvement systems, engaging directly with families, Elders and community, networking and engagement with other sector agencies, supervision meetings and other internal staff strategies, and organisational effort focused on the National Quality Framework (ECE). Several centres reported using AEDI and other state-wide data sets to understand their communities, and one indicated that they had engaged specific supports to enhance their data collection capabilities.

B.9 GOVERNANCE

CFCS reported a high level of confidence in the effectiveness of governance arrangements on a number of dimensions. Eighty eight per cent agreed that they supported the effective planning, development and operation of the centre, 94 per cent that they supported partnerships and integration, and 88 per cent that governance arrangements enabled the local community to influence decisions about the centre (see Figure 9).

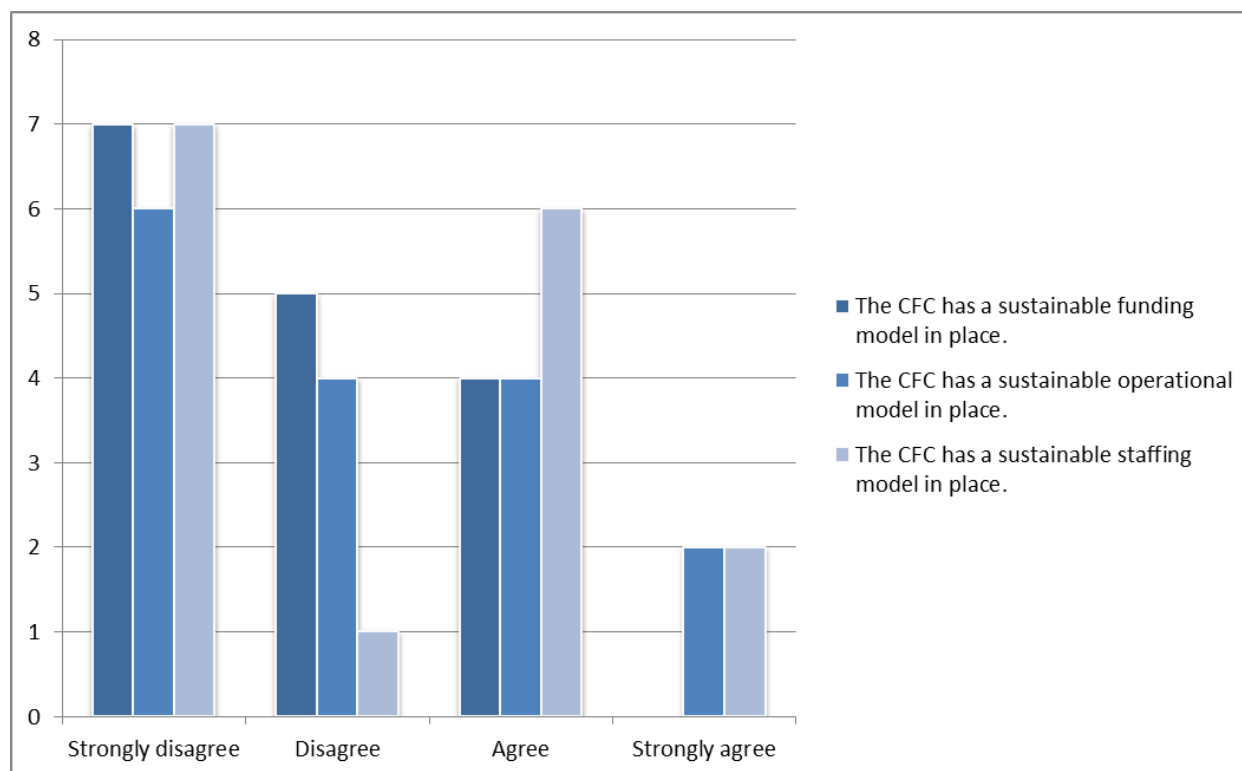
FIGURE 9 – CFC SELF-REPORTED CONFIDENCE IN GOVERNANCE ARRANGEMENTS



B.10 SUSTAINABILITY

Sustainability of CFCs was an area of concern for many survey respondents. Three quarters did not consider that there was a sustainable funding model in place, 63 per cent did not consider the operational model to be sustainable and half did not consider the staffing model to be sustainable (see Figure 10). There were no identifiable trends in the data which suggested that particular characteristics of the organisations were associated with different levels of sustainability.

FIGURE 10 – CFC SELF-REPORTED CONFIDENCE IN ORGANISATIONAL SUSTAINABILITY



Respondents consistently highlighted significant concerns about the viability of the CFCs in the absence of dedicated funding, and several made reference to the difficulty attracting and retaining a workforce with funding uncertainty. Several CFCs reported that workforce development strategies had gone some way

toward addressing staffing issues, but that these were not necessarily a low-cost solution given the training and supports that needed to go with these positions.

Other impacts of perceived funding uncertainty included difficulties getting security of lease tenure, and one respondent noted that while the childcare benefit providing one funding stream it did not cover the real costs of operating these services, but that increasing costs to families was perceived to conflict with the purpose and focus of the CFCs. Other revenue streams reportedly being explored included Medicare billing.

Appendix C

Children and Family Centres

TABLE 24 – CHILDREN AND FAMILY CENTRES – ABORIGINAL AND TORRES STRAIT ISLANDER NAMES

CFC LOCATION	STATE/TERRITORY	ABORIGINAL AND TORRES STRAIT ISLANDER NAME
Minto	NSW	Waranwarin
Mount Druitt	NSW	Yenu Allowah
Ballina	NSW	Ballina
Gunnedah	NSW	Winanga-Li
Nowra	NSW	Cullunghutti
Toronto	NSW	Nikinpa
Brewarrina	NSW	Dhirraway Dhaarun Bawu
Lightning Ridge	NSW	Walanbaa Dhuralli
Doonside	NSW	Ngallu Wal
West Belconnen	ACT	-
Gunbalanya	NT	-
Maningrida	NT	-
Ngukurr	NT	-
Yuendumu	NT	-
Palmerston	NT	-
Cairns	Qld	-
Doomadgee	Qld	Dumaji
Ipswich	Qld	-
Logan	Qld	-
Mackay	Qld	-
Mareeba	Qld	-
Mornington Island	Qld	Ngakulwen Nyerrwe (hub) and Kirdi Mayarr (long day care centre)
Mount Isa	Qld	Ngukuthati
Palm Island	Qld	-
Rockhampton	Qld	-
Ceduna	SA	-
Ernabella	SA	-

Whyalla	SA	Gabmididi Manoo
Christies Beach	SA	Taikurrendi
Geeveston	Tas	Wayraparattee
Bridgewater	Tas	Tagari Lia
Whittlesea	Vic	Bubup Wilam
Bairnsdale	Vic	Dala Yooro
Halls Creek	WA	Ningkuwum-Ngamayuwu
Fitzroy Valley	WA	Baya Gawiy Buga yani Jandu yani u
Kununurra	WA	-
Roebourne	WA	-
Swan	WA	-

Sydney

Tower 2, Level 23, Darling Park
201 Sussex Street Sydney, NSW 2000
t +02 8233 9900
f +02 8233 9966

Melbourne

Level 12, 120 Collins Street
Melbourne, VIC 3000
t +03 8663 4888
f +03 8663 4999

Brisbane

Level 7, 123 Albert Street
Brisbane, QLD 4000
t +07 3007 3800
f +07 3007 3811

Perth

Level 1, 55 St Georges Terrace
Perth, WA 6000
t +08 9346 0500
f +08 9221 1779

Australia • Asia • Middle East
w urbis.com.au e info@urbis.com.au