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MECSH EVALUATION 2019-2024

Summary Report

Centre for Child Development and Education
Menzies School of Health Research

Chief Investigator Gary Robinson

Project staff
Danielle Aquino
Christel van den Boogaard
John Condon
Alexandra Gregory
Edwina Nagy
Athira Rohit
Jiunn-Yih Su
Kayli Wild

Associate Investigators
Kim Caudwell
Heather D'Antoine
Anita D'Aprano
Steve Guthridge
Ļäwurrpa Maypilama
Ruth Wallace

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SUMMARY REPORT

This report summarises the findings from the evaluation of the Maternal Early Childhood Sustained Home-visiting (MECSH) program over its first five years (2019–2024) in the Northern Territory (NT). Together with the main report, it provides a comprehensive account of how the program was implemented in remote NT contexts, the extent to which it reached and engaged families, and what key components were delivered. The report also explores program retention, what women valued about their participation, and how a locally grounded, relationship-based model of care has taken shape.

The evaluation highlights both the successes and the challenges of implementing MECSH in very remote areas, including the potential strengths of a culturally responsive and community-based workforce. Importantly, it presents evidence that the model can provide meaningful support to women with complex needs – support that builds trust, strengthens social connections, and reduces barriers to care. These insights offer a strong foundation for refining, sustaining and expanding this model of care for women and their families in the NT.

THE MECSH PROGRAM

MECSH is a nurse-led home visiting program that supports families from pregnancy through to toddlerhood. It provides preventative support, with a focus on maternal aspirations and wellbeing, child development and responsive parenting (Kemp et al., 2012).

What sets MECSH apart from some other home visiting and parenting programs is that:

- It is delivered through existing universal health care services
- The nurse works alongside a dedicated social care practitioner who provides additional support to the family
- It can be offered to all mothers, regardless of age or number of children, but is targeted toward women with additional support needs (Kemp et al., 2011).

Originally developed and implemented in metropolitan Sydney, MECSH has since been adopted in various settings across Australia and internationally (Goldfeld et al., 2017; Kemp et al., 2022; Khang et al., 2024). In 2019, the program was implemented for the first time with Aboriginal families in remote NT communities by three Aboriginal Community Controlled Health Services (ACCHS):

- Miwatj Health Aboriginal Corporation (Miwatj)
- Sunrise Health Service Aboriginal Corporation (Sunrise)
- Katherine West Health Board Aboriginal Corporation (KWHB)

A fourth health service commenced but did not complete the program.

Initial adaptations for the NT

Before MECSH was implemented in the NT, partners agreed to several modifications in the standard program structure to suit the local context:

- Nurses did not need to be qualified child and family health nurses but could be general registered nurses or midwives.
- Aboriginal cultural support workers and Aboriginal Health Practitioners could be part of the MECSH team.
- All women in the community who were pregnant were considered eligible – there was no formal pre-enrolment assessment procedure.
- The program duration was extended for an additional year, supporting families until the child turned three.

Implementation roles

The program was implemented by Miwatj, Sunrise, and KWHB. Implementation support to health services was provided by Translational Research and Social Innovation (TReSI) at Western Sydney University, a member of the right@home consortium led by the Australian Research Alliance for Children and Youth. TReSI was responsible for monitoring program fidelity, delivering MECSH training and advanced practice workshops, and providing implementation support. The NT Government Department of Health (NT Health) oversaw grants management and supported implementation. Menzies School of Health Research was funded by the NT Government to evaluate the program and report progress to partners.

Workforce structure and local integration

Each ACCHS was responsible for employing staff and embedding MECSH within their existing primary health care programs. Across the three services, ten MECSH nurse positions were established, with all MECSH staff employed directly by the ACCHS.

Staffing models varied across the sites due to travel distances and accommodation availability. In some areas, nurses lived in the community full-time; in others, they commuted daily or stayed for 1–2 week periods. Recruitment and retention of staff, already a known challenge in remote primary health care (Veginadu et al., 2024), also affected MECSH delivery. Among nurses who left their role before June 2024, 21% had remained in the role for more than two years, while 53% had been in the role for less than 12 months.

While all ACCHS planned to recruit a social care practitioner or social worker, only one was able to maintain a dedicated MECSH social care practitioner position throughout the evaluation period. All three ACCHS engaged one or more community-based Aboriginal cultural workers or a regional senior Aboriginal advisor to support MECSH delivery. Each health service also designated a MECSH program coordinator with clinical and managerial responsibility, in line with their organisational requirements.

Program training and professional support

MECSH training consisted of a 5–6 day in-person Foundation Training workshop, supplemented by self-directed online modules. Throughout the evaluation, practitioners consistently reported that training content and delivery were not tailored to the NT context. Although various adaptations were trialled, including training of trainers, online delivery, and a mentor model, the in-person annual workshops remained the preferred mode for Foundation Training. A sustainable approach to training and professional support of NT practitioners was not fully developed.

A monthly Community of Practice (CoP) meeting was established early in implementation, initially led by NT Health and Western Sydney University, and later facilitated by NT MECSH practitioners themselves. These online discussions, along with annual in-person workshops, became the primary avenue for practice support. Scheduled advanced practice ‘deep dive’ training was not delivered after 2021.

EVALUATION METHODS

The project received ethics approval from the Human Research Ethics Committee of NT Health and Menzies School of Health Research (2020-3696) and the Charles Darwin University Human Research Ethics Committee (H20078). Grounded in developmental evaluation (Patton, 2010), the research employed a mixed-methods approach, combining both quantitative and qualitative methods.

Quantitative Analysis of Health Service Data:

This part of the evaluation focused on analysing health service data to understand the delivery of maternal and child health care, including MECSH services, to women in MECSH communities from 1 January 2019 to 30 April 2024. It involved working with practitioners to redesign clinical items in Communicare (electronic health information system) to capture detailed information on MECSH program delivery. De-identified data for all eligible women in the communities were provided by ACCHS. This data covered:

- Women and children's characteristics
- The implementation of MECSH components
- Routine maternal and child health care delivery.

The evaluation compared services provided to women (and their children) who were offered or enrolled in MECSH with those who were eligible but not offered or enrolled and received standard care only. The report highlights the reach, participation, fidelity, retention, and initial outcomes of MECSH service delivery. The final phase of quantitative analysis, scheduled for completion in 2026, will link primary healthcare data with de-identified NT government data to assess the impact of MECSH on health, hospitalisations, and social outcomes.

Health Service Data

Qualitative Interviews and Surveys:

In parallel, qualitative methods were used to explore the perspectives of both practitioners and parents. Over the course of the evaluation, researchers conducted interviews with 47 practitioners and managers involved in delivering services in MECSH communities, either face-to-face or online. Each year, researchers travelled to communities to invite parents who were either involved in or eligible to receive MECSH to participate in interviews. In total, 198 parents from remote communities in the East Arnhem and Big Rivers regions were interviewed. These interviews included:

- Survey-style questions about health, families, and parental strengths and challenges
- Open-ended questions about parenting experiences, family relationships, involvement in MECSH, and what parents liked most in the support provided by practitioners.

Interview data were analysed by looking for key topics and patterns recurring within and across interviews to understand factors that shape parenting experiences. This helped identify strengths, challenges, and areas for improvement in the program.

Practitioner interviews

Parent interviews

Feedback and support for practice

This timeline describes the primary evaluation activity for each year. Throughout the evaluation, feedback and recommendations were regularly provided to stakeholders via annual progress reports, the MECSH Governance Council, and Community of Practice (CoP) Forums. In addition to these reports, some findings have been published (Gregory et al., 2024), with more manuscripts in preparation.

In 2022, a Resource Development Group (RDG) was formed, consisting of Menzies researchers, ACCHS coordinators, MECSH practitioners, and Aboriginal staff from the three health services. This group oversaw the development of new resources in consultation with parents and practitioners. The group met online regularly and at annual Community of Practice workshops to create and refine resources following periods of testing in community.

Evaluation and Resource Development Project Data Collection and Workshops
Health Service Data received from ACCHS in 2021, 2022 & 2024
Interviews: 236 with mothers, 14 with fathers & 69 with practitioners
13 community consultation workshops
29 RDG meetings
3 CoP workshops

2019
MECSH implementation begins
Evaluation design

2020
Preliminary discussions & data collection
+ Progress report

2021
Data collection
+ Progress report

2022
Data collection
+ Resource Development Project established
+ CoP workshop
+ Progress report

2023
Data collection & preliminary analysis
+ Progress report
+ CoP workshop

2024
Analysis
+ CoP workshop
+ Final Report

2025
Sharing findings
+ Further analysis
+ Resource testing
+ Summary report
+ Community feedback
+ Academic outputs




FINDINGS

Program reach

From January 2019 to April 2024, a total of 1,412 women were eligible to enrol in MECSH across the three regions, based on their residence in a participating community during pregnancy or in the first eight weeks after birth. Of these, 634 women were offered a place, and 563 women enrolled, this means 89% of women offered the program accepted it. This is above the NT's performance target of 75%.

Notwithstanding the phased start-up of the program and gradual recruitment of nurses in the first two years, overall program coverage reached 45% of all women who were pregnant or less than 8 weeks postpartum during the program's implementation. In some communities, enrolment reached as high as 65%.

At the end of April 2024, 185 women were actively receiving care, with caseloads averaging 20 clients per allocated nurse. Recent data suggests that caseloads of 25 may be sustainable, indicating growing capacity and reach.

45% of eligible women and their families were engaged in enhanced care and psychosocial support through the MECSH program.

Characteristics of the whole cohort

Baseline characteristics of the eligible cohort (Table 1) show that women were an average age of 26 years, with 20% under 20 years old. Most women had experienced multiple pregnancies, with an average of 2 previous births (ranging from 0 to 9). There was high engagement in antenatal care, with 88% attending at least one clinic visit for their current pregnancy, 63% attending in the first trimester, and 65% having at least seven antenatal checks. Teenage women demonstrated higher engagement, with 94% attending at least one antenatal visit and 74% attending the recommended number of seven or more visits. For birth outcomes, the average birth weight of babies in the cohort was 3007 grams, with 18% born low birth weight and 16% born preterm; of these outcomes, lower proportions were among teenage women.

Offer and uptake

There were no formal intake criteria specifying which women should be offered the program. It is therefore important to explore the characteristics of women who were targeted for participation.

It is likely that all eligible women could benefit from the additional support provided by the program. First-time mothers were not more likely to be offered the program. However, women offered the program were younger and were significantly more likely to have multiple children (median 2). This suggests that nurses saw young mothers already with children as needing help.

More of the women offered MECSH had health and psychosocial concerns recorded during pregnancy through to eight weeks post-partum (Table 2):

- 21% reported drug use during pregnancy (vs 11% not offered)
- 31% had recorded experience of family or domestic violence (vs 22%)
- 38% had a mental health concern (vs 23%)
- 48% had a chronic health condition (vs 33%).

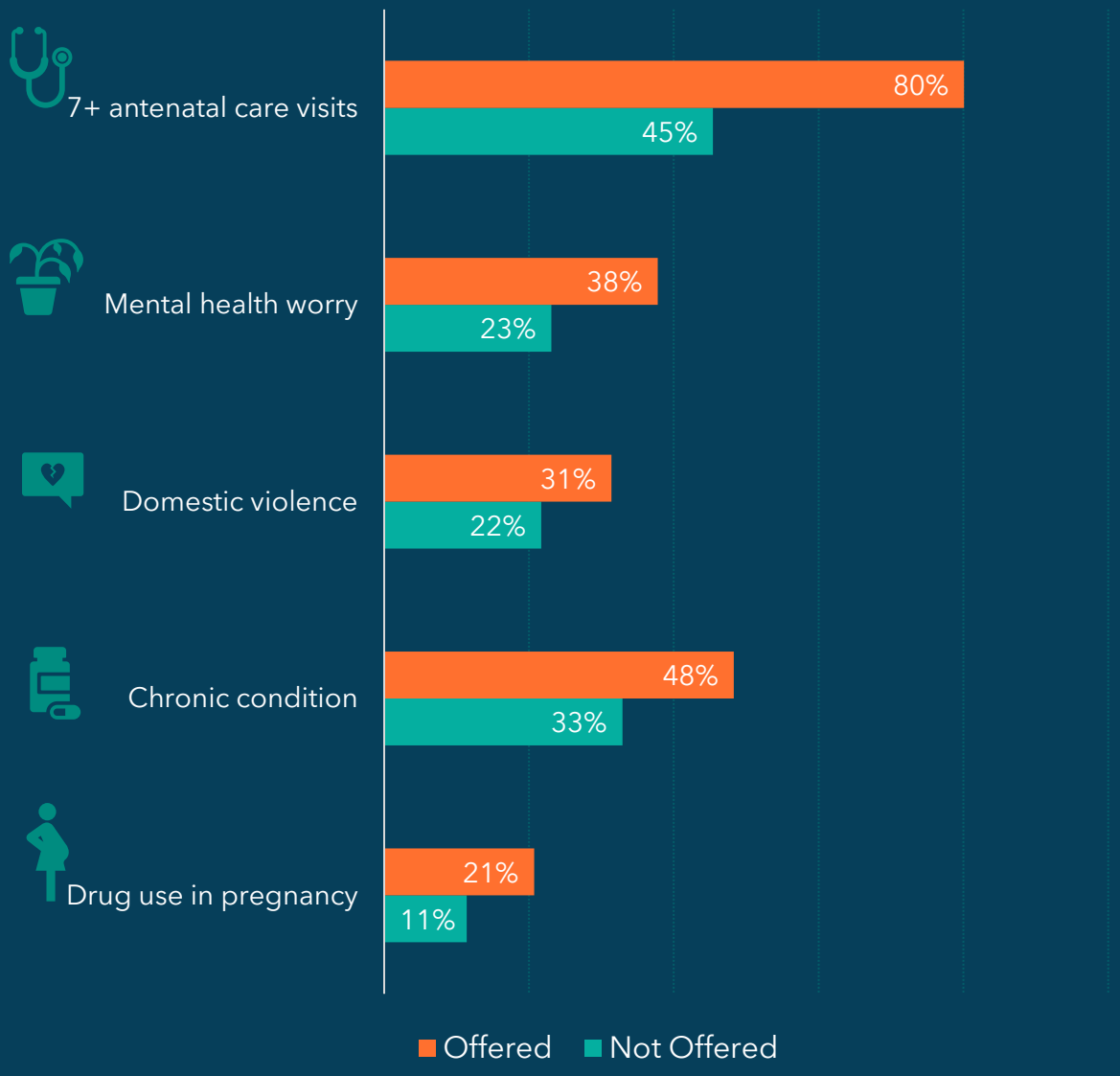
The main entry point to MECSH was through antenatal care. Women who were more engaged with antenatal services and other healthcare during pregnancy were more likely to be offered the program (Table 2). This suggests that effort is needed to reach women with low engagement in routine care, who might fall through service gaps.

Uptake and enrolment data further underscore the program's engagement of women with identified needs. Of the women offered, women with a mental health concern were 1.8 times more likely to enrol, and women with a chronic health condition were 2.3 times more likely to enrol (Table 2).

Overall, MECSH demonstrated the ability to engage women at higher risk of poor outcomes – those living with a mental health concern, chronic health condition, drug use, or exposure to violence. At the same time, women who attended fewer antenatal visits were less likely to be offered the program, indicating a need for more outreach or alternative referral pathways for those with unstable health service engagement or challenging social circumstances or who are mobile between communities.

MECSH engaged women with higher health and social support needs.

Characteristics of women who were offered MECSH during their eligibility period (between pregnancy and 8 weeks post-partum) [2]



[2] See Table 2, Appendix

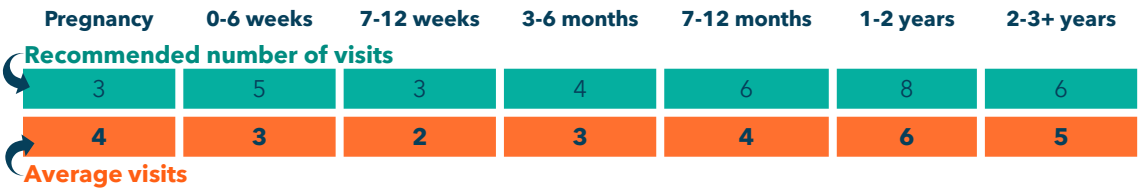
Program fidelity: visits & content

According to the MECSH schedule, women enrolled in pregnancy should receive 35 visits, and women starting the program postnatally should receive 32 visits. Visits should be more frequent in the first year and gradually decrease until the child turns three. Program targets were to achieve at least 75% of the scheduled visits in each period.

Over five years, the program provided 9480 visits by MECSH nurses, 877 visits by social care practitioners, and 853 records of attendance at a MECSH group session.

The antenatal period was the only time where mean number of visits exceeded the number of scheduled visits. The low number of visits during the first six weeks after birth is partly explained by delays returning from hospital after birth (Figure 1).

Figure 1: Recommended vs. average number of visits for women enrolled in MECSH

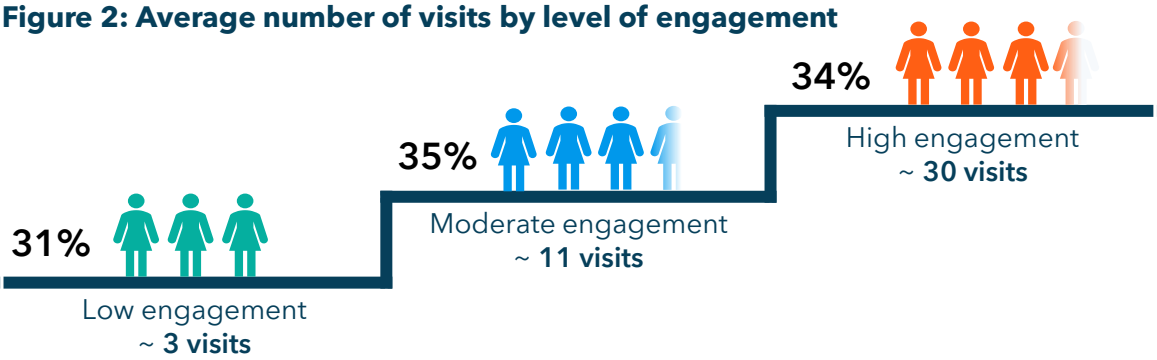


Frequency of visits improved over time. By 2024, women were receiving 1.8 times more visits per month than those enrolled in 2019.

These averages, however, mask significant differences in engagement. While women in the program had an average of two MECSH nurse visits per month, some remained in the program despite very limited contact, and others received up to 14 visits within a month (with the highest overall visits being 92 in the program).

For women who stayed in the program until their child turned one, there was wide variation in participation. For 31% there was low level of engagement, receiving less than 25% of recommended visits. For 35% there was moderate engagement, receiving between 25% and less than 75% of recommended visits, and for 34% there was high engagement, receiving 75% or more of recommended visits during the time they were enrolled (Figure 2).

Figure 2: Average number of visits by level of engagement



Level of engagement was not associated with women's age or whether she had other children. Understanding the factors affecting very high and very low service use, such as individual women's preferences, complexity of circumstances, and other barriers to engagement, is needed to improve program participation and ensure well-targeted support according to need.

MECSH nurse visits

Visits are intended to consist of a flexible range of topics in response to the needs of the client, combined with specialised focus modules relating to child development and parenting. Most women received anticipatory guidance about maternal health and wellbeing, preparation for birth and parenting, infant and child health and wellbeing, support with family relationships, and links to community resources.

The most common topics discussed during MECSH nurse visits were:

- emotional wellbeing (87% of women)
- maternal health (84%)
- infant health (76%)
- child development (75%)
- family support (75%)
- sleeping and settling (70%)
- family violence (68%)
- child feeding (67%)
- environmental health (66%)
- safety (66%)
- goals and aspirations (65%)
- smoking (64%)
- community resources (62%)
- child oral health (58%)
- breastfeeding (56%)
- finances (52%)
- preparation for parenting (51%)
- housing (50%)

These patterns suggest that nurses maintained a focus on anticipatory guidance and preventive care covering physical, emotional, and practical aspects of parenting. The data shows a strong emphasis on women's wellbeing, early child development, and social determinants of health.

Social care visits

In addition to nurse visits, MECSH provides preventive psychosocial support through social care practitioners. These practitioners tended to focus on factors influencing women's circumstances such as safety, housing, finances and child protection.

Compared with women not enrolled, women enrolled in MECSH were 2.5 times more likely to be visited by a social care practitioner (27% vs. 11%). Only one region maintained dedicated MECSH social workers: there, 88% of enrolled women had a visit with the social worker.

The most common topics of concern when a social care practitioner inquired were:

- Assistance with Centrelink (77% of women)
- Current or past patterns of domestic and family violence (67%)
- Current or past child protection involvement (56%)
- Maternal mental health concern (56%)

Compared to women not enrolled in MECSH, those enrolled were 2.5 times more likely to receive support from any social care practitioner.

Scheduled program content

Despite the broad coverage of relevant topics, fewer women received the structured 'focus modules' on child development and parenting that are part of the MECSH program.

- Only 15% of women received most of the Learning to Communicate sessions.
- Only 21% received most of the Promoting First Relationships sessions.
- A significant proportion had no record of receiving any sessions from these modules (32% and 45%, respectively).

Practitioners reported several barriers to delivering these scheduled modules, including limited training, challenges with visit timing, lack of cultural and contextual relevance, and the need to prioritise urgent social and health needs.

In many cases, visits were adapted to focus on what seemed most meaningful and relevant to the woman on the day. This flexibility enables practitioners to meet women's real-time needs. However, these components are intended to strengthen parental responsiveness to the growing infant. The structure, training and integration of these modules was insufficient to support consistent delivery. These modules need redesign to ensure that they can be implemented with sufficient consistency and intensity to achieve targeted parenting outcomes, while retaining flexibility to needs.

Retention in MECSH

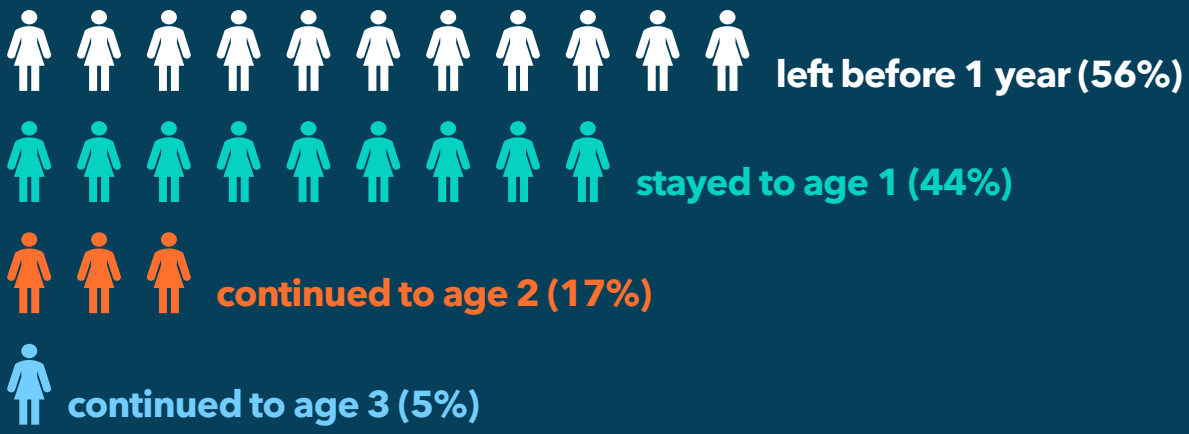
Women stayed in MECSH for an average of 15.4 months. While less than the intended length of time in the program of 3 years this is a positive achievement for the stage of development of MECSH when compared with similar programs (Brand & Jungmann 2014). Retention varied between regions. In one region retention averaged 20 months and in the other regions averaged 14 months.

Performance measure	**Target**
Retained to 1 year	65%
Retained to 2 years	58%
Retained to 3 years	50%

Of women who exited before 30 April 2024, retention at 1, 2 and 3 years was lower than the performance targets (Figure 3).

Figure 3: Proportion of women retained to child age 1, 2 and 3 †

†Excludes 'still enrolled'



The main reasons recorded for women leaving before their child's third birthday reflect women's mobility and complexity of circumstances, as well as implementation challenges in remote settings:

- Moved out of a MECSH community (22%)
- Disengaged from the program (e.g., repeated missed visits, hard to locate) (22%)
- No nurse available to deliver the program for extended periods (20%)
- Completed the program or felt they no longer needed support (12%)

Importantly, two program factors were significantly associated with longer retention:

1. Visits from a MECSH social care practitioner
2. Having a nurse in community visiting her at least once a month

This highlights the value of consistent staffing and the importance of a multidisciplinary approach to care. When social care was integrated, women were more likely to remain engaged, particularly those with multiple children, who often needed support with parenting older children and managing family challenges.

First-time mothers were less likely to stay in MECSH until their baby was 2 years or older. However, early exit was not associated with age, emotional wellbeing risk, antenatal care attendance, or substance use in pregnancy.

These findings point to a need for tailored strategies to increase retention, especially for:

- First-time mothers
- Women who are mobile between communities
- Those showing early signs of disengagement

Retention was also impacted by workforce availability. Prolonged vacancies in nurse positions contributed to early exits, underscoring the need for workforce retention and continuity solutions.

Interviews with parents suggest that MECSH meets different needs for different women. While first-time mothers may require stronger engagement and ongoing relationship-building, multiparous women often benefit from MECSH's capacity to support complex family and psychosocial needs. This reinforces the importance of personalised approaches that respond to life stage, experience, and family context.

Strategies to sustain a stable, trusted workforce are critical to keeping women engaged and ensuring continuity of care.

What women valued in the program

Women in the program consistently reported high levels of trust in their MECSH practitioners. This trust was grounded in how practitioners showed up through practical support, respectful communication, and confidentiality (Gregory et al., 2024). These elements were often the first step in building genuine connection.

> ***I felt she was lovely and helping and support, like my next mother. I only trust MECSH nurse, I've been trusting her since I got pregnant.***
>
> **MECSH mum**

From the thematic analysis of parent interviews, three core areas of MECSH practice stood out as most valued by women:

1. Practical care and increased access to other support
2. Learning new things
3. Social and emotional support

Practical support to access health and social services. Women valued help navigating health services, support for older children or partners, and assistance dealing with Centrelink and housing issues. This often meant that MECSH practitioners worked across systems, connecting women with the right services and advocating for their needs.

Women benefited from learning new things in the program, about their baby's growth and development, how to look after the baby, and about their own health. Practitioners extended this learning and support beyond the mother and baby, often involving siblings, partners, and extended family members.

> ***[I] sit down with the whole family, because sometimes it's not just the parent and child. It's more of the whole family, so you've got aunty and uncle or grandparents who are living in the same house who need supports.***
>
> **MECSH nurse**

Many women placed particular importance on the emotional support they received from their MECSH provider. What mattered was having someone who genuinely listened, without judgment or imposing their own agenda. Women described their MECSH nurse or social care practitioner as someone they could count on during moments of stress or uncertainty.

MECSH helping us out, talking about how we're doing with our kids, how we're feeling, checking up on the kids' health, if they're feeling right, if we need anything. … I'm really happy that I've got them and they're supporting me when I'm feeling down and I'm worried. I got them, they got my back. I can ask them anything.

MECSH mum

When this kind of relational and responsive support was provided, it helped women feel seen and capable. It fostered safety and confidence even in the face of complex personal or family challenges. This reinforces the unique value of a healthcare model grounded in trust, continuity and knowing the family.

Emergent outcomes

Indications of improvements in care and health outcomes for women and their children are evident from case examples and primary health care data. Further analysis of primary health care outcomes continues, and analysis of hospitalisation and child protection impacts is planned for 2026.

Proactive screening and assessment

Women enrolled in MECSH compared with those not offered were much more likely to receive screening for domestic and family violence and emotional wellbeing during pregnancy and in the first three years after birth. Children of MECSH enrolled mothers were more likely to have comprehensive developmental assessments.

- Women in MECSH were screened for domestic and family violence an average of three times, compared with just 0.3 times for eligible women not in the program.
- 83% of MECSH participants had a record of at least one emotional wellbeing screen (such as the EPDS or KMMS), compared with 52% of eligible non-participants.
- More children of MECSH enrolled mothers had a comprehensive development screen (35% vs 10%).

Addressing unmet concerns and needs

Case material from interviews with parents and practitioners highlighted how the MECSH teams were active in responding to previously unaddressed physical and neurodevelopmental concerns of older children of MECSH clients and actively engaged other practitioners to achieve this.

In these cases, the clinical knowledge and skills of the nurse, and their unique position in taking time to listen, observe and interact with families in their homes and other settings allowed for mothers' concerns about their older children to come forth. In the absence of a program like MECSH, it is likely that these concerns would have remained unaddressed or escalated.

We do deal with all these other situations that the families have and that the actual clinics and nurses don't have the time or resources to be able to work with. That's where we can support the families, so that extended type of role ...

MECSH Nurse

Planning for safety

Having "hard conversations" was often necessary when women disclosed or MECSH practitioners observed risks to women and children's safety. Case material from parent and practitioner interviews revealed the importance of the MECSH teams' ability to work with the whole family to make and enact plans that ensured safety of children and family preservation. For example: managing feeding difficulties with vulnerable infants, encouragement of alternatives to harsh discipline of older children, and with both partners to plan for safety for children in relationships involving drug and alcohol misuse and violence. The support provided is client-led, whilst remaining focused on the safety and wellbeing of the client and her children.

Improved access to interdisciplinary care and support

The practical help to access health and social care that women valued, had real impact for families. MECSH team skill and capacity to take time to understand the underlying determinants of women and children's health concerns and actively facilitate interdisciplinary support resulted in improvements in social, material and financial circumstances in the family, for example ensuring all household members were receiving appropriate Centrelink payments.

> ***I guess in this program you're looking at 'what's the real story? Why are they malnourished?' And that's the part where we're able to sit down and just really understand what's actually happening in the background.***
>
> **MECSH Nurse**

Women also relied on their MECSH practitioners to take time to clarify and explain information received from other health providers, improving women and children's uptake of preventive care. In the remote service delivery context, characterised by high burden of acute care, high workforce turnover and use of short-term agency staff (Veginadu et al., 2024) providers do not always have the opportunity or skills to engage women as partners in care. MECSH teams buffered women from some of the discontinuities in care, providing a safe and stable connection with the health service.

WAYS FORWARD:
AN EMERGING MODEL OF CARE

Over five years of implementation in the NT, a model of enhanced maternal health and parenting support had emerged that is flexible, relational and responsive to the needs of women and their family. Targeted investment is needed to embed and sustain this kind of program based on staff continuity and local workforce development.

Core domains of practice

Drawing on findings from parents and practitioners, three core domains of practice defined the NT model (Figure 4):

1. **Practical care and increasing access:** Direct action to overcome barriers, including navigating services, connecting with supports, or helping address risks related to housing, safety, or family wellbeing.
2. **Learning new things:** Practical, accessible anticipatory guidance on maternal, child and family health, development and parenting, communicated in a way that respects the woman's strengths, worries and priorities.
3. **Social and emotional support:** A kind, responsive, non-judgmental practitioner who asks how the woman is feeling, and empowers her by listening and supporting with underlying causes of stress and difficulty.

Figure 4: Domains of practice

Characteristics of good practice

What is important in this model of care is not just what is delivered, but how it is delivered. MECSH practitioners in the NT demonstrated ways of working that are essential to success:

- **Taking time** to build relationships and trust, with women, families and in the community.
- **Listening**, asking about her worries, being responsive to her needs, following her lead and being an advocate.
- **Understanding complexity**, and the interconnectedness of health, emotional wellbeing, relationships and family processes.
- **Working with strengths**, seeing her, walking alongside her aspirations, understanding culture and connection, and involving family.
- **Persisting**, being consistent, being present, continuing to engage in periods of difficulty and despite missed visits.

How care is organised

- Care is led by a nurse with experience in maternal and child health, together with local Aboriginal co-workers and cultural advisors. This partnership helps ensure care is both clinically and culturally safe.
- Social workers play a crucial role for women with complex social support needs. Likewise, cultural support workers bring critical knowledge, relationships and continuity that non-Aboriginal staff cannot provide.
- Visits take place wherever it works best for women; at home, under a tree, or in a dedicated MECSH space. This flexibility supports access and trust. Group activities also provide alternative ways of learning and support.
- The woman is recognised as the client, with her needs, worries and goals at the centre. But care also involves her broader family and networks, acknowledging that parenting is supported through relationships, community and culture.

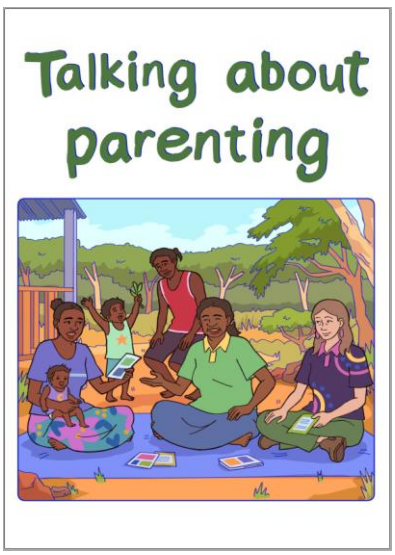
New resources

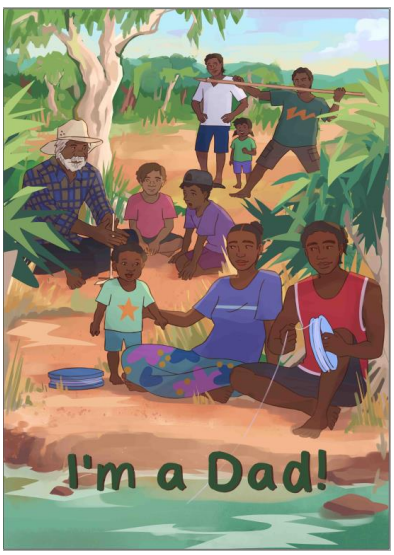
From 2022-2025, a suite of new program resources was created with practitioners and parents in MECSH communities. The new resources aim to strengthen practitioner-family relationships, discussion, and two-way learning. They can be integrated in the MECSH model of care and within a range of programs and service delivery models that support Aboriginal families and communities in the NT.

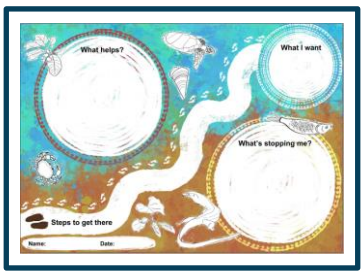
The resources include:

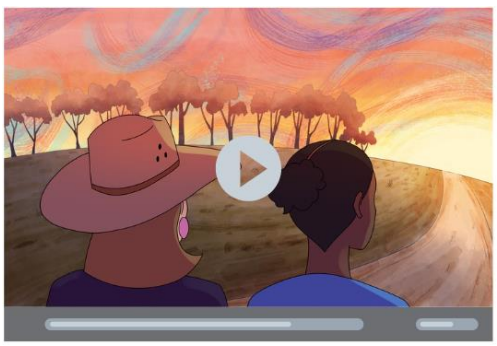
- Strength-based strategies around parenting aspirations and responsive care
- Tools for engaging fathers and what they want for their families
- Multi-lingual, pictorial and culturally relevant content
- Videos that demonstrate the relational approach to care.

Explore the new resources at menzies.edu.au









IMPLICATIONS:
HOME VISITING IN THE NT

Over five years of implementation, the three Aboriginal Community Controlled Health Services (ACCHS) made strong progress in building a home visiting program that reached half of all women with babies and young children in their regions. The program successfully engaged women with higher health and social needs, many of whom are missed or underserved by other services.

Over time, the number of women enrolled steadily grew, caseloads increased, and more MECSH visits were delivered. These achievements came despite major disruptions, including the Covid-19 pandemic and natural disasters that affected many communities. The growth in participation and improvement in retention achieved by MECSH in the NT is comparable with or stronger than similar programs in this context (Nguyen et al 2018).

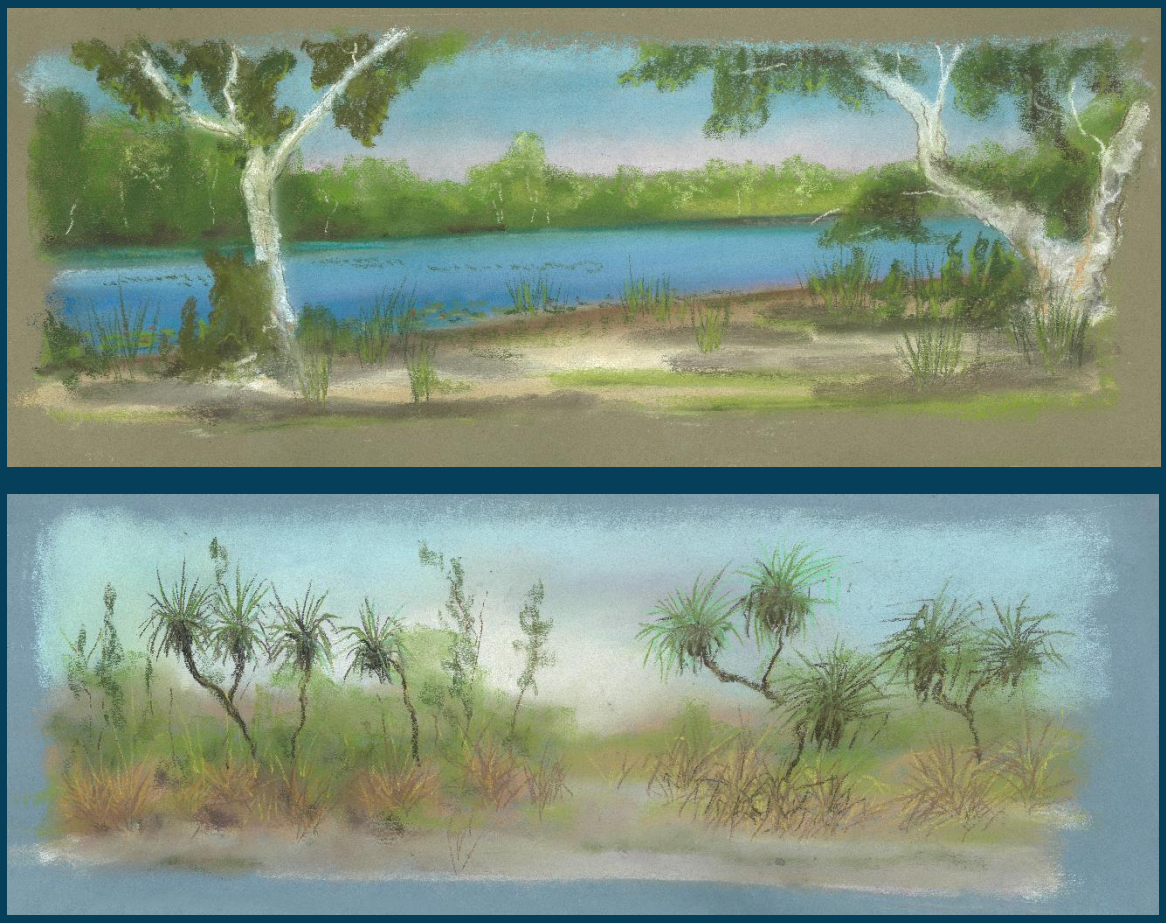
While there is evidence of program growth and strengthening over time, some original fidelity indicators were not fully met, particularly in areas such as number of visits and delivery of focus modules. Rather than indicating failure, this highlights the importance of adaptive and relational approaches required to provide responsive care. Through the evaluation of NT MECSH, key elements of a home visiting model have taken shape.

To sustain and strengthen the model, the following actions are recommended:

- **Support home-visiting teams:** Continue investment in the local workforce, including home-visiting nurses, community cultural workers, and social care practitioners, ideally with a mix of genders to support partner and family engagement. Strengthen support to practitioners through regular case reviews, Community of Practice meetings and reflexive supervision to enhance professional and practice growth.
- **Revise implementation targets:** Re-design achievable targets for program implementation, including caseload, service schedules, visit composition, and integration of new resources. Retain the focus on social and emotional wellbeing and responsive care and strengthen structured modules focusing on parenting. Develop NT-specific monitoring and quality improvement frameworks to track progress, identify challenges, and adjust strategies as needed.
- **Enhance governance and service integration:** Establish clear governance frameworks to guide refined program delivery, with well-defined roles and responsibilities. Integration with primary health care is enhanced when supported by senior management and underpinned by policies that promote interdisciplinary collaboration. This includes strengthening links with maternal and child health services, allied health and specialist services, and social care.
- **Develop NT-based training and support:** Re-develop program training to improve timeliness, ensuring staff can access it as soon as they begin their roles. New training should be tailored to the NT context and delivered by trainers with NT practice experience. Clarify training requirements for social care practitioners, program coordinators, clinical supervisors, and service managers to facilitate integration of home visiting into primary healthcare. Additionally, NT-specific training should incorporate new parent engagement resources that align with a refined model of care that is fit for remote dwelling families.
- **Secure support for sustainability:** Ongoing support from the government is required to build workforce capacity, maintain morale, and ensure there is adequate funding for both program delivery and re-design of training to ensure consistency of approach based on evidence across the sector. The program would benefit from continued external support to maintain momentum, provide training and expertise, foster knowledge sharing, and buffer against high staff turnover in remote settings.

CONCLUSION

This evaluation has established that a home visiting model like MECSH can provide vital support to women facing significant and often intersecting health and social challenges. A major strength of this approach is the ability to offer additional support to all pregnant women, to build confidence, strengthen social connections and increase access to broader support. Despite the many challenges of remote health service delivery, implementation of MECSH over the first five years has shown that this model is feasible in very remote areas, reaching almost half of women with young babies. With targeted investment by government, a locally-embedded workforce and supportive program structures, ACCHS are well-positioned to continue delivering this model of enhanced maternal and child health care for women and families.



NT Landscapes (2024) by Paul Seden are a series of works depicting different parts of the NT. This series was commissioned as part of the Resource Development Project for the *I'm a Dad!* comic. These works capture river country and pandanus country.

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Tables

Table 1. Cohort Characteristics

Bold indicates significant difference between groups

Factors	Age group by age at start of period of eligibility			All eligible women
	< 20 years	20-34 years	≥ 35 years	
Number of women (%)	280 (19.8%)	990 (70.1%)	142 (10.1%)	1412
Other children				
No previous births(%)	**83.6%**	**39.5%**	**19%**	46.2%
Number of other births, median (range)	**1 (0-3)**	**2 (0-8)**	**4 (0-9)**	2 (0-9)
Antenatal care attendance				
Any antenatal care visits	**93.7%**	**86.8%**	**80.1%**	87.6%
Number of antenatal care visits, median (range)	9 (0-33)	8 (0-38)	10 (0-26)	9 (0-38)
0 visits	**6.3%**	**13.3%**	**20.9%**	12.5%
1-4 visits	**11.3%**	**15.7%**	**14.0%**	14.7%
5-6 visits	**8.8%**	**8.5%**	**5.8%**	8.4%
7 or more visits	**73.6%**	**62.5%**	**59.3%**	64.5%
Gestation at first visit, mean (SD) weeks	14.2 (13.1-15.3)	13.4 (12.8-14.0)	13.5 (11.5-15.4)	13.6 (13.1-14.1)
First antenatal care visit in first trimester	55.4%	61.0%	67.4%	60.4%
Health and wellbeing				
At risk on emotional wellbeing screen	30%	29.9%	16.4%	29.1%
Mental health worry	30.1%	27.4%	29.9%	28.2%
Domestic and family violence disclosure	30.5%	24.4%	21.2%	25.3%
Chronic condition	22.2%	25.3%	27.0%	24.8%
Smoking during pregnancy	61.5%	66.9%	61.5%	61.5%
Alcohol use during pregnancy	**22.9%**	**33.5%**	**38.4%**	31.8%
Other drug use in pregnancy	15.5%	15.6%	15.7%	15.6%
Birth				
Birth type				
Normal vaginal	55.2%	49.8%	48.3%	50.7%
Complicated vaginal	16.7%	12.5%	6.0%	12.7%
Caesarean	25.1%	31.9%	37.1%	31.0%
Unknown	2.9%	5.9%	8.6%	5.6%
Birth weight, mean (SD), grams	3057.9 (2973.4-3142.4)	2993.0 (2941.5-3044.5)	3002.6 (2871.0-3134.2)	3007.1 (2965.3-3049.0)
Low birth weight	13.9%	19.7%	17.0%	18.3%
High birth weight	**1.3%**	**5.5%**	**4.0%**	4.5%
Gestational age at birth, mean (SD), weeks	**38.4 (38.1-38.7)**	**37.6 (37.4-37.8)**	**37.1 (36.4-37.9)**	37.7 (37.5-37.9)
Preterm birth	**14.2%**	**18.6%**	**26.0%**	18.4%

Table 2. Comparison of characteristics at eligibility for women offered and not offered the MECSH program[3]

Bold indicates statistically significant difference between groups

	Whether offered MECSH while eligible	
	Not offered (n=632)	**Offered** (n=634)
Age	**25.8 years**	**24.7 years**
< 20 years	**17.3%**	**23.5%**
20-34 years	**74.4%**	**70.2%**
≥ 35 years	**8.4%**	**6.3%**
Other children		
No previous births	50.3%	45.6%
Number of other births, median (range)	**1 (0-9)**	**2 (0-8)**
Antenatal care		
Any record of antenatal care	**84.2%**	**96.5%**
First antenatal care visit in first trimester	52.2%	63.4%
Number of antenatal care visits for eligible birth		
0 visits	**15.8%**	**3.5%**
1-4 visits	**27.2%**	**9.9%**
5-6 visits	**11.6%**	**6.5%**
7 or more visits	**45.4%**	**80.1%**
Health and wellbeing		
More than low risk on emotional wellbeing screen	16.5%	19.6%
Mental health worry	**23.1%**	**37.8%**
Domestic and family violence disclosure	**21.7%**	**31.4%**
Smoking during pregnancy	63.2%	67%
Alcohol use during pregnancy	27.4%	31.3%
Other drug use in pregnancy	**11.4%**	**20.7%**
Chronic health condition	**32.9%**	**48.3%**

[3] Excludes the 146 women who were eligible before a nurse started offering the program in their community


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