women want to know
discuss pregnancy & alcohol

Women Want to Know project evaluation

REPORT FOR THE FOUNDATION FOR ALCOHOL RESEARCH AND EDUCATION (FARE)

SEPTEMBER 2016

Australian Government
Department of Health

fare
Foundation for Alcohol Research & Education

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About this publication

Hall & Partners Open Mind were engaged by the Foundation for Alcohol Research and Education (FARE) to conduct an independent evaluation of the *Women Want to Know* project. Launched in mid-2014, the project encourages health professionals to routinely discuss alcohol and pregnancy with women, and to provide advice consistent with the National Health and Medical Research Council (NHMRC) *Australian guidelines to reduce health risks from drinking alcohol*.

The evaluation aims to assess the awareness of the WWTK campaign and its key messages, the use and engagement with the resources, and the overall success of the project.

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About Hall & Partners Open Mind

Hall & Partners Open Mind (HPOM) is one of Australia's leading social and market research and evaluation agencies, with over 30 researchers across our offices in Sydney and Melbourne. HPOM works with federal, state and territory government departments, not-for-profit and commercial organisations on a broad range of program, service and communications evaluation studies.

HPOM is committed to delivering robust, transparent and honest assessments of impact and outcomes, against the aims and objectives, using analysis and exploratory frameworks developed over more than 20 years' of practice. By combining qualitative and quantitative methodologies, HPOM is able to explain the reasons for success or failure and provide actionable recommendations to enhance ongoing program development and to inform best practice more broadly.

About FARE

The Foundation for Alcohol Research and Education (FARE) is an independent, not-for-profit organisation working to stop the harm caused by alcohol. Alcohol harm in Australia is significant. Over 5,500 lives are lost every year and more than 157,000 people are hospitalised making alcohol one of our nation's greatest preventative health challenges.

For over a decade, FARE has been working with communities, governments, health professionals and police across the country to stop alcohol harms by supporting world-leading research, raising public awareness and advocating for changes to alcohol policy. In that time FARE has helped more than 750 communities and organisations, and backed over 1,400 projects around Australia.

Acknowledgments

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We also thank the members of the *Women Want to Know* Project Working Group and the Australian College of Midwives, the Royal Australian New Zealand College of Obstetricians and Gynaecologists and the Royal Australian College of General Practitioners for their ongoing collaboration on this project; and acknowledge the assistance of the Telethon Institute for Kids, the AQUA study at Murdoch Children's Research Institute and the Western Australian Drug and Alcohol Office for their assistance in the development of the *Women Want to Know* project resources.

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EXECUTIVE SUMMARY

The *Women Want to Know* project

The *Women Want to Know* (WWTK) project was launched by the Foundation for Alcohol Research and Education (FARE) in mid-2014. The project encourages health professionals to routinely discuss alcohol and pregnancy with women, and to provide advice consistent with the National Health and Medical Research Council (NHMRC) *Australian guidelines to reduce health risks from drinking alcohol*. The NHMRC Guidelines state that maternal alcohol consumption can harm the developing fetus or breastfeeding baby, and therefore recommend that for women who are pregnant, planning a pregnancy or breastfeeding, not drinking is the safest option.

Drinking alcohol during pregnancy can cause damage to the unborn child. Alcohol consumption during pregnancy is associated with an increased risk of miscarriage, lower birth weight, stillbirth and premature birth, and Fetal Alcohol Spectrum Disorders (FASD).

FASD is the term given to the range of physical, developmental and/or neurobehavioural conditions resulting from prenatal alcohol exposure. This may include poor language and communication skills, lower IQ, poor memory, short attention span, motor coordination problems and social and behavioural problems. According to the most recent version of the Australian FASD Diagnostic Instrument (2016), there are two diagnostic categories within FASD:

- 'FASD with three sentinel facial features' (similar to the previous diagnostic category of Fetal Alcohol Syndrome/FAS) and
- 'FASD with less than three sentinel facial features' (which encompasses the previous diagnostic categories of Partial Fetal Alcohol Syndrome and Neurodevelopmental Disorder - Alcohol Exposed).[1]

The problems associated with FASD are lifelong and can have profound consequences for individuals. However, early recognition, diagnosis and therapy is critical and can improve conditions. FASD is also completely preventable if pregnant women abstain from consuming alcohol.[2]

The campaign examined in this report, WWTK, is unique in that it targets health professionals rather than patients directly. Specifically, WWTK targeted General Practitioners (GPs), midwives and obstetricians/gynaecologists (specialists) across Australia.

The WWTK project involved two main components:

- Accredited training to provide health professionals with information and tools to enable discussions about alcohol and pregnancy. These training modules were delivered online via the Australian College of Midwives (ACM), Royal Australian College of General Practitioners (RACGP) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).
- Resources to support health professionals to discuss alcohol and pregnancy with women. This comprised of three leaflets for health professionals and one for patients, plus eight videos which

[1]Telethon Kids Institute (n.d). *Alcohol, Pregnancy & FASD*. Retrieved from http://alcoholpregnancy.telethonkids.org.au/understanding-fasd/what-is-fasd/

[2] Williams, J.F. & Smith, V.C. (2015) *Fetal Alcohol Spectrum Disorders,* American Academy of Pediatrics, 136:5

were made available as part of the online training course, through the Department of Health (DoH) YouTube playlist, and via the WWTK website (www.alcohol.gov.au).

Evaluation objectives and methodology

FARE required an independent consultant to conduct an evaluation of the WWTK project. The evaluation aims to assess:

- awareness of the WWTK campaign and key messages
- use and engagement with the resources
- any change in health professionals' knowledge, attitudes and comfort in discussing alcohol with pregnant women as a result of campaign exposure
- any change in health professionals' practice as of a result of campaign exposure
- the appropriateness of resources developed for the WWTK project (leaflets and videos)
- the effectiveness of offering continuing professional development (CPD) points as an incentive for enrolment and completion of the free online courses
- the effectiveness of the promotional strategies used in attracting enrolments to the online courses
- the effectiveness of online training course content in improving health professionals' knowledge on the subject and influencing future behaviours in this area.

The evaluation comprised:

- an online survey of 257 health professionals (103 GPs, 103 midwives, 51 specialists), with results compared to a benchmark survey conducted in August 2013 (i.e. prior to the launch of the WWTK project)
- two online discussion forums with WWTK training participants (one for specialists, one for midwives)
- three focus groups with GPs and one with midwives
- in-depth interviews with midwives (n=3) and specialists (n=6)
- in-depth interviews with WWTK project stakeholders (n=10)
- analysis of available project documents and administrative data, including project progress reports, communication and dissemination strategies, website activity statistics, leaflet distribution statistics, online training enrolment and completion statistics.

The WWTK project was funded (by the DoH) and delivered (by FARE) in two phases: the first from mid-2012 to the end of 2014 and the second from mid-2015 to 2016. As such, the second phase of the project was in progress when this evaluation was conducted between 11 March and 11 April 2016.

Context

A number of changes have taken place since the development of the WWTK campaign began in mid-2012, which have impacted on the environment in which the project is being delivered. In particular, since mid-2012 the issue of FASD has become more prominent in terms of national policy.

In November 2012 the final report of a national FASD inquiry (*FASD: The Hidden Harm – Inquiry into the Prevention, Diagnosis and Management of Fetal Alcohol Spectrum Disorders)* was tabled in Parliament. The Commonwealth Government responded in August 2013 by announcing $20 million over four years for a national FASD action plan (*Responding to the Impact of Fetal Alcohol Spectrum Disorders in Australia – A Commonwealth Action Plan 2013-14 to 2016-17*) and the FASD Action Plan was launched in June 2014 (although with reduced funding of $9.2 million). This plan identified five priority areas for action to reduce the impact of FASD across Australia, including the following two areas which are of particular relevance to the WWTK project:

- "Recognise the preventable nature of FASD and support continuation of efforts to prevent FASD building upon existing government program activity
- To support the health and broader workforce to prevent FASD and to better respond to the needs of families impacted by it."

It is also worth noting that the current 2009 National Health and Medical Research Council (NHMRC) *Australian guidelines to reduce health risks from drinking alcohol* ('the Alcohol Guidelines') – which replaced the 2001 iteration that had previously included a recommended amount of consumption for pregnant women who choose not to abstain during pregnancy – were relatively new in 2012. However, these have now been available for seven years.

Summary of key findings and implications

1. **Overall, the WWTK project was successful in reaching a reasonable proportion of the target health professionals, given the scope of the project and the challenges involved in achieving 'cut-through' among this hard-to-reach audience.**

The WWTK promotional activities were successful in driving visitors to the campaign website in significant numbers, with 18,042 users visiting the site by 1 March 2016.

The campaign also successfully prompted requests for relatively large numbers of the printed WWTK leaflets, mainly from health services and hospitals, with more than 60,000 copies ordered in total.

The WWTK resources (leaflets or videos) reached 14 per cent (n=37) of relevant health professionals surveyed. That is, 14 per cent of the sample could recall having come across at least one of these resources when prompted. If this level of awareness was replicated across the entire target population of practicing midwives, specialists and GPs in Australia (estimated at approximately 49,500), this would mean that nearly 7,000 health professionals (6,936) had come across the WWTK collateral.

This level of recall is encouraging, particularly given: the budget for the entire project was relatively modest; the gap in promotional activities that occurred as a result of the way the project was funded; the gap between the initial wave of promotional activities (in 2014) and the evaluation survey; as well as the fact that health professionals are bombarded with large volumes of information on a day-to-day basis. For example, a 2008 survey of 180 GPs conducted by Choice found that these health professionals

received, on average, ten promotional mailings per week and that 62 per cent received ten or more such mailings a week.[3]

To give projects such as WWTK the best chance of competing in this environment and to allow their potential impact to be maximised by building up momentum, it is recommended that funding is provided (from the outset) for the ongoing promotion of any resources developed.

2. **The two training courses that could be assessed as part of this evaluation (ACM and RANZCOG) were successful in positively impacting the attitudes and behaviour of participating professionals, according to feedback from training participants.**

Analysis of the feedback forms shared by ACM and the findings from the discussion boards with ACM and RANZCOG participants indicates that the WWTK training was well received and had some positive impacts on attitudes and behaviour, as well as knowledge.

In particular, some participating professionals had been prompted to question their own long-held beliefs about alcohol consumption during pregnancy (for example, the assumption that women were generally already aware of the adverse effects of alcohol consumption during pregnancy).

A number of participants also indicated that they had begun to initiate more conversations with pregnant women as a result of the training and/or felt more confident in having such conversations. They reported that the WWTK training gave them the tools, knowledge and the confidence to initiate conversations about alcohol with their patients and to carry them through. Advice on how to ask questions about potentially sensitive topics, motivational interviewing techniques, and how to ensure that the patients felt comfortable and empowered (rather than threatened) had contributed to this.

In addition, almost all (96 per cent) midwives who completed the ACM feedback form said they were likely to recommend the course to others.

However, it was not possible to assess the effectiveness of the RACGP training course as part of this evaluation.[4] This highlights the importance of funding evaluations for health promotion projects from the outset. By doing so, all relevant stakeholders can be involved in developing the evaluation approach and ensuring relevant arrangements have been made to access the necessary data (for example by building this into partnership agreements and contracts).

[3] Choice (2014). *Drug company influence on GPs. Is your prescribed medicine really the best option?* Retrieved from: https://www.choice.com.au/health-and-body/medicines-and-supplements/prescription-medicines/articles/drug-company-influence-on-gps

[4] In-line with contractual arrangements, it was not possible to arrange for RACGP to send course participants an invitation to contribute to the evaluation and, in-line with privacy legislation, contact details could not be passed on directly to FARE or HPOM. In addition, only five GPs had completed a standardised course feedback form to date (too few for meaningful analysis) so it has not been possible to assess the effectiveness of the RACGP training course as part of this evaluation.

3. Take-up and completion of the online training, especially among GPs and fully qualified specialists, would ideally have been higher given that this was deemed a core part of the WWTK strategy.

The training courses delivered and developed in partnership with the three professional colleges (ACM, RACGP and RANZCOG) were a core element of the WWTK strategy. The *Brief Literature Review*, commissioned as part of the developmental phase, found that skills training may be more effective in encouraging health professionals to discuss alcohol with their patients than simply providing them with education in the form of written resources.

However, health professionals who have come into contact with the WWTK project are much more likely to have received the WWTK leaflets than to have taken part in the training.

As of March/early-April 2016, a total of 1,458 health professionals had enrolled in the three training courses (ACM: 922, RACGP: 275, RANZCOG: 261). Although these take-up rates are reportedly not unusual, the numbers they correspond with clearly represent only a small proportion of the total target audience (around 2 per cent of survey participants indicated that they had recently participated in training on 'Alcohol and Pregnancy' delivered by the colleges), suggesting that more needs to be done to raise awareness of the training and encourage take-up.

In addition, the majority of member enrolments in the RANZGOG course were trainees (n=193) and doctors undertaking the certificate of Women's Health, RANZCOG Diploma or RANZCOG Advanced Diploma (n=43), rather than Fellows (n=9). Feedback from the four registrars who contributed to the training participant online discussion board also indicates that participants had completed the WWTK course as a study aid and as part of their revision process.

It is encouraging that the course has attracted trainees, as it suggests that the content was viewed as useful and relevant to this audience. Further, once this cohort become qualified the information and messages conveyed will hopefully impact on their practice as specialists.

However, going forward it will be important to encourage more practicing health professionals to participate in the course, by convincing them that the content will be relevant and useful to them (as discussed below). This will help to ensure that the advice currently being given to patients aligns with the Alcohol Guidelines.[5]

4. The CPD accreditation for the WWTK was not sufficiently motivating on its own to prompt health professionals to take-up the course.

CPD accreditation for the training was expected and/or considered 'nice to have,' by relevant groups of health professionals. However, this did not act as a strong enough incentive to encourage participation in the WWTK training. This was especially the case for GPs and specialists, who seemed to have a wide range of accredited training options available to them. Midwives were somewhat more attracted by this offer, particularly as the training was free of charge.

All three health professional groups generally needed to feel that the content of any course made investing their limited time worthwhile. While CPD accreditation goes some way to meeting these

[5] The ACM and RACGP enrolment data was not broken down by whether training participants were fully qualified or students.

criteria for some health professionals, the primary challenge for engaging this audience is providing 'new' content.

The practicing GPs and specialists who participated in the qualitative elements of this evaluation tended to feel that they knew as much as they needed to about pregnancy and alcohol. They indicated that, to take part in training on this topic specifically, there would need to be new evidence about the impact of alcohol consumption, particularly at low levels, during pregnancy. As such, if significant new evidence has emerged since the training has been developed, or if/when new evidence becomes available, this should certainly be incorporated into the WWTK training and used as a motivator in training promotion activities, particularly for these two groups.[6]

There is also evidence that offering additional incentives, such as a recent RANZCOG prize draw (to have membership fees paid for a year), for completion of the training can help to boost both enrolments and completion rates.

Midwives who participated in the discussion groups and in-depth interviews tended to be much more open to taking part in training on the topic of pregnancy and alcohol. This group felt that there was scope for them to increase their understanding of the impacts of alcohol during pregnancy and how to discuss the topic with patients effectively and sensitively. This feedback indicates that the main task for encouraging take-up among this group of health professionals is to raise awareness of the WWTK training. That said, some of the midwife training participants who contributed to the discussion boards reported that the course had been recommended to them by lecturers or clinical coordinators. As such, opportunities to identify and engage influencers in the midwife community (and possibly also the GP and specialist communities) to champion the training should certainly be expanded if possible (though it is acknowledged this may be resource intensive to achieve).

It should also be acknowledged that some health professionals across all three groups (GPs, specialists and midwives) expressed a preference for face-to-face training and professional development events rather than a course specifically on alcohol and pregnancy. This was primarily because face-to-face events offered them the opportunity to learn about a variety of topics or new developments, as well as the opportunity to meet others working in the field. And, purely from the point of view of CPD accreditation, some participants felt it was easier to attend conferences or events that allowed them to accrue multiple points at a time rather than many one-off short courses. Consideration should therefore be given to investing additional resources in the provision of training via such face-to-face events, to complement the existing online training resources.

In relation to promotion of the training specifically, it is notable that the opportunity to promote the training via the WWTK leaflets was not maximised. Only one of the four leaflets mentions the availability of the online training course, and this information is somewhat hidden on the back page rather than being front and centre. Given the importance of the training to the WWTK strategy, promoting the training and encouraging take-up should have been a key focus of the leaflets.

[6] Note, one of the actions outlined in the *Commonwealth Action Plan to reduce the Impact of FASD 2013-14 to 2016-17* is to: "Build the evidence base and available data on alcohol consumption during pregnancy to be better able to monitor progress in reducing maternal alcohol consumption through improving data collections such as the National Drug Strategy Household Survey."

5. **Comparison of the benchmark and post-intervention online survey results show that the WWTK project did not result in statistically significant levels of attitudinal or behaviour change among the overall target audience of health professionals.**

Regardless of the appropriateness of the WWTK resources and training, this lack of statistically significant change was to be expected given the low recall and participation. Only 14 per cent of survey respondents could recall having seen any of the leaflets or videos, and only two per cent indicated that they had participated in training on this topic. Although this level of awareness is positive in the context of the project scope, it was unlikely to be sufficient for any statistically significant change to be demonstrated at the overall target population level.

However, there was a positive shift seen in awareness of the Alcohol Guidelines. Specifically, there was a significant decrease in the proportion of GPs and specialists reporting that they had not heard of the Alcohol Guidelines (from 31 to 20 per cent and from 30 to 14 per cent respectively). As we are not aware of any other national awareness raising campaigns to promote the Alcohol Guidelines among either health professionals or indeed the general population during this time, it seems reasonable to conclude that the WWTK project at least played a role in this.

One of the measures that did not show any significant change was the proportion of health professionals reporting that they did not routinely ask pregnant women about their alcohol consumption (around one in seven). The qualitative research showed that health professionals' ongoing belief that women are generally aware of the Alcohol Guidelines relating to pregnancy continues to play a part in this.

However, it could be argued that the even bigger issue is that the findings indicated that when advice was given, the advice did not *consistently* reinforce the Alcohol Guidelines. For example, the qualitative elements of the evaluation revealed there was a tendency for health professionals who did inform pregnant women of the Alcohol Guidelines to, inadvertently and perhaps subtly, undermine this. For example, by indicating if asked that "an occasional glass of wine is fine" on "special occasions" or celebrations. Similarly, when survey respondents were asked what advice they generally gave to women about alcohol consumption during pregnancy, around one in five reported giving various types of advice that could potentially undermine the Alcohol Guidelines.[7] This includes eight per cent who advised that consuming a small amount of alcohol occasionally is reasonable. This is presumably linked to the finding from the survey that just over one in ten GPs and specialists (and three per cent of midwives) continued to believe that one or two drinks per day can be safely consumed without any risk to the fetus.

6. **The WWTK resources reportedly had a positive impact on knowledge, attitudes and/or behaviour among at least some health professionals, but a number of key weaknesses were also identified. In particular, the sheer volume of information contained in the leaflets was off-putting and meant that important messages were missed.**

Some discussion group participants (the majority of whom had not seen any of the WWTK resources before) felt that the resources would have some positive impact on their propensity and confidence to

[7] For example, to cut down/minimise amount of alcohol, to avoid alcohol during the first trimester, not to binge drink, to limit alcohol consumption to one standard drink per day and a small amount of alcohol occasionally was reasonable.

talk with pregnant women about alcohol. Midwives in particular, felt reassured that it was a topic that women wanted to hear and learn more about.

Between n=21 and n=22 of the survey respondents who recognised one or more of the WWTK materials (n=37) agreed that the resources had increased their understanding of a range of relevant issues and increased their comfort in discussing alcohol and pregnancy with patients. A similar number reported that they had initiated conversations or had more conversations with women about alcohol consumption during pregnancy.

However, around one in five (n=8) of the survey respondents who recognised the resources (n=37) admitted that their behaviour had not changed as a result of seeing them. Additionally, only n=2 of these survey respondents indicated that they referred to the AUDIT-C more often as a result (and only two per cent of all the health professionals surveyed used the tool to assess a pregnant patient/client's level of alcohol consumption). Discussion group participants explained that while the AUDIT-C appeared to be a useful tool, it would primarily be used to help them assess and monitor alcohol consumption among 'problem drinkers' rather than as a screening tool that they would realistically have time or inclination to use with all pregnant women. This implies that simply providing the AUDIT-C tool to health professionals, even accompanied by written instructions and advice, will not be sufficient to result in its regular use as a screening tool for pregnant women. For future campaigns, it is perhaps worth considering whether the AUDIT-C questions could be built into the standardised questionnaires/checklists often used by health professionals to collect information about a range of lifestyle factors. It is also worth considering whether health professionals could be remunerated for assessing an individual's alcohol consumption and delivering a brief intervention, via MBS payments. In the case of WWTK, this latter option was assessed as unfeasible within the budget and time constraints of the project as part of the early development process.

Further, many GPs and specialists in the discussion groups felt that neither the other leaflets nor the videos were likely to impact on their practice. This was primarily because they felt there was still a lack of 'hard' evidence and conclusive research about the impact of lower levels of alcohol on an unborn baby and/or because they felt they were already following the recommendation to convey the Alcohol Guidelines to pregnant patients.

Some GPs also felt affronted and defensive about the implication they perceived in the videos that health professionals were not advising pregnant women about alcohol or were giving the wrong advice. Again, they said that they always passed on the guideline that the safest option was not to drink during pregnancy (even if some were effectively undermining the Alcohol Guidelines when asked about occasional drinking, as noted above). This group certainly did not feel encouraged to reflect on or alter their own practice.

When feedback on the WWTK videos was provided by those who had seen them played in the context of the training (as primarily intended), some liked learning via a combination of mediums (such as videos and written text). However, there were also some criticisms of the videos, with reports that they were too staged or stilted, while others perceived them as too tedious, slow, and repetitive. Some RANZCOG training participants expressed frustration that they couldn't choose to skip the videos. It is also worth noting that references to the new Alcohol Guidelines were perceived as outdated and certainly not a motivator for engaging with the resources or training. As mentioned, this would not have been the case when the project was originally initiated in 2012.

A key issue that was consistently raised across the discussion groups and interviews was that the number of leaflets and amount of information in each of them was overwhelming. This meant the materials were unlikely to be read by busy health professionals and/or that key messages would be lost. The leaflet

introducing the WWTK project, in particular, was widely seen as unnecessary and lacking any information of real value to health professionals. As noted, health professionals are bombarded by a large number of promotion resources from a range of sources on a day-to-day basis.

To increase the likelihood that key information will be absorbed and to avoid resources being wasted, standalone written materials targeted at health professionals should ideally be condensed to fit onto one resource. This resource should focus on conveying the most important message(s), a clear call to action and clear motivator(s) for that call to action, along with signposts to additional sources of information for those who need it. Similarly, promotion through conferences should focus on securing strategic speaker places which allow the key messages of the project to be conveyed to an engaged audience. This engagement is likely to be more effective than simply providing health professionals with leaflets in 'showbags', given the vast amounts of written material that tend to be provided at these events. In the case of WWTK, the timing of the additional funding meant that some deadlines for conference abstracts were missed in Phase Two and the project was therefore limited in its methods of distribution.

The Brief Literature Review found that a resource that health professionals could give to patients about pregnancy and alcohol would support health professionals in having potentially challenging conversations with their patients, and would also directly help to educate and motivate women. The discussion group findings indicate that the leaflet for patients developed as part of WWTK did help to fill a gap, as it was seen by health professionals as a useful tool that would help to back up the advice they were giving. Although, some again suggested that the leaflet was trying to convey too much information and that key messages could get lost.

The weaknesses identified above, especially the information overload issue and the potentially counter-productive reaction to the videos among GPs, should ideally have been identified and addressed in the early stages of development via formal concept testing, which was not conducted, primarily due to budgetary constraints.

7. Separate resources and promotional materials would ideally have been developed for midwives and GPs/specialists

Midwives tended to differ from GPs and specialists in a range of ways relevant to this project. This included differences in their level of comfort in discussing alcohol with pregnant women, the extent to which midwives perceived that they would benefit from training on the topic, the factors that might motivate them to participate in training on this topic, and their reaction to the WWTK resources (as discussed above). This feedback suggests that separate resources and promotional materials would ideally have been developed for midwives and for GPs/specialists. For example, midwives may be more motivated by promotional materials for training which focus on increasing understanding of the issues and providing advice on having conversations about alcohol with pregnant women. In comparison, GPs/specialists may be more motivated by a focus on staying up-to-date with new research findings relating to the impact of alcohol during pregnancy. Again, draft materials should ideally be concept tested with each of the relevant target audiences.

8. **Future efforts to increase awareness and understanding of the Alcohol Guidelines among health professionals should ideally be accompanied by a wider awareness raising campaign targeted at the public.**

WWTK was funded on the basis of increasing awareness and understanding of the Alcohol Guidelines relating to pregnancy among health professionals, and supporting them to provide advice consistent with this to their patients. While this aim remains important, health professionals and a number of stakeholders who participated in the qualitative elements of this evaluation tended to feel that a wider campaign was required to raise awareness and understanding of the Alcohol Guidelines relating to pregnancy. They believed that this would help reinforce and 'back-up' information provided by health professionals about the Alcohol Guidelines. A separate survey conducted by FARE (in 2014) among women who had recently been pregnant or breastfed a baby found that 15 per cent believed that "drinking while pregnant is ok in moderation" and a further one per cent believed that "drinking while pregnant is not harmful to the fetus".[8] Therefore, the presence of a consumer-facing health promotion campaign should aim to counter common misconceptions and anecdotal evidence relating to alcohol consumption during pregnancy, particularly at moderate to lower levels.

It is also important to remember that health professionals are themselves members of the wider community and are influenced by cultural attitudes to alcohol and their own personal experiences. A wider awareness raising campaign may, therefore, also indirectly influence the knowledge, attitudes and behaviours of health professionals – especially if it results in the issue being perceived as more prominent/current or them being asked about it more often by their patients. Further, this would align with specific actions to enhance efforts to prevent FASD outlined in the *Commonwealth action plan responding to the impact of FASD in Australia*, including the following recommendations:

- Identification of and use of best models of early intervention activities to avoid alcohol-related harm, and include promoting the risks of consuming alcohol during pregnancy.
- Build the capacity of the workforce, in particular primary care, non-government organisations, and other governments to deliver the message that it is safest not to drink any alcohol during pregnancy.

Overall conclusion

In summary, the WWTK project appears to have been successful in terms of playing at least a part in raising awareness of the Alcohol Guidelines among Australian GPs and specialists (though not midwives). Despite a small sample size, there was also indicative evidence that the 14 per cent who recalled the project resources had picked up the key messages and felt this had a positive impact on their attitudes and to a lesser extent their behaviours. The project was also successful in developing and delivering accredited online training courses that had a positive impact on the attitudes and behaviour of participating health professionals (according to feedback received from training participants).

However, the project did not successfully achieve a significant positive shift in the attitudes and behaviour of the three key target groups of health professionals at the overall population level. It is

[8] Foundation for Alcohol Research and Education (FARE). (2014). *Annual alcohol poll 2014: Attitudes and behaviours*. Canberra: FARE.

possible that with more effective promotional strategies the WWTK resources as they currently stand might produce a positive impact observable at the population level. However, this impact is likely to be greater if the resources were more focused on promoting the training component given its clearer impact. It is therefore recommended that the project be continued, but with a focus on promoting the take-up of training, rather than the wide-scale distribution of leaflets as standalone resources. There would also certainly be value in a separate yet complementary campaign aimed at raising awareness of the Alcohol Guidelines among the general public.

Recommendations

The recommendations drawn from the evaluation are summarised below, under the relevant evaluation objective(s). It may be possible to implement some of these recommendations during the remainder of the current WWTK project. Others will be relevant for informing best practice for other preventive health projects or any future iterations of WWTK.

Objective: assess level of awareness of campaign and engagement with the resources

1. Funding for similar health promotion projects should ideally allow for the ongoing promotion of any resources developed (from the outset), to allow their full potential impact to be maximised by building up momentum.
2. Continue the phase two approach of focusing promotional efforts on increasing the take-up of training in particular, as the evaluation adds support to the hypothesis that the training is more effective than written resources in isolation.
3. Promotion through conferences should focus on securing speaker places that allow the key messages of the project to be conveyed to an engaged audience (the timing of the additional funding meant that some deadlines for conference abstracts were missed in phase two). This is likely to be more effective than simply providing health professionals with leaflets, given the amount of written material that tends to be provided at these events and health professionals' limited time to engage with such resources.
4. Although it was out of scope for the WWTK project, efforts to raise awareness of the Alcohol Guidelines for pregnancy and breastfeeding among health professionals should ideally be complemented by a campaign to raise awareness and understanding of alcohol and pregnancy among the wider population. Such a campaign would help to counter common misconceptions and anecdotal evidence, as well as reinforce the advice being given by health professionals.[9]

[9] A separate survey, conducted by FARE (*Annual alcohol poll 2014: Attitudes and behaviours*) rather than directly as part of this evaluation, among women who had recently been pregnant or breastfed a baby, found that 15 per cent of women believed that "drinking while pregnant is ok in moderation" and a further one per cent believed that "drinking while pregnant is not harmful to the fetus".

Objective: assess any change in HPs knowledge, attitudes, comfort and behaviour in discussing alcohol with pregnant women

5. Continue efforts to raise awareness among health professionals that there is no evidence that low levels of alcohol consumption are safe during pregnancy and that this is the basis for the current Alcohol Guidelines. If or when evidence emerges which demonstrates that low levels of consumption do cause harm, then this should certainly be a key focus of future projects/campaigns.

6. Similarly, continue to focus efforts on convincing health professionals of the importance of giving a message that is always consistent with the Alcohol Guidelines. This should extend to occasions when health professionals are asked for their own personal opinion, for example about whether the occasional drink, such as on 'special occasions', is acceptable. Ensuring that correct advice is consistently given among those who are already discussing alcohol and pregnancy with their patients is arguably even more important in the immediate future than encouraging health professionals who do not initiate these conversations to do so.

Objective: assess the appropriateness of resources developed during the campaign

7. Given that the various target groups for the WWTK project tended to react differently to the resources (with midwives in particular tending to react more positively than GPs and specialists), any future campaigns should consider developing separate materials that specifically target the needs of each of the main target groups of health professionals.

8. Draft materials should be tested with their target audience, in this case 'grassroots' health professionals and women of childbearing age, to make sure they are as effective as possible. This important stage of resource development should also be taken into account when projects are funded.

9. In future projects, given the high volume of written materials that health professionals need to process in their day-to-day practice and the understanding that such materials can only achieve so much when received as standalone resources, written materials should ideally be condensed to fit into one resource. This should focus on conveying: the most important message(s), clear call(s) to action and clear motivator(s) for the call(s) to action, along with a few key pieces of information, plus signposts to additional information. More specifically, it is suggested that a condensed leaflet could most usefully include the following (these suggestions would require further development and testing among the target audiences – and the messaging ideas are for illustrative purposes only):

    - Key message territories – a significant proportion of women believe that drinking while pregnant is ok in moderation and/or are not aware of the Alcohol Guidelines, and the vast majority want and expect health professionals to discuss alcohol with them.

    - Call to action – always advise women that the safest option is not to drink any alcohol when pregnant or trying for a baby: "don't mix your messages like people mix their drinks – even occasional drinking is never ok". This could possibly also be coupled with the direct advice to initiate a conversation about alcohol with all women who are pregnant or planning a pregnancy.

    - Call to action – sign up for free CPD accredited training, which will provide even experienced practitioners with more information about the evidence underpinning the Alcohol Guidelines, and help them hone their skills in talking to women about this potentially sensitive issue.

- Information:
  - summary of the 5As
  - summary of evidence underpinning the Alcohol Guidelines – ideally split into the evidence relating to low (for instance, no evidence that this is safe), moderate and high levels of consumption (evidence of harm)
  - brief explanation of and link to an online version of the AUDIT-C tool, positioning it as an assessment tool for all pregnant women (not just 'problem drinkers').

10. It is suggested that the WWTK videos are best retained for use within the context of training or conference presentations and perhaps only promoted more widely to midwives (as the videos were best received by this group).
11. Consider whether the AUDIT-C questions could be built into the standardised questionnaires/checklists often used by health professionals to collect info about a range of lifestyle factors. And/or consider whether health professionals could be remunerated for assessing an individual's alcohol consumption and delivering a brief intervention, via MBS payments. This latter option was assessed as unfeasible within the budget and time constraints of the WWTK project as part of the early development process.

Objectives: assess the effectiveness of offering continuing professional development (CPD) points as an incentive for enrolment and completion of the free online courses and the effectiveness of the promotional strategies used in attracting enrolments

12. Encourage more practicing health professionals (as well as trainees) to participate in the WWTK training course by convincing them that the content will be relevant and useful to them. For example, by utilising the emergence of any significant new evidence as a motivator.
13. Where possible, consider tailoring materials to promote the training specifically towards the training needs and motivators of midwives and GPs/specialists separately. For example, midwives may be more motivated by promotional materials for training which focus on increasing understanding of alcohol and pregnancy, and advice on having conversations about this with pregnant women. While GPs/specialists may be more motivated by a focus on staying up-to-date with new research findings relating to the impact of alcohol during pregnancy.
14. Ensure promotional activities aimed at midwives are targeted to reach as many midwives as possible who are not members of the ACM, as well as members. For example, this might include continuing and expanding efforts to engage directly with representatives from relevant hospital departments and healthcare settings to promote the importance and utility of the training and, if feasible within the available budget, via direct communication with health professionals (for instance, via relevant mailing lists, if available).
15. If budget allows, continue to investigate and utilise options to offer some face-to-face training to supplement the online training as and when opportunities arise. Ideally this would include events where training on multiple topics is provided, such as conferences and in-hospital training sessions, to reach health professionals who are less likely to choose to take part in a standalone course on this topic or who prefer a face-to-face approach.

16. Continue to offer CPD accreditation for course completion, but also investigate the addition of other incentives, such as the competition recently introduced for participation in the RANZCOG training.[10]

17. Continue to offer the training free of charge (this was particularly attractive to midwives).

Objective: assess the effectiveness of online training course content in improving health professionals' knowledge on the subject of alcohol and pregnancy and influencing future behaviours in this area

18. Ensure that any new evidence is incorporated into the WWTK training course materials as swiftly as possible, especially about the effects of low level and/or moderate levels of alcohol consumption. Not only is it important for health professionals to be made aware of new evidence as it arises, but this would also provide motivation for participation in the training.

19. In future health promotion projects, aim to ensure that relevant permissions are in place from the outset to allow all relevant target audiences to be taken into account in evaluation findings. In this case, it was not possible to arrange for RACGP to send course participants an invitation to contribute to the evaluation and, in-line with privacy legislation, contact details could not be passed on directly to FARE or HPOM, without the relevant permissions having been sought from participants.

20. Investigate the possibility of offering additional incentives, such as the RANZCOG prize draw, for full completion of training, as already noted.

[10] At the time of writing a similar scheme was also being developed by RACGP.

BACKGROUND AND OBJECTIVES

Alcohol consumption has a significant impact on the health and wellbeing of Australians, with 2010 data indicating 5,554 deaths in that year were attributable to alcohol consumption and 157,132 hospitalisations as a result of alcohol or alcohol-related violence.[11] The Foundation for Alcohol Research and Education (FARE) works with community, government, health professionals and police across Australia to stop these harms by supporting research, RAISING awareness, and advocating for change in public policy.[12]

A key area of focus for FARE is alcohol and pregnancy. Drinking alcohol during pregnancy can cause damage to the unborn child. Alcohol consumption during pregnancy is associated with an increased risk of miscarriage, lower birth weight, stillbirth and premature birth, and Fetal Alcohol Spectrum Disorders (FASD).

FASD is the term given to the range of physical, developmental and/or neurobehavioural conditions,[13] resulting from prenatal alcohol exposure. This may include such as poor language and communication skills, lower IQ, poor memory, short attention span, motor co-ordination problems and social and behavioural problems. According to the most recent version of the Australian FASD Diagnostic Instrument (2016), there are two diagnostic categories within FASD:

- 'FASD with three sentinel facial features' (similar to the previous diagnostic category of Fetal Alcohol Syndrome/FAS) and
- 'FASD with less than three sentinel facial features' (which encompasses the previous diagnostic categories of Partial Fetal Alcohol Syndrome and Neurodevelopmental Disorder - Alcohol Exposed).[14]

The problems associated with FASD are lifelong and can have profound consequences for individuals. However, early recognition, diagnosis and therapy can improve conditions. FASD is also completely preventable if pregnant women abstain from consuming alcohol.[15]

In 2009, the National Health and Medical Research Council (NHMRC) produced the *Australian guidelines to reduce health risks from drinking alcohol* (the 'Alcohol Guidelines').[16] Guideline 4 relates to alcohol consumption during pregnancy and states:

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[11] Gao, C., Ogeil, R.P., & Lloyd, B. (2014). *Alcohol's burden of disease in Australia*. Canberra: Foundation for Alcohol Research and Education (FARE) and VicHealth in collaboration with Turning Point. Retrieved from: http://www.turningpoint.org.au/site/DefaultSite/filesystem/documents/EMBARGO-FARE-Alcohol-Burden-of-disease-Report.pdf

[12] Foundation for Alcohol Research and Education (n.d.). *About FARE*. Retrieved from: http://www.fare.org.au/about

[13] Williams, J.F. & Smith, V.C. (2015). Fetal Alcohol Spectrum Disorders, *American Academy of Pediatrics*, 136:5

[14] Telethon Kids Institute (n.d.). *What is FASD*. Retrieved from: http://alcoholpregnancy.telethonkids.org.au/understanding-fasd/what-is-fasd/

[15] Williams & Smith., Op Cit.,

[16] National Health and Medical Research Council (NHMRC). (2009). *Australian guidelines to reduce health risks from drinking alcohol*. Retrieved from: https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf

Maternal alcohol consumption can harm the developing fetus or breastfeeding baby.

- A: For women who are pregnant or planning a pregnancy, not drinking is the safest option.
- B: For women who are breastfeeding, not drinking is the safest option.[17]

The *Women Want to Know* project

The *Women Want to Know* (WWTK) campaign was launched by FARE in mid-2014. The campaign encourages health professionals to routinely discuss alcohol and pregnancy with women[18] in line with the NHMRC Alcohol Guidelines. It is unique in that it targets health professionals, rather than patients directly.

As outlined in the WWTK Project Rationale, a process of research, analysis and consultation was undertaken to inform the development of the project. In particular, it was identified that:

- "While there may be awareness among health professionals of the Alcohol Guidelines, the way in which this is communicated to consumers varies, particularly with respect to providing a message consistent with the Alcohol Guidelines.
- There are a range of barriers that health professionals encounter in raising alcohol consumption with consumers generally and this is also true for pregnant women.
- No national resources are available to assist health professionals raise conversations about alcohol consumption with pregnant women."

A number of potential options for addressing these issues were also identified and assessed against four criteria before it was decided that the project would involve two main components, namely:

- resources to support health professionals to discuss alcohol and pregnancy with women
- accredited training to provide health professionals with information and tools to enable these discussions.

The resources include:[19]

- a leaflet for health professionals on pregnancy and alcohol (2-sided A4)
- a leaflet on assessing alcohol consumption in pregnancy using AUDIT-C (2-sided A4)
- a leaflet for women on pregnancy and alcohol (A4 Z-fold leaflet)
- a leaflet on the Women Want to Know project (A4 Z-fold leaflet)
- videos demonstrating health professionals discussing alcohol and pregnancy with women

[17] Ibid.
[18] Australian Government Department of Health (n.d.). *The Women Want to Know project.* Retrieved from: http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/0FF96125D3B433FDCA257CCF00055046/$File/FARE%20WWTK%20General_v11.pdf
[19] Australian Government Department of Health (n.d.). *About the WWTK project*. Retrieved from: http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/wwtk

- videos of women and health professionals reflecting on this experience
- a video outlining the importance of the WWTK project.

The accredited training is provided through three e-Learning courses delivered by the Royal Australian College of General Practice, Royal Australian College of Obstetricians and Gynaecologists and the Australian College of Midwives.

The resources and training aim to support health professionals in initiating conversations about alcohol with pregnant women and women planning pregnancy by:

- increasing their knowledge about FASD and the other risks associated with alcohol consumption during pregnancy and about how to assess alcohol consumption
- demonstrating the evidence-base for the Alcohol Guidelines and for the effectiveness of brief interventions
- increasing their comfort in raising the topic and providing guidance to health professionals on how to broach the topic
- providing solutions that minimise the burden on health professionals to initiate conversations about alcohol
- understanding the competing priorities of health professionals.

In the project design stage, it was acknowledged that work with health professionals should ideally be accompanied by a public education campaign that targets the whole community on the importance of not drinking during pregnancy. However, given that the project was time and resource limited it was agreed that the project focus should first be on changing the behaviour of health professionals that are most likely to engage with women who are pregnant or planning pregnancy (and this was the basis/criteria on which the project was funded).

The issues that *Women Want to Know* seeks to address

A literature review and audit of resources was conducted for FARE in 2013.[20] This review, which explored the available information sources for health professionals about pregnancy and alcohol, identified a series of barriers facing health professionals when it comes to discussing alcohol with their patients, including:

- lack of knowledge of risk
- lack of knowledge around recommendations
- lack of skills and tools to intervene
- fear of negative reaction
- perceived lack of self-efficacy

[20] Ipsos SRI. (2013). *Australian guidelines to reduce health risks from drinking alcohol 2009: Brief literature review and audit of resources*. Canberra: Foundation for Alcohol Research and Education (FARE).

- preconceived ideas about who is at risk
- competing priorities.

The literature review identified that health professionals face personal and situational barriers to discussing the subject of alcohol and pregnancy with their clients and that further skills training and education would assist them to facilitate these conversations. It finishes by suggesting that:

> *Skills training may be more effective in encouraging health professionals to discuss alcohol with their patients than simply providing them with education in the form of written resources. An approach that combines elements of both may be most effective.*

Following on from the literature review, a survey was undertaken with health professionals in 2013 to establish a baseline of health professionals' use of the Alcohol Guidelines.[21]

WWTK aims to address the issues identified by the research by providing health professionals with resources and information about the Alcohol Guidelines and to assist them in talking to relevant patients about alcohol.

Evaluation objectives

FARE required an independent consultant to conduct an evaluation of the WWTK project. The objective of the evaluation research was to determine the reach of the WWTK campaign and the extent to which the project had had an impact on the behaviour and knowledge of health professionals in relation to alcohol consumption and pregnancy.

The project resources evaluated as a part of the research included:

- print resources, with four leaflets produced as a part of the WWTK project
- video resources, with eight filmed videos
- online training via RACGP, RANZCOG and ACM.

The evaluation of the project was based on project activity since the launch of the project on 1 July 2014 up to March 2016, when research was conducted. Out of scope for the evaluation were state and territory based promotional initiatives and adapted resources, as well as new campaign materials (online adverts 'She's pregnant, she's drinking', 'The occasional drink is ok, right?' and '1 in 5 continue drinking when pregnant') launched by FARE in February 2016 to promote the WWTK training course (although these materials may have contributed to awareness of WWTK and/or to training take-up rates).

Application of relevant evaluation framework

The evaluation approach focused on assessing the success of the project in terms of its impact on the behaviour of health professionals, by utilising a range of evidence sources, including a follow-up to the benchmark survey conducted among health professionals in August 2013. A summary of the program logic is as follows:

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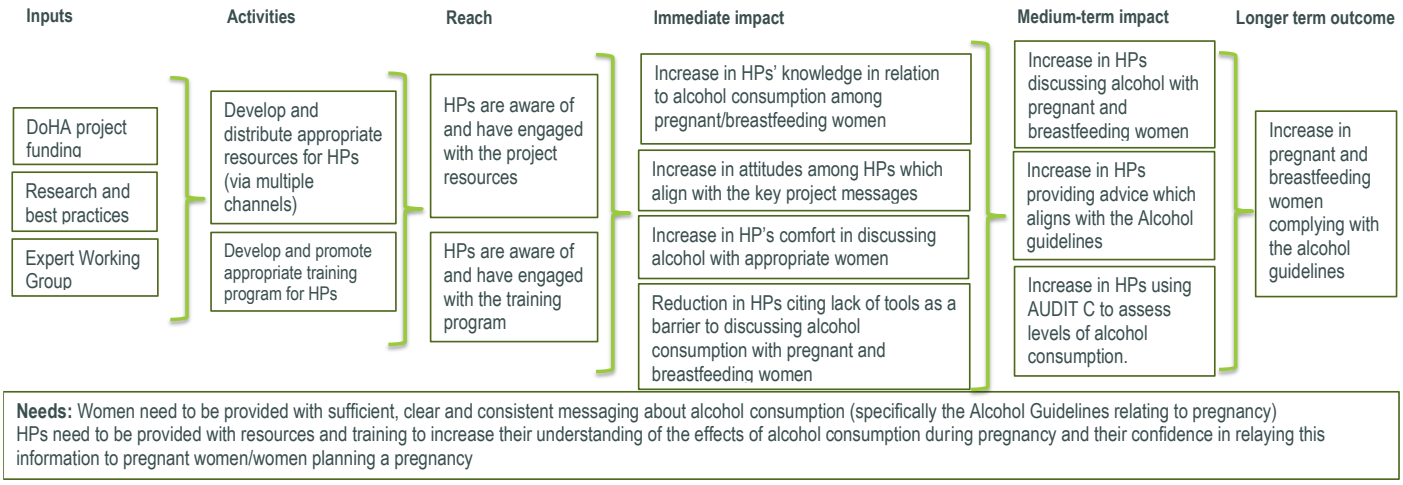
[21] Ipsos SRI (2014). *Health professionals' use of Australian Alcohol Guidelines.* Retrieved from: http://www.fare.org.au/wp-content/uploads/research/Ipsos-SRI-Report_Baseline-survey-of-health-professionals_Quota-survey-FINAL-200514.pdf

Figure 1: Evaluation program logic[22]



[22] It is important to acknowledge that, in an ideal world, there would also be benchmark data in place to allow comparison of the behaviour of pregnant women who were pregnant, breastfeeding or planning to conceive before the launch of the project to behaviour of women in these groups following its implementation. However, collecting this data in a robust manner would have been (and would still be) prohibitively expensive, given the small proportion of women who are pregnant or breastfeeding in Australia at any one time. In this type of situation, which is not unusual for projects with ambitious social aims, it is a valid approach to focus on assessing the intermediate impacts and to use a clearly articulated program logic to demonstrate how these impacts are expected to result in the intended longer-term outcomes.

This program logic underpinned the evaluation framework that was developed for the evaluation. The framework was used to assess the impact of WWTK:

- The impact evaluation provides a robust assessment of the project's effectiveness in influencing health professionals (HP)'s knowledge, attitudes and behaviour.
- The process evaluation elements provide insight into why the project as a whole was successful and the strengths and weaknesses of each of the key elements (such as the training program and the campaign resources), taking into account both the practical aspects of the implementation (including the effectiveness of the resource distribution approach) and the creative aspects (the leaflets and video content).

The inclusion of process evaluation elements was crucial to ensure that learnings from the implementation of WWTK can contribute to the development of future iterations of the project as well as best practice more widely in relation to behaviour change interventions (especially those relating to alcohol).

The evaluation framework, shown in Table 1, classifies each of the research objectives as either process, reach, immediate impact or medium-term impact objectives and ties each of these to one or more sources of evidence that collected for the evaluation.

Table 1: Evaluation framework

Objective	Classification	Evidence source(s)
Assess level of awareness of campaign and key messages (includes recall and retention of key messages)	Reach	– Post-intervention survey of HPs
Assess appropriateness of resources developed during the campaign (by the target audiences)	Process	– Focus groups with HPs – Post-intervention survey of HPs – Stakeholder interviews
Assess use and engagement with the resources (by the target audiences)	Reach	– Post-intervention survey of HPs – Administrative data (Mail and Marketing Services data, data from the Department of Health Website)
Assess any change in HPs knowledge, attitudes and comfort in discussing alcohol with pregnant women as a result of campaign exposure	Immediate impact	– Pre and post-intervention survey of HPs
Assess any change in HPs practice as of a result of campaign exposure	Medium-term impact	– Pre and post-intervention survey of HPs
Assess effectiveness of offering continuing professional development (CPD) points as an incentive for	Process	– Online discussion boards with course participants – Administrative data (course enrolments and completions)

enrolment and completion of the free online courses		– Focus groups with HPs – Stakeholder interviews
Assess effectiveness of the promotional strategies used in attracting enrolments to the CPD courses	Process	– Survey of HPs – Online discussion boards with course participants – Administrative data (course enrolments and completions) – Focus groups with HPs – Stakeholder interviews
Assess effectiveness of online training course content in improving HPs' knowledge on the subject and influencing future behaviours in this area	Immediate impact Medium-term impact	– Survey of HPs – Online discussion boards with course participants – Administrative data (participant feedback forms) – Stakeholder interviews

RESEARCH METHODOLOGY

Overview

An overview of the primary data collection methods used in this evaluation is shown in Table 2.

Table 2: Methodology overview

Element	Audience	Number of participants
Online survey	Health professionals (GPs, midwives and specialists)	n=257 (103 GPs, 103 midwives, 51 specialists)
Online discussion forum with training participants	Midwives and specialists	19 midwives 6 specialists
Focus groups	GPs	3 groups of 6-7 GPs
Focus groups	Midwives	1 group of 6-7 midwives
In-depth interviews	Stakeholders	n=10
In-depth interviews	Midwives	n=3
In-depth interviews	Specialists	n=6

These components of the evaluation were conducted between 11 March and 11 April 2016.

Detailed methodology

Post-intervention online survey

Purpose

The purpose of the post-intervention survey was to evaluate the WWTK project by:

- assessing changes in health professionals' attitudes and behaviour as a result of the WWTK project
- evaluating the awareness of the project and the project resources (logo, leaflets, videos and training)
- evaluating the response to project resources (leaflets, videos and training).

Sampling

In order to compare, in a robust manner, the results from the post-intervention study with the pre-intervention survey completed in August 2013, the online survey methodology was replicated as closely as possible. To ensure consistency, the same sample size and quotas were aimed for among the main target audiences (100 GPs, 100 midwives and 50 obstetricians/gynaecologists). A representative sample of Aboriginal health workers was not included in the post-intervention survey, even though they were included in the benchmark survey, as they were not the primary target audience for the main WWTK resources developed following the benchmark survey. Resources for Aboriginal health workers and Aboriginal and Torres Strait Islander women and families have been developed specifically for this target group (adapted from the WWTK resources), but these will be evaluated independently by the respective

agencies. As such, to ensure a like-for-like comparison between the benchmark and post-intervention surveys Aboriginal health workers have been excluded from the benchmark survey results presented in this report.

The post-intervention survey was conducted between 11 March and 7 April 2016. Participants were encouraged to participate in the survey, and thanked for their time, via a payment of $50 for GPs, $40 for midwives and $100 for specialists (standard incentives for health professionals participating in panel surveys).

Questionnaire development and content

A 15 minute online questionnaire was developed, the first ten minutes of which were replicated from the benchmark survey and the remaining five minutes focusing on evaluating the WWTK project resources (leaflets and videos). The WWTK project resource evaluation section was designed to establish:

- unprompted awareness of the project and its resources – by asking if health professionals recall having seen any resources about alcohol consumption among women and asking them to describe what they have seen
- prompted awareness of the print resource (leaflets) – by showing screenshots of the four leaflets together (with the logo visible but the messaging/text too small to read in detail)
- where the leaflets were seen and type/extent of engagement with them (for instance, had they read them, kept them on record, passed on to colleagues)
- prompted awareness of the video resources – by showing short (c. ten second) clips of each
- unprompted recall of the project resource messages
- prompted recall of the project resource messages (hidden among 'red herring' messages)
- awareness of, and participation in, the WWTK professional development courses
- self-reported impact of the project resources on attitudes and behaviour.

Benchmark survey data was collected via an open link/invitation (publicised by the participating colleges) as well as via an online panel. However, the open link data was not included in the baseline survey report as it could not be robustly combined with the data from the online panel (this analysis was provided separately). Therefore, there was limited value in including an open link invitation to the health professionals' survey in the evaluation. As such, the resources that would have been devoted to this were diverted to other aspects of the evaluation.

Analysis approach

For the evaluation survey, analyses were conducted to determine campaign reach, message take-out, response to materials and impact of the campaign on knowledge, attitudes and behaviours. As the project resource awareness was relatively small (n=37 survey responders), it was not possible to report any findings based on those who were aware of the resources by sub-group. For the same reason, it was also not possible to carry out statistically robust comparisons between those who recognised the resources and those who did not.

On measures asked in both the benchmark (pre-intervention) and evaluation survey (post-intervention) (primarily the knowledge, attitudinal and behavioural questions), we have conducted statistical significance testing and significant shifts have been marked throughout the report (overall and within

each of the three health professional groups). A significantly increase has been highlighted with ⬆, while a significant decrease has been highlighted with ⬇.

As well as testing for differences between the benchmark and evaluation survey responses, we also tested for significant differences between the health professional groups in the evaluation survey. A significantly higher result has been highlighted with **green** font colour, while a significantly lower result has been highlighted with **red** font colour.

The data was analysed using Q Research Software package. Analysis was performed using standard inferential statistics with a confidence level of 95 per cent. An independent sample test was used to assess change and compare sub-groups of health professionals (GPs, midwives and specialists) in the analysis. Only statistically significant differences between the benchmark and evaluation surveys and between sub-groups are commented on in the report.

It was decided that there was no need to weight the data, as the quotas for each of the health professional groups were met and the overall profile versus the benchmark was sufficiently comparable in terms of age, gender, role, income bands of patients seen and location variables.

Online discussion boards

Two online discussion boards were held over two days (29 and 30 March 2016) with participants in the online training courses offered through RANZCOG and ACM. Each discussion board took place over two days and involved around 20 minutes of each participant's time per day. The HPOM moderator posed a series of questions as the fieldwork progressed, which participants responded to (in writing). As in a face-to-face discussion group the moderator probed for more information where appropriate and encouraged participants to respond to the points made by others in the group. This approach allowed participants to provide detailed feedback in their own words and respond to each other, while also allowing them to contribute at time(s) that suited them. It also allowed for the inclusion of geographically dispersed health professionals.

RACGP was unable to provide contact details for training participants in their program and so GPs participating in this training were unable to be included in this component of the evaluation.

Purpose

Online discussion boards were conducted as part of the evaluation of the online training course, to provide a detailed understanding of the aspects of the course that were most and least engaging and effective in terms of increasing knowledge and influencing behaviour and, importantly, why this was the case.

Sampling and participant profile

All of the health professionals who had participated in the ACM and RANZCOG training courses were sent an email from the relevant college inviting them to provide feedback for the WWTK evaluation by participating in an online discussion board about their training experience. Incentives of $150 per person were offered to encourage participation and to thank participants for their time.

Expressions of interest were received from eight participants in the RANZCOG training. Of these, six were able to take part in the RANZCOG discussion board (including four O&G registrars, one senior resident in O&G and one obstetrician/gynaecologist). Five worked in public hospitals and one worked in a private practice.

Expressions of interest were received from 66 participants in the ACM training. Given that the number of available places was limited, two were excluded as they were in administrative rather than patient

facing roles, along with one GP. Those who identified themselves as students were also excluded, as a key part of the discussion would be around the impact of participation on day-to-day practice. Of the remaining 58, a random selection of 21 were invited to log on to the discussion, of whom 19 went on to actively participate. The ACM discussion board included a range of midwives in terms of their geographical location (covering metropolitan and rural areas and all states), whether they worked in private or public practice settings and level of experience. Most worked in antenatal care, rather than with women who were planning a pregnancy or breastfeeding.

Discussion groups and in-depth interviews with health professionals (who had not participated in the WWTK training)

Qualitative fieldwork for the WWTK evaluation included the following components:

- three discussion groups with GPs (one each in Sydney CBD, Parramatta, and the Melbourne CBD)
- one discussion group with midwives (in Sydney CBD)
- six in-depth interviews undertaken via phone with specialist obstetricians/gynaecologist (referred to collectively in this report as specialists)
- three in-depth interviews undertaken with midwives currently working in antenatal clinics in public hospitals.

Purpose

Group discussions and interviews were conducted with health professionals to ascertain their awareness and level of engagement with the WWTK project. This fieldwork also provided insights into the aspects of the project resources they found most and least compelling and why (that is, the process elements of the evaluation in particular). In other words, the qualitative research aimed to provide crucial insight into why the project has been more or less successful and the lessons that can be learnt from this.

Group discussions contained six to seven participants per group and lasted 1.5 hours. The groups took place between 22 and 30 March 2016. Participants were recruited through two accredited recruiters with expertise in sourcing health professionals to participate in research (using a combination of databases of health professionals who had already signed up to take part in research and who lived in the vicinity of the proposed discussion group locations, 'snowballing',[23] and, in the case of midwives, also 'cold-calling' the maternity departments of a range of public and private hospitals). GPs were paid $200 and midwives $150, to encourage participation and to thank them for their time (the differing fees reflect the differing amounts that are generally required to act as an incentive with these audiences).

In-depth interviews with obstetricians and gynaecologists lasted around 30-45 minutes. The interviews took place during early to mid-April 2016. These interviews were recruited by adding a question to the online post-intervention survey which asked respondents (specialists only) if they might be willing to take part in a follow-up interview. An incentive of $250 was offered to encourage participation.

[23] In market and social research, snowballing is a non-probability sampling technique where existing study participants recruit future participants from among their acquaintances.

Participant profile

GPs who participated in the Sydney and Melbourne discussion groups worked in a broad mix of geographic and socio-economic areas and with patients from a range of cultural backgrounds, in a mix of private and public practices. The GPs had differing levels of experience, and included those who had been qualified for a couple of years and those with more than 30 years' experience. Most had gained their qualifications in Australia while a few had trained overseas. All GPs participating in the groups saw women in their practice who were pregnant or planning to be pregnant; and some were involved in providing shared obstetric care with public hospitals.

Among the specialists who were interviewed five worked in private practice, one was based in a large public maternity hospital, and one was a private fertility specialist.

The midwives who participated in in the dedicated discussion group were all working in private hospitals. This group were in the main involved in caring for women who had presented to the hospital with pregnancy complications or to give birth (as those without complications generally only attended appointments with their chosen specialist). Therefore, an additional three in-depth telephone interviews were also undertaken with midwives who were working in antenatal clinics within public hospitals. While these individual interviews did not provide the opportunity to observe the ways in which the issues and WWTK materials would have been discussed in a group setting, they ensured that perspectives from professionals working in both public and private settings were represented.

Stakeholder interviews

Ten one hour interviews were conducted with project staff from FARE, members of the project Working Group, representatives from the relevant colleges and the agencies involved in developing the communications strategy and materials. The interviews took place between late-March and mid-April 2016. The aim of these interviews was to provide context to the evaluation findings by exploring project development and implementation processes and to gain feedback from stakeholders on the relative successes of the project and its implementation.

Qualitative analysis approach

Our interpretation of the qualitative data included 'Active Listening' to, and observation of, the way participants approached and reacted to the topic. That is, noting not just what was said but also what was not said, the underlying beliefs that were inherent and implied in each conversation, as well as the language and terminology used. We used a number of techniques to ensure the validity of our qualitative conclusions, including individual moderator review of notes/tapes and thematic coding, and collective analysis sessions, involving all moderators, in which themes were compared and the reasons for any differences analysed.

Administrative data

Available data

To further provide context to evaluation findings and support the evaluation of process elements of the project, FARE shared a variety of administrative data based on the project activity to date. This included:

- project progress reports submitted for each of the two phases of the project
- project rationale for communications strategy
- project timeline from the beginning of the project in June 2012 up to March 2016

- communications strategy
- project dissemination strategy
- website activity statistics (www.alcohol.gov.au)
- leaflet distribution statistics
- free and paid advertising reach data
- promotion activities summary
- information on advertising campaign promoted through Facebook, MJA and Circus Media
- online training enrolment and completion statistics from RACGP, ACM and RANZCOG.

Interpreting the findings

The majority of the evaluation fieldwork took place between the end of March and early April 2016 and the administrative data was also provided at around the same point in time (or earlier in some cases, as stated where relevant throughout the report). The majority of analysis for the evaluation took place mid-late April 2016. As such, project activities that have taken place since then are not taken into account in the evaluation results.

Limitations

As outlined above, it was not possible to arrange for RACGP to send course participants an invitation to contribute to the evaluation (as this was not included in the original contract) and, in-line with privacy legislation, contact details could not be passed on directly to FARE or HPOM. In addition, only five GPs had completed a standardised course feedback form to date (too few for meaningful analysis) so it has not been possible to assess the effectiveness of the RACGP training course as part of this evaluation.

Also, in relation to the evaluation of the online training programs, as participants for the online discussion boards were necessarily recruited on an opt-in basis via an invitation sent by ACM and RANZCOG, it is possible that those who had a more positive experience may have been more likely to volunteer to take-part in this evaluation activity than those who had a negative experience. Although, the provision of a financial incentive for participation ($150) should have helped to mitigate this risk.

As the overall recall of the project in the online post-intervention survey was relatively low (37 health professionals were aware of the print or video resources), it was not possible to carry out statistically robust comparisons between this group and those that did not recognise the campaign as a part of this evaluation.

PROJECT IMPLEMENTATION

This section is primarily descriptive - it provides an overview of the development and implementation of the WWTK project.

Context

In mid-2012, when the WWTK project was initiated, the NHMRC's 2009 Alcohol Guidelines were relatively new. These Alcohol Guidelines replaced the 2001 iteration, which had included a recommended amount of consumption for pregnant women who choose not to abstain during pregnancy.

In addition, the issue of FASD was beginning to receive greater attention in Australia. In September 2012 FARE released *The Australian Fetal Alcohol Spectrum Disorders Action Plan 2013-2016* and in November 2012 the final report of a national FASD inquiry (*FASD: The hidden harm – Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorders)* was tabled in Parliament. The Commonwealth Government responded in August 2013 by announcing $20 million over four years for a national FASD action plan (*Responding to the impact of Fetal Alcohol Spectrum Disorders in Australia – A Commonwealth Action Plan 2013-14 to 2016-17*) and the FASD Action Plan was launched in June 2014 (although with reduced funding of $9.2 million). This plan identified five priority areas for action to reduce the impact of FASD across Australia, including the following two areas which are of particular relevance to the WWTK project:

- "Recognise the preventable nature of FASD and support continuation of efforts to prevent FASD building upon existing government program activity
- To support the health and broader workforce to prevent FASD and to better respond to the needs of families impacted by it."

Funding

The WWTK project was initially funded by DoH for the period 2012-2014. Additional funding was then granted in July 2015 for a second phase of the project (2015-2016), which, at the time of writing, is still underway. The budget for the first phase of the project was $595,000 (exc. GST), with funds allocated to specific elements, as shown in Table 3. The budget for the second phase was $414,000 (exc. GST), including an allocation of $110,000 for evaluation purposes (also shown in Table 3), giving a total project budget of $1,009,000 (exc. GST).

Table 3: Project funding

	Funds allocated
Phase one (2012-2014)	
Staffing and recruitment costs	$100,000
Project management costs	$30,000
Scoping project including Audit and literature review and pre-intervention survey	$90,000
Development of communications strategy	$45,000
Development and production of communication materials and resources and professional development tools	$190,000
Implementation of the project including disseminating the information, promoting and launching the project and development of CPD components to support the project	$140,000
Total phase one (ex GST)	***$595,000***
Phase two (2015-2016)	
Staffing costs	$110,000
Project management costs	$33,000
Promotion and Dissemination	$161,000
Project evaluation	$110,000
Total phase two (ex GST)	***$414,000***
PROJECT TOTAL (EX GST)	***$1,009,000***

Source: Funding/Grant agreements for Phase I and Phase II.

The budget for the project was relatively modest, given its aims. These included the development, delivery and ongoing promotion of a national awareness raising campaign which needed to reach three separate groups of health professionals (GPs, midwives and specialists), plus the development, delivery and ongoing promotion of three online training courses for health professionals.[24]

[24] It was originally intended that the project would also involve "research to determine the extent to which information on the Alcohol Guidelines is included in medical and nursing university degrees in Australia". However, DOH and FARE agreed to remove this activity as it was determined to be a project within itself and beyond the capacity available within the grant.

Development and implementation phases

Key stages involved in the development and implementation of WWTK project to date are summarised below:

1. Development of a governance framework, including the establishment of a Working Group (October 2012).

A Working Group of representatives from the relevant major health professional bodies was set up to provide consultation and input into all elements of the project. The following organisations were represented:

- FARE (Working Group Chair)
- Maternity Choices Australia (previously Maternity Coalition)
- Australian Medical Association (AMA)
- Australian College of Midwives (ACM)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- University of Sydney
- Royal Australian College of Physicians (RACP)
- Australian Medicare Locals Alliance (now defunct)
- Royal Australian College of General Practitioner's (RACGP).

FARE also liaised with individual members of the Working Group on particular aspects of the project outside of the regular Working Group meetings. This included Working Group members being part of Steering Groups for the online training/e-learning courses, being directly involved in the development of the project resources and promoting the project by writing articles, presenting at conferences and running webinars.

Members of the Working Group who participated in this evaluation indicated that the Working Group meetings were well managed by FARE in terms of ensuring that there were clear outcomes for each session and that discussions remained focused on the project objectives and scope. They also felt that the process was genuinely consultative and their views were taken into account by FARE.

2. Audit and literature review (commissioned November 2012).

FARE commissioned an independent research company to conduct an audit of available resources for health professionals on pregnancy and alcohol and a rapid literature review to provide an understanding of the willingness of health professionals to discuss alcohol and pregnancy with consumers and the practices that better facilitate this, as well as their awareness and use of the Alcohol Guidelines. This research informed the final communications strategy, implementation plan and the project resources.

The literature review revealed that little was known about current levels of awareness and usage of the Alcohol Guidelines among Australia's health professionals. It also found that health professionals experience a range of personal and situational barriers when initiating conversations about alcohol and that any resources developed through the project would need to overcome these. The audit identified 26 resources for health professionals on the subject of pregnancy and alcohol, but only eight that focused solely on the subject of alcohol and the Alcohol Guidelines. Analysis of these resources concluded that although none fully addressed the key issues raised in the literature review, two

resources could potentially be adapted to create new national resources to educate and support health professionals on the Alcohol Guidelines, as part of the WWTK project.

3. Development of a communications strategy (commissioned November 2012, initial ideas presented to the Working Group March 2013, final strategy presented June 2013).

A specialist communications agency was appointed by FARE to undertake the developmental work for the communications strategy for the project. This included:

- a consultation event (forum) with 30 health professionals who represented key organisations (including members of the Working Group)
- telephone interviews with health professionals.

The initial work highlighted that the project needed to:

- increase health professionals' motivation to discuss alcohol with women by providing incentives to do so
- support health professionals to have conversations about alcohol with women by providing easy to use tools, building confidence in the evidence and providing practical examples of how conversations can take place.

It also identified that GPs, obstetricians, gynaecologists and midwives are the health professional groups that most frequently interact with women who are pregnant or planning pregnancy. These groups therefore became the primary audiences for the project. In addition, it was found that most health professionals are members of one of the professional colleges that represent their interests and that are responsible for the professional registration and continuing professional development. Therefore, key collaborators for the project were identified as being as:

- Royal Australian College of General Practitioners (RACGP)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Australian College of Midwives (ACM)
- Australian Medical Association (AMA).

All of the development work conducted to this point combined to indicate a range of options that could potentially be pursued to change health professionals' behaviour. This included:

- training and education to increase health professionals' knowledge and challenge assumptions about alcohol consumption during pregnancy (potential options included print resources, web-based resources, online training, face-to-face-training, conference presentations and articles in journals/newsletters)
- tools to assist health professionals to undertake conversations about alcohol (potential options included print or web-based resources, validated screening tools, use of medical software and patient reminders)
- addressing concerns over competing priorities by providing incentives (potential options included the provision of CPD modules/points for undertaking the training/financial remuneration through the Medicare Benefits Schedule - MBS).

These options were assessed against four criteria: suitability based on available evidence, suitability based on consultation with health professionals, availability and appropriateness of existing resources

based on the literature review and audit, and the available budget and time for the project. The use of medical software, MBS payments and face-to-face training were rejected at this stage due to time and budgetary constraints - the other elements were taken forward for development, as follows below.

4. Development and finalisation of project resources (June 2013 – June 2014).

The final WWTK project comprised the following two core elements:

- **Print resources – four leaflets**, including three for health professionals, plus one which could be passed on by health professionals to relevant patients, as already described. FARE developed the content of the leaflets in consultation with Working Group members, DoH, content experts (including Professor Elizabeth Elliot, the Telethon Institute for Child Health Research and the Drug and Alcohol Office (DAO) of Western Australia – as it was in the process of developing its own resources on alcohol and pregnancy as part of WA FASD Model of Care). In addition, feedback on the leaflet for women was sought from the Maternity Coalition, Beyond Blue and PANDA. A specialist health communications agency was commissioned by FARE to design the leaflets in consultation with FARE. Feedback on the draft documents was also sought from the Working Group as a whole, although one stakeholder felt that by this stage they were already close to final, so there was only scope for relatively minor changes to be made.

- **Three online training courses with CPD accreditation**, targeted at each of the three main health professional groups and delivered through RANZCOG, RACGP and ACM. The training was provided online to maximise the potential reach within the available funding allocation. The ACM and RANZCOG courses were made available free of charge to both members and non-members. The RACGP course was also made available free of charge, but to members only. Steering groups were put in place to guide the development of each course, comprising the FARE project lead, the WWTK Working Group member representing the relevant college, college members, college staff, and the Telethon Institute for Child Health Research. Each college followed its standard review and approval processes for developing new training resources, including piloting. Relevant stakeholders interviewed as part of the evaluation indicated that the process of developing the training generally went smoothly and that the content developed by FARE and the steering groups was suitable for implementation in the form of an online/e-learning course.

A series of videos was also produced for the WWTK project. The aim of the videos was to highlight the evidence underpinning the Alcohol Guidelines and to demonstrate how conversations about alcohol and pregnancy could take place within a patient consultation. The primary purpose of the videos was to form part of the online training, although they were also made publicly available on the WWTK pages of the DoH alcohol website and via the DoH YouTube channel. The scripts for the videos were developed by FARE, informed by role-plays conducted as part of the consultation forum held early in the development stage, and reviewed by one of the Working Group members representing GPs. The videos were filmed by the same health communications agency that developed the leaflets (using a combination of actors for the patients in the role-play scenarios, real patients for the interviews, and practicing health professionals for the role-play and reflection videos). Some of the Working Group members were directly involved in this process (including one member who featured as the GP in two of the videos). The Working Group as a whole was also asked for its feedback once the videos had been produced, but it is not clear how much scope there was for adjustments to be made at this stage. Neither the videos nor the leaflets were formally concept tested with health professionals outside of the Working Group.

As noted, the DoH alcohol website (www.alcohol.gov.au) housed copies of all of the WWTK project resources (videos and leaflets), along with links to additional resources (including the NHMRC Alcohol Guidelines), and the respective health professional organisation websites and training courses.

5. Project launch (1 July 2014), distribution of resources and promotion (July – December 2014).

The WWTK project was officially launched by then Minster for Health Senator the Hon Fiona Nash and a panel comprised of FARE staff and Working Group members on 1 July 2014 in Sydney. Promotional activities, including the direct distribution of the WWTK leaflets, promotion of the online training courses and promotion of the project as a whole took place between July and December 2014 (further details about promotional activities are provided in the Project Reach and Engagement and Training sections of this report).

It is noted that the project timeframe was extended twice – initially to 30 December 2013 and again to 30 September 2014, as a result of a change of Commonwealth Government, which had led to delays in completing the clearance processes and sign off of the project.

There was then a period of relative inactivity between December 2014, when the funding for WWTK came to an end, and July 2015 when the second round of funding was provided.

6. WWTK phase two (July 2015 – currently ongoing).

The second phase of WWTK began in July 2015. A dedicated project manager was recruited to manage the WWTK project, for four days per week, in August 2015. Previously, the first phase of the project had been managed by existing FARE staff, alongside other commitments. Key activities in phase two (to date) have included:

- re-establishing relationships with Working Group members and partners
- re- establishing promotional activities
- commissioning and co-ordinating the WWTK evaluation
- reviewing jurisdictional use of the AUDIT-C tool and alcohol screening processes during antenatal care
- continuing efforts to raise awareness of the WWTK project and resources (via a range of promotional activities), with a particular focus in early 2016 on promoting the training (further details about promotional activities are again provided in the Project Reach and Engagement and Training sections of this report).

In addition, various state-based activities have been undertaken, including adapting the WWTK resources for use among Aboriginal and Torres Strait Islander communities in New South Wales and the Northern Territory, promoting the WWTK resources specifically to health professionals in the Australian Capital Territory (having been awarded a $10,000 ACT Government Innovation Grant) and working with the Telethon Institute for Kids in Western Australia to facilitate the development of resources for midwives in the region to increase the routine use of the AUDIT-C screening tool. As noted in the Detailed Methodology section, these state-based resources were not directly assessed as part of this evaluation as they will be evaluated separately.

At the time of writing, new avenues to promote the project were also being pursued. Of particular note, an expression of interest was send by DoH (initiated by FARE) to all CEO's of the newly established Primary Health Networks (PHNs). Of the 31 PHNs approached, 7-10 expressed interest in collaborating and these conversations were pursued by FARE.

EVALUATION FINDINGS

Current practice

The findings in this section are based on the group discussions (three with GPs, one with midwives) and individual interviews (with six specialists and three midwives), which were conducted with the primary aim of assessing the appropriateness of the WWTK resources. However, before the project resources were introduced, the discussions began with an exploration of current knowledge and practice in relation to pregnancy and alcohol. Key themes from this discussion are outlined here as only a handful of these participants had come across the WWTK project/resources before taking part in the evaluation and, as such, they provide contextual information that is relevant for interpreting and understanding the main evaluation findings (including reactions to the resources and take-up of training)

Where differences between the midwives working in private hospitals (who participated in the group discussion) and the midwives working in public hospitals (who participated in individual in-depth interviews) were observed, they are documented below.

According to these health professionals, the asking of questions and the provision of advice regarding alcohol consumption was a standard part of the consultations undertaken by GPs, specialists and midwives with women in the early stages of their pregnancy and those who were planning a pregnancy. The topic was discussed less commonly with women who were breastfeeding.

However, the quality of the conversations and the advice they were given varied considerably across the different health professional groups. Midwives and specialists in public hospitals and the specialists who had a specific interest in fertility appeared to have more in-depth conversations and were guided by procedures that ensure they always directly question women about how much alcohol they previously and currently consume. Conversely, GPs and specialists (particularly those working primarily in the private system) typically spoke of relying on women to raise the issue and ask questions or giving the topic only a cursory mention. For example, by asking a basic yes/no question about current alcohol consumption and/or simply stating that not drinking alcohol was the safest option during pregnancy.

> *"Most people when you ask if they're drinking, they'll say no and the conversation ends there as you need to take it at face value, you can't challenge what a patient says." – GP.*

The midwives working in private hospitals rarely had conversations with their patients about alcohol. They explained that they generally did not see women until they were giving birth, unless they were admitted earlier with some sort of complication. In this latter scenario, they did not feel it would be appropriate to raise the subject, as this may imply that alcohol was a potential cause of the complication. An additional and perhaps stronger barrier was that these midwives did not see discussing the issue as within their role or remit. Rather, this was viewed as a topic that would be raised and discussed by the obstetrician(s). This was seen as preferable as the obstetrician had an ongoing relationship with the patient and would also see them earlier on, when the discussion would be more appropriate and also likely more effective. There was a tendency to think that by the time midwives in private hospitals saw patients it was too late to talk to them about alcohol. Further, the midwives working in private hospitals were very cautious about speaking directly to women about alcohol as they didn't want to overstep their boundaries/role or damage the woman's relationship with her obstetrician, particularly as they were 'paying customers'.

Across the other health professional groups (including midwives working in public hospitals), discussions regarding alcohol were generally included with questions relating to a woman's 'lifestyle' – specifically,

smoking, diet, drugs and, to a lesser extent, exercise. Time constraints and the need to cover a number of issues and undertake physical examinations meant that little time was allocated to specifically talk about alcohol. It was noted that the exception would be a woman who has been identified or identified herself as having a 'problem' with alcohol. In these instances, necessary actions would be taken to establish her current level of drinking and to refer her to an appropriate service. Past medical history, culture, education or religion was also used by some health professionals as a means to determine whether or not they would even need to discuss alcohol with individual women.

> *"The reality is that alcohol is only one thing in a whole list of things we need to talk to them [pregnant women] about – like diet, exercise, lifestyle changes, what they can or can't eat, or even if they can go near cats." – GP.*

GPs and specialists also indicated that many women come to consultations with their own agenda and list of questions. Therefore, it was commonplace to have to address their anxieties about a range of issues, which often included drinking prior to knowing they were pregnant (at which point the main focus was on providing reassurance), as well as questions as to how much alcohol they could actually consume. Some saw women as wanting to talk specifically about alcohol as they were '*looking for approval*' to drink at low levels while pregnant and had received conflicting information from friends, family and online sources.

> *"They Google everything and this can be a problem." – Specialist.*
>
> *"The main question they usually ask is: 'is it total abstinence or can I have one or two?' …sometimes I think they are seeking permission to drink." – GP.*
>
> *"Whether its [that you haven't done any damage by drinking] true or not, it doesn't matter, they are reassured – no one wants to stress." – GP.*

Across the group discussions and interviews, there was evidence that many health professionals did not typically dig deeply to establish exactly how much pregnant women were previously, and/or currently, drinking. Indeed, they tended to routinely interpret descriptions such as "I'm a social drinker" as meaning someone who drank or used to drink a couple of glasses of wine a few times a week and consider these patients as not at risk. In addition, alcohol consumption is something that is only discussed during the initial visit and it is the exception for a woman to be asked if she was drinking in the later stages of their pregnancy.

Most of the medical professionals consulted for this phase of the evaluation purported that women from mid to high socio-economic backgrounds or who were well educated were more likely to know that drinking in pregnancy is not recommended. In their experience, these women tended to have stopped drinking once they found out they were pregnant (or perhaps while they were trying to conceive, especially if they had been undergoing fertility treatment) and if anything this demographic were among those who were concerned about having consumed alcohol before they knew they were pregnant. However, it was also suggested that this group may also be likely to conceal their behaviour if it was not consistent with the Alcohol Guidelines. Less educated women and those from lower socio-economic backgrounds were perceived as more likely to be unaware that drinking alcohol during pregnancy should be avoided and be more likely to need to be referred to dedicated services for problems and ongoing monitoring.

The consensus across these groups and interviews was that it is appropriate for alcohol to be discussed as early in the pregnancy as possible or when women are known to be actively trying to conceive. When the pregnancy was confirmed by a GP, at the booking-in interview with a midwife at a public hospital, or at the first appointment at ten to 14 weeks with a private specialist were also times that

recommendations were seen as appropriate and that women were likely to ask specific questions about alcohol. Alcohol was not something that was routinely discussed on an ongoing basis throughout pregnancy, unless the patient had been identified as a 'problem drinker'. As mentioned, it was generally assumed by those who saw patients later in pregnancy that this issue would have been addressed in the early stages and there was perhaps even a sense that it was 'too late' to raise the issue in the latter stages of pregnancy.

On the whole, these health professionals felt comfortable talking with pregnant women about alcohol and determining whether alcohol was a cause for concern (with the exception of the midwives working in private hospitals, for the reasons already discussed). GPs in particular noted that they were often required to discuss sensitive topics with their patients and that the issue of alcohol in pregnancy was by no means the most difficult among these. However, there were situations which were identified as potentially challenging. This included discussions with at-risk women (who might, for example, have been drinking, smoking and taking drugs) who were likely to disengage and not attend appointments if they were pushed too hard on the issue of alcohol, difficulties with the potential for women to give an inaccurate account of their current behaviour (or even to intentionally lie), and the time constraints of having to cover a number of topics in detail. It was suggested that in situations where pregnant women had been engaging in a range of behaviours that would pose risks during pregnancy, such as drinking, smoking and drug-taking, health professionals had to consider what was achievable and where to prioritise their efforts. There was a sense that drug-taking and smoking were perceived by health professionals as having the most serious implications for a fetus and that they may therefore have to be given more attention and/or that health professionals may realistically have to settle for achieving a reduction in drinking, rather than total abstinence.

> *"If you see a party girl who had accidentally gotten pregnant and is taking drugs, you have bigger problems to deal with than alcohol." – GP.*
>
> *"I find it challenging to tell others not to do this or not to do that." – GP.*
>
> *"When you are seeing someone who is already having complications, it's hard to bring up – By the way, are you still drinking socially?" – GP.*

Awareness and use of the current guidelines

Across the qualitative research awareness of the current Alcohol Guidelines was almost universal. However, there were key differences in how these recommendations were communicated by health professionals. Midwives and specialists working in antenatal clinics in public hospitals, as well as the fertility specialists, tried to ensure they conveyed to women that no alcohol was the safest option and that they should avoid drinking any alcohol during their pregnancy. The midwives in public hospitals were very strongly guided by their hospital's protocols and indicated that while they would try to address any concerns about alcohol consumed early in the pregnancy, they were obliged and felt very comfortable recommending that women not drink at all during the rest of their pregnancy.

> *"I have to work through the patient record and there are four key questions that I have to ask: did you drink alcohol before you were pregnant; how much were you drinking; are you drinking alcohol currently; and how much are you currently drinking. It is the same for smoking." – Midwife.*

However, some GPs and specialists, perhaps especially those primarily working with private patients, indicated they adhered less strongly to the Alcohol Guidelines and questioned the evidence that alcohol could be harmful at very low levels. This group typically spoke of telling women what the current Alcohol Guidelines recommend, (that is, that the safest option is not to drink) but then on occasions diluting it

when directly asked for their own opinion on lower levels of alcohol consumption. For instance, by saying that they believed *'an occasional glass of wine is fine',* for special occasions such as weddings or in some cases more regularly (such as the odd glass of wine with dinner). Indeed, some had used their own or their partner's experience as evidence that it wasn't necessary for women to abstain completely.

> *"If alcohol does come up, I go along the line that there is no evidence that a drink a day causes any harm whatsoever. Whereas FASD has only been connected with large amounts of alcohol. I don't think that the odd glass of wine with dinner has any impact. When my wife was pregnant she had the odd glass of wine and everything was fine." – Specialist.*

> *"I only frame it in terms of a glass of wine or two, I really don't think that an occasional glass of wine makes any difference at all." – Specialist.*

These GPs and specialists spoke of feeling hesitant to take a 'hard-line' approach with their patients regarding alcohol as they felt this would increase their anxiety and cause unnecessary stress and concern. They were also likely to focus on the most serious impacts of alcohol consumption that occurred as a result of heavy drinking throughout the pregnancy.

> *"If she just drinking just a little more than she should be then I'm comfortable to have the discussion and not refer her to a specialised service. But I don't expect people to be saints and just to stop on my say so. I tend to take a gradual approach of realistic goals…and follow-up and give praise when praise is due and get them to admit and seek help if needed." – Specialist.*

> *"The biggest problem is reassuring and stop the worrying about those who have had a few drinks." – GP.*

Current resources regarding alcohol in pregnancy

Most health professionals who participated in the discussion groups and interviews were not aware of any dedicated resources related solely to alcohol and pregnancy and suggested that information on this topic tended to be included with advice about diet and other lifestyle elements. At most, if patients wanted more standalone information on this topic they would be directed to look online at 'reputable government websites'.

Those working in public hospitals noted that a detailed information booklet prepared by the hospital and given to women at their first antenatal appointment is a comprehensive resource that covers most issues related to pregnancy. This booklet includes the current Alcohol Guidelines and some background information and information about FASD, and patients are encouraged to read this book thoroughly. Similarly, some GPs and specialists also provided their patients with some sort of information pack, which included a brochure with information about a range of lifestyle factors in pregnancy, such as food to be avoided, smoking and alcohol.

> *"We give women a 40-page booklet about general pregnancy and it includes a chapter on alcohol. Rather than try to talk about everything in a lot of detail, which we simply don't have time to do, I encourage them a number of times to read the book and come back with any questions at their next appointment. I think it is important for women to take some responsibility in educating themselves about their pregnancy." – Midwife.*

The evidence throughout the qualitative research was that health professionals perceived that it would be useful to have a leaflet that provided some level of detail and evidence to support the current recommendations about alcohol in pregnancy. Many felt that this would provide them with a resource they could give to patients to address any questions they have or to be included in a 'show bag' given to patients that includes leaflets and brochures on a range of information and services.

Project reach and engagement

Evaluation objectives:

- Assess level of awareness of campaign and key messages
- Assess use and engagement with the resources

In order for the campaign to have had any impact on the attitudes, knowledge or behaviour of health professionals it first must have reached a reasonable (within the context of the available budget) proportion of the target audience.

Effectiveness of strategies to promote the project resources

The WWTK project was promoted through a range of methods. This included the original launch event and associated activities, publications and journals targeted at health professionals, presentations at conferences, notices/adverts on the home page of various peak bodies and the professional colleges, direct emails to the contacts on FARE's mailing lists, satchel inserts and stands at conferences, the direct mail of the WWTK leaflets to various peak bodies and professional organisations, and a direct mail-out of leaflets to GPs/GP practices via INFO-MED. The training was also specifically promoted, mainly via the professional colleges delivering the training (effectiveness of the promotion of the training is specifically is discussed in the Online Training Program section).

Many of these activities were aimed at raising awareness of the project and encouraging health professionals and relevant organisations to visit the WWTK website (www.alcohol.gov.au) to access the project resources and to download or request copies of the leaflets.

Between 1 July 2014 and 1 March 2016, 18,042 users visited the WWTK website, 80 per cent of whom were new visitors. There is no data available on how many copies of the resources were downloaded (as HTML or PDF documents) from the website. However, data from the National Mail and Marketing Service (NMMS) shows that the promotion activities resulted in requests for over 60,000 copies of the leaflets in total between July 2014 and March 2016. As would be expected, given that they were intended to be handed out to patients, the 'Information for women' leaflet was ordered in the largest quantities, as follows:

- 46,162 copies of the 'Information for women about pregnancy & alcohol' (Blue leaflet)
- 5,855 copies of the 'Information for health professionals on assessing alcohol consumption in pregnancy using AUDIT-C leaflet'
- 5,476 copies of the 'Information for health professionals on pregnancy & alcohol' leaflet
- 6,116 copies of the 'WWTK project' leaflet (red).

Of all the leaflets ordered, most (76 per cent) went to health services. The remainder went to hospitals (ten per cent), government agencies (seven per cent), as well as GPs (six per cent). These leaflets were presumably then passed on to individual health professionals and patients (at GP health services, hospitals etc.)

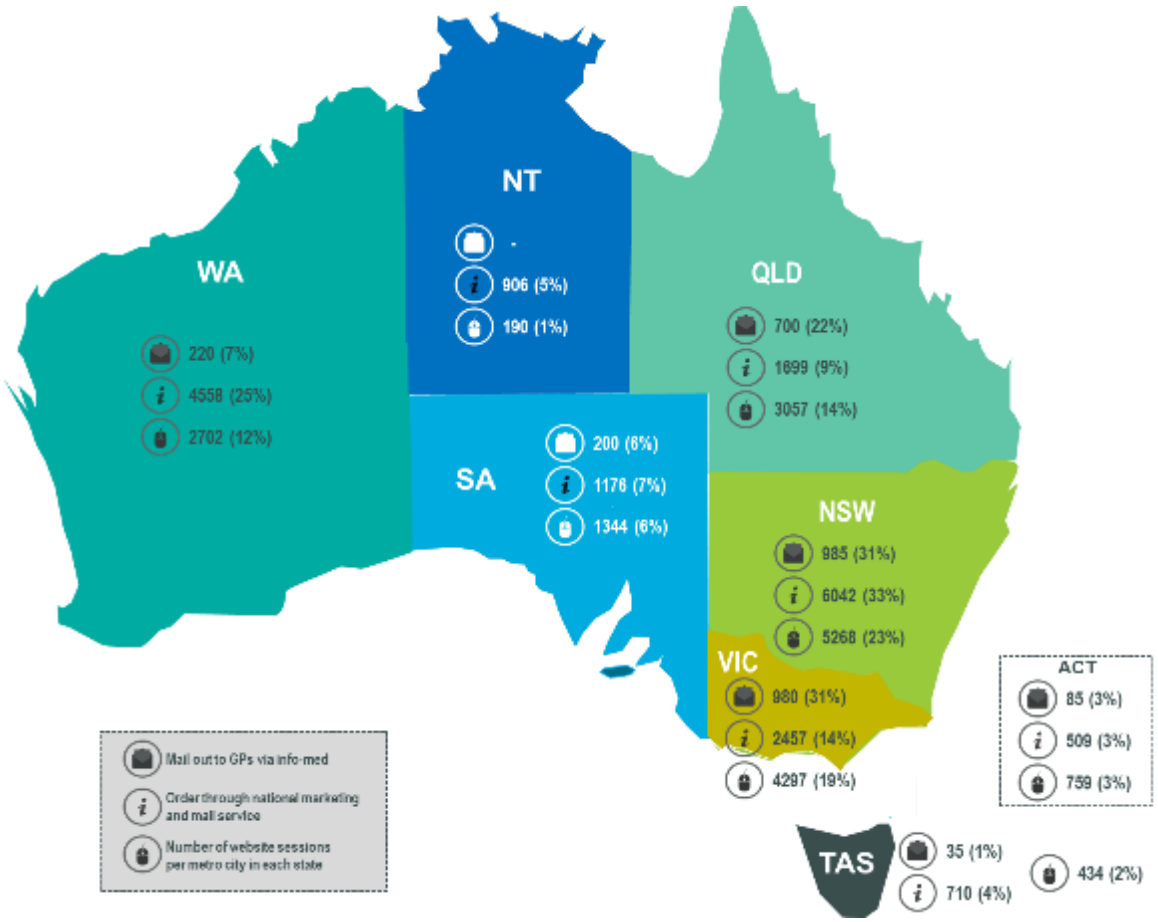
FARE also distributed a total of 5,266 printed leaflets as of March 2016. This included providing leaflets directly to health professionals at conferences (in conference bags and via exhibition stands) and sending a total of 402 copies of the leaflets directly to various relevant health-related organisations across Australia, such as GP super clinics and local health districts. Given the relatively low total number

of leaflets sent to these organisations the intention was presumably to raise awareness and to encourage each organisation to order/download additional copies as required.

In addition, during the second half of July 2014, packs containing printed resources were mailed directly to around 3,205 GP *practices* across Australia by INFO-MED. According to the information on INFO-MED's website it is able to reach up to approximately 13,690 GPs across Australia. Given that there are 26,885 practicing GPs in Australia (according to the 2014 workforce report by Australian Institute of Health and Resources) this suggests that this mail-out might have been expected to reach roughly half of practicing GPs.

Figure 2 summarises the geographical distribution of the WWTK resources, in terms of the printed resources sent to GPs via INFO-MED and printed resources ordered via the NMMS. In the absence of geographical data for the users of the WWTK website, the figure below also summarises the number of *sessions* recorded per main city in each state to give a rough indication of the distribution of website usage. However, it should be noted that the number of sessions does not necessarily translate into unique users. This analysis shows that the distribution pattern broadly reflects the population distribution across the states and territories, with the largest concentrations in New South Wales and Victoria and the smallest in the Northern Territory.

Figure 2: Geographical distribution of resources



In summary, in the context of the available budget for the whole project, the promotional activities were successful in driving visitors to the website in significant numbers, as well as prompting requests for a relatively large number of leaflets. The direct mail-out should have reached up to half of the practicing

GPs in a best-case scenario. There was no equivalent mass mail-out to midwives but they may have received printed copies via the orders placed by health services and hospitals. Health professionals may also have been alerted to the resources on the website by the various journal articles and adverts, although these are presumably more likely to have been seen by professionals who are most engaged with these types of publications.

The evaluation survey of health professionals is the best available indicator of the overall success of the promotional strategy in terms of raising awareness of the project and getting the resources into the hands of the relevant health professionals (project reach). However, it must be acknowledged that many of these activities took place in the second half of 2014, including the large-scale direct mail-out of leaflets, so it is possible that *recall* of the resources, which is necessarily the main measure used by the survey, would have been higher had an evaluation survey been conducted closer to that date. The survey results for this are presented below.

Prompted awareness

Overall, one third (33 per cent) of health professionals were aware of at least one element of the WWTK project. That is, they reported having: heard of WWTK (when shown the logo), seen the leaflets (when shown screen shots of each leaflet), seen the videos (when shown a short clip of each) or heard about the 'pregnancy and alcohol training' delivered by any of the colleges.

More than half (55 per cent) of the specialists were aware of one or more element, which was a significantly larger proportion than the other health professional groups, as shown in Table 4. This difference is mainly accounted for by higher levels of awareness of the training among specialists (see Table 5).

Table 4: Total awareness of WWTK project and resources

	GPs		Midwives		Specialists		Overall	
	%	n	%	n	%	n	%	n
Yes (aware of any element)	27	28	28	29	**55**	28	33	85
No	73	75	72	74	45	23	67	172
Unweighted n	*103*		*103*		*51*		*257*	

Q28. Before today, had you heard of the *Women Want to Know* project [logo shown]?

Q29. Here are short clips from six longer videos. Do you recall seeing any of these videos before?

Q30. Below is a screenshot of a leaflet from the *Women Want to Know* project, do you recall seeing this specific leaflet before today?

Q39. Have you heard about the online e-learning course on Pregnancy and Alcohol with Continuing Professional Development (CPD) accreditation available for Health Professionals through RACGP, RANZCOG, ACM and other colleges?

Unweighted base: n = 257 post-intervention survey, all respondents

Looking at each of the elements separately, seven per cent indicated that they had heard of the project, when prompted with the WWTK logo, before being shown the leaflets or video clips. Around one in ten (11 per cent) recalled one or more of the leaflets. Seven per cent recalled one or more of the videos. This gives a total of 14 per cent who reported having seen either the leaflets or the videos. Analysis of data from the 2014 workforce report by Australian Institute of Health and Resources shows that there were approximately 49,500 practicing health professionals across the three relevant categories (26,885 GPs, 1,516 gynaecologists/obstetricians and 21,140 midwives) in 2014. If the levels of awareness reported in the survey were replicated across this target population, this would mean that just under 7,000 health professionals (6,936) had come across the WWTK leaflets or videos.

It is however important to acknowledge that awareness of the videos seems high given that these were primarily shown as part of the training (two per cent of survey responders indicated they had participated in the training, as discussed below) and there were 100 or fewer unique views for each of the individual videos on the WWTK website (as of 1 March 2016). It therefore seems possible that there was an element of false recall, perhaps as a result of the videos sharing some similarities with other health promotion resources. The highest number of unique views was for the video titled 'Pregnancy and alcohol – best practice examples of health professionals discussing pregnancy and alcohol with women' (featuring GP) which had 103 views (as of 1 March 2016).

One quarter (24 per cent) had heard about the online e-learning course on Pregnancy and Alcohol (with CPD accreditation). This was significantly higher among specialists (43 per cent). It should be noted that this figure may include recall of training related to alcohol and pregnancy offered independently of the WWTK project, depending on how health professionals interpreted this question (see Q39 wording in Table 5). Overall, 15 per cent of health professionals had seen the leaflets, videos or taken part in the training.

Table 5: Recall of each project resource

	GPs		Midwives		Specialists		Overall	
	%	n	%	n	%	n	%	n
Yes – the project (logo)	2	2	9	9	16	8	7	19
Yes – leaflets (any)	10	10	10	10	14	7	11	27
Yes – videos (any)	9	9	5	5	10	5	7	19
Yes – aware of training	21	22	17	17	43	22	24	61
Yes – done training	3	3	1	1	0	0	2	4
Yes – leaflets or videos (net)	12	12	14	14	22	11	14	37
Seen leaflets or videos or participated in training (net)	14	14	14	14	22	11	15	39
Unweighted n	*103*		*103*		*51*		*257*	

Q28. Before today, had you heard of the *Women Want to Know* project?

Q29. Here are short clips from six longer videos. Do you recall seeing any of these videos before?

Q30. Below is a screenshot of a leaflet from the *Women Want to Know* project, do you recall seeing this specific leaflet before today?

Q39. Have you heard about the online e-learning course on Pregnancy and Alcohol with Continuing Professional Development (CPD) accreditation available for Health Professionals through RACGP, RANZCOG, ACM and other colleges?

Unweighted base: n = 257, all respondents

There is little evidence that certain groups of health professionals were more likely than others to have been reached by the campaign, as there is no statistically significant difference between the profile of those who had seen a leaflet or video or participated in the training and the profile of all health professionals surveyed. This comparison was made for key profile questions including: health professional group (GPs, midwives, specialists), gender, age, location, typical income profile of patients, number of patients seen by facility and size of facility (number of health professionals).

Looking at each of the leaflets separately, the recall was fairly evenly spread across the four resources (four per cent to six per cent).

Table 6: Recall of individual leaflets

	GPs		Midwives		Specialists		Overall	
	%	n	%	n	%	n	%	n
Information for health professionals on assessing alcohol consumption in pregnancy using AUDIT-C	3	3	4	4	10	5	5	12
Information for health professionals on pregnancy & alcohol	4	4	3	3	6	3	4	10
The Women Want to Know project	4	4	5	5	6	3	*5*	12
Information for women about pregnancy & alcohol	5	5	6	6	8	4	*6*	15
Unweighted n	*103*		*103*		*51*		*257*	

Q30. Below is a screenshot of a leaflet from the *Women Want to Know* project, do you recall seeing this specific leaflet before today?

Unweighted base: n = 257 for post-intervention survey, all respondents

It is important to bear in mind that only 37 survey respondents recognised any of the leaflets or videos so the percentage results based on 'recognisers' throughout this report should be interpreted with caution. Had just a small number of these survey responders given a different response, the percentage results would have looked quite different.

The 27 health professionals who recognised the *leaflets* were asked how they came across these. It is unwise to draw any firm conclusions based on this number of respondents, but indicatively they were most likely to have come across the leaflets through articles in journals, newsletter or magazines (n=7/26%), communication from professional bodies (n=6/22%), or at a conference (n=5/19%). Four respondents or fewer had come across them from a range of other sources. Also indicatively, the 19 respondents who recognised the *videos* were most likely to have come across them via communication from professional bodies (n=8/42%), articles in journals, newsletter or magazines (n=4/21%), from colleagues (n=4/21%), from www.alcohol.gov.au (n=4/21%). Three respondents or fewer had come across them form a range of other sources.

Engagement with the project resources

Health professionals who could recall having seen any of the leaflets were also asked what they did with each leaflet. Many of those who had seen each leaflet had read it, passed it on to a colleague, or handed it to a patient (42 to 67 per cent, depending on the leaflet). However, this leaves between 33 per cent and 58 per cent (depending on the leaflet) who could not recall having engaged with the resource in any of these ways. Again, the number of respondents who had seen each of the leaflets was very small, so the percentage results should be interpreted with caution.

Among health professionals who had come across any of the four leaflets, almost half (48 per cent) indicated that they had personally read at least one of them (and 52 per cent had read or shared at least one of them). This equates to five per cent of all of the health professionals surveyed, and is an encouraging figure when we take into account all of the literature health professionals receive from various sources on a daily basis. For example, a 2008 survey of 180 GPs conducted by Choice found that these health professionals received, on average, seven face-to-face visits a month from pharmaceutical representative, plus ten promotional mailings per week, and 62 per cent of the GPs surveyed reportedly received ten or more promotional mailings a week.[25] The WWTK project had to compete in this context for health professions' attention.

[25] Choice (2014). *Drug company influence on GPs. Is your prescribed medicine really the best option?* Retrieved 3 from: https://www.choice.com.au/health-and-body/medicines-and-supplements/prescription-medicines/articles/drug-company-influence-on-gps

Table 7: Action taken post receiving the leaflet

	Information for health professionals on assessing alcohol consumption in pregnancy using AUDIT-C		Information for health professionals on pregnancy & alcohol		The Women Want to Know project		Information for women about pregnancy & alcohol	
	%	n	%	n	%	n	%	n
Glanced at it, but didn't read it	33	4	30	3	25	3	27	4
Didn't read it, but kept it on the file	-	-	20	2	-	-	-	-
Read it but didn't keep it	25	3	-	-	8	1	27	4
Read it and kept it on file	33	4	30	3	25	3	27	4
Handed on to a patient or client	n/a	n/a	n/a	n/a	n/a	n/a	7	1
Shared it with colleagues	8	1	10	1	8	1	7	1
Don't remember	-	-	10	1	33	4	7	1
Read it (net)	**58**	**7**	**30**	**3**	**33**	**4**	**53**	**8**
Read it, handed on to patient or shared with colleagues (net)	**67**	**8**	**40**	**4**	**42**	**5**	**67**	**10**
Unweighted n	*12*		*10*		*12*		*15*	

Q31. Which of the following best describes what you did with this specific leaflet?

Unweighted base: n = 37 for post-intervention survey, asked of those who recall seeing any of the leaflets

Note: Handed on to a patient or client statement was only applicable to the blue leaflet

Key message take-outs from the project resources

Those who recalled having seen any of the leaflets or videos were asked what they thought the main messages being conveyed were. A few health professionals spontaneously cited the key "No alcohol is safest option" message. However, a larger number suggested that the materials were aiming to convey the importance of health professionals discussing alcohol consumption with pregnant patients. A few illustrative examples of the comments received include the following:

"No alcohol is the best option. There are support services available if desired or required. Most women are not aware of the effects that alcohol consumption has on fetus/baby being breastfed." (Videos)

"That not drinking is the safest option to choose. The 5As for health professionals. That it is important to ask all pregnant and breastfeeding women about their alcohol consumption and to openly discuss it." (Videos)

"Try your best. *B*e aware of the guidelines, be non-judgemental. Harm minimisation. No guilt. *G*ive them [patients] the information to make decisions." (Leaflets)

"Alcohol during pregnancy and breast feeding is undesirable." (Leaflets)

When prompted with a number of messages, most of which were included in the WWTK materials, and asked which best described what they were trying to convey, at least three-quarters recognised the two overarching messages. This included "For women who are pregnant or planning pregnancy, not drinking is the safest option" (68 per cent for videos, 81 per cent for leaflets) and "Health professionals should ask all pregnant women about their alcohol use" (74 per cent for videos and leaflets).

However, only half (52 per cent) picked up that "Women expect healthcare professionals to raise the topic of alcohol consumption during pregnancy" from the leaflets. Also, a sizable minority selected the 'red herring' message which was actually contrary to the Alcohol Guidelines and not included in any of the materials "Women who are pregnant or planning pregnancy should drink no more than two standard drinks in a week" (16 per cent for videos, 19 per cent for leaflets). The fact that this was mistaken for a valid campaign message, likely relates to the finding, discussed later, that a minority of health professionals were not aware of the Alcohol Guidelines.

Table 8: Key message take-outs from videos or leaflets

	Videos		Leaflets	
	%	n	%	n
For women who are pregnant or planning pregnancy, not drinking is the safest option	68	13	81	22
Health professionals should ask all pregnant women about their alcohol use	74	14	74	20
For women who are breastfeeding, not drinking is the safest option	53	10	70	19
Women are often willing to make changes to their lifestyle during pregnancy if advised	74	14	70	19
Health professionals should ask all women planning a pregnancy about their alcohol use	68	13	67	18
Health professionals should ask all breastfeeding women about their alcohol use	63	12	63	17
The 5As can make it easier to discuss alcohol consumption with pregnant women or women planning pregnancy	47	9	56	15

One way to assess a woman's alcohol consumption is by using the AUDIT-C (Alcohol Use Disorders Identification Test – Consumption)	16	3	56	15
Women expect healthcare professionals to raise the topic of alcohol consumption during pregnancy	63	12	52	14
Women who are pregnant or planning pregnancy should drink no more than 2 standard drinks in a week	16	3	19	5
None of the above	11	2	4	1
Unweighted n	*19*		*27*	

Q35. Which of the following statements best describe what these *Women Want to Know* project materials (videos or leaflets) were trying to convey? Please select all that apply.

Unweighted base: n=37 who recalled seeing any of the leaflets or videos

Impact of the project on health professionals' attitudes, knowledge and behaviour

Evaluation objectives:

- Assess any change in HPs knowledge, attitudes and comfort in discussing alcohol with pregnant women as a result of campaign exposure
- Assess use of and engagement with the resources
- Assess any change in HPs practice as of a result of campaign exposure

One of the most robust ways to evaluate the impact of a project is to compare relevant measures among the target population before and after its inception. For the WWTK project, this means comparing benchmark and post-project survey responses related to knowledge, attitudes and behaviours about alcohol consumption during pregnancy. Of course, the greater the reach, the more likely it is that such pre-post comparison will show change (assuming the project resources were effective). In this case, as only 15 per cent could recall having seen the WWTK videos or leaflets or participating in the training,[26]

[26] Two per cent reported having completed the training and 14 per cent reported having seen the videos/leaflets. However, this totals 15 per cent of participants, rather than 16 per cent, as there was overlap between these groups.

it was to be expected that few such population shifts would be observed and this was borne out by the analysis described in the following sections.[27]

Pre-post project change in knowledge and attitudes

Understanding of risks associated with alcohol consumption

Health professionals were asked to state the main risks associated with someone consuming alcohol when pregnant, as an open-response question. Their responses were then 'coded' into themes, with reference to the categories used in the benchmark survey. Caution should be used when considering change in proportion results based on open response questions as a certain degree of interpretation is necessarily involved in allocating responses to each code. Any such changes should be considered indicative, unless they reflect a broader pattern of change observed throughout the survey.

In any case, analysis suggests that the perceived risks remained similar between the benchmark and post-project surveys, with the exception of a decrease in the proportion mentioning intrauterine growth restriction, or IUGR, (from 21 per cent to 11 per cent) and an increase in the proportion of midwives specifically suggesting that alcohol could cause developmental delays/low IQ (from 13 per cent to 24 per cent).

Overall, the majority (67 per cent) recognised that FAS/FASD is associated with alcohol consumption in pregnancy. Far fewer mentioned a range of other risks, including miscarriage/still birth (seven per cent), as shown in Table 9. Specialists were most likely to mention FAS (82 per cent).

Further analysis of the post-intervention survey results shows that FAS was much more likely to be mentioned than FASD (67 per cent compared to six per cent overall).[28]

Table 9: Main risks associated with women consuming alcohol while pregnant (top mentions)

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
FAS/FASD	67	63	72	73	82	86	72	72
Can cause developmental delays/low IQ	4	14	13	24 ↑	8	12	10	18
Intrauterine growth restriction (IUGR)	20	6 ↓	20	12	26	18	21	11 ↓
Damage to baby (general)	13	9	24	10 ↓	10	8	17	9
Can cause miscarriage/still birth	8	7	15	9	6	4	10	7
Low birth weight/SGA	11	7	12	7	8	0	10	5

[27] For the same reason, it was also not possible to meaningfully compare the post-project responses of recognisers to those of non-recognisers – an approach that is often used to help tie observed change to a project as opposed other external factors.

[28] This breakdown was not available for the pre-intervention survey data.

Baby born with chemical dependency/withdrawal issues	4	5	6	3	0	8	4	5
Can cause premature labour	8	4	14	5	14	4	12	4
Congenital abnormalities	10	6	11	3	6	4	10	4
Behavioural problems	1	4	5	5	6	2	4	4
Negative effects of mothers' health	4	0	2	6	10	2	4	3
Mother at risk of falls/accidents	6	2	1	2	10	6	5	3
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q10a. What are the main risks associated with someone consuming alcohol while pregnant?

Unweighted base: n = 251 for pre-intervention survey, n = 257 for post-intervention survey

Table only shows mentions above two per cent, based on the post-survey

Health professionals were asked the same question in relation to breastfeeding, again in an open-response format. Analysis of coded responses indicates that at an overall level the only change was a decrease in the proportion of health professionals mentioning potential neglect of a baby or impaired parenting as a result of alcohol consumption (from 23 per cent to 11 per cent). Among the individual professional groups, there was also an increase in the proportion of GPs mentioning impaired health effects for the baby (not specified), from nine to 24 per cent.

Looking at the post-project findings, the largest proportion (37 per cent) of health professionals stated (correctly) that alcohol consumed when breastfeeding passes into the breast milk and on to the baby. This was a particularly common suggestion among midwives (53 per cent). One quarter (24 per cent) overall believed that drinking alcohol while breastfeeding could cause developmental delays. A range of other risks were suggested by one in six or fewer, as shown in Table 10.

Table 10: Main risks associated with women consuming alcohol when breastfeeding

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Exposure of baby to alcohol/baby is consuming alcohol	33	29	65	53	26	18	44	37
Can cause developmental delays/low IQ	19	21	18	22	14	33 ↑	18	24
Sedation/Sleepy baby	11	17	9	15	10	22	9	17
Impaired health effects on the baby (general)	9	24 ↑	8	12	8	12	8	17
Neglect of baby/impaired parenting	20	9 ↓	26	10 ↓	22	18	23	11 ↓
Poor milk supply/lactation issues	5	8	4	9	10	4	6	7
Feeding issues	5	6	4	7	2	6	3	6

Physical health of mother	3	8	0	4	6	4	2	5
Co-sleeping/mother smothering baby	5	3	10	5	2	6	6	4
Behavioural problems	4	3	4	5	0	6	3	4
Dependency syndrome/baby may experience withdrawal symptoms	2	3	3	3	4	6	3	4
Risk of liver damage	5	4	1	4	4	2	3	4
Increased risks of SIDS	6	0	7	8	0	0	5	3
Lack of data on safe levels	0	0	2	5	2	6	1	3
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q10b: What are the main risks associated with someone consuming alcohol while breastfeeding?

Unweighted base: n = 251 for pre-intervention survey, n = 257 for post-intervention survey

Table only shows mentions above two per cent, based on the post-survey

When asked directly how many drinks of alcohol a pregnant woman can consume per day without any risk to the fetus, the proportion of health professionals who believed that one or two drinks could be safely consumed remained unchanged following the WWTK project, at eight per cent. There was also no significant change in the proportion stating that only abstention from alcohol carried no risk (90 per cent).

Midwives were least likely to believe that one or two drinks per day posed no risk (three per cent). This misconception was more common among GPs (11 per cent) and specialists (12 per cent).

Table 11: Number of alcoholic drinks a pregnant woman can consume per day without risk to the fetus

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
None	80	88	95	95	78	84	86	90
One or two	14	11	2	**3**	16	12	10	8
Three or four	1	-	-	-	-	-	-	-
Don't know	5	1	3	2	6	4	4	2
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q11. How many drinks of alcohol per day can a pregnant woman consume without any risk to the fetus?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Familiarity with and attitudes towards the Alcohol Guidelines

At the overall level there was no significant change between the benchmark and post-project surveys in terms of health professionals' familiarity with the Alcohol Guidelines. It was still the case that around one in five (19 per cent) had not heard of them and only around a third (33 per cent) felt familiar with them.

However, looking at each of the health professional groups separately**, awareness of the Alcohol Guidelines had increased among GPs and specialists**. That is, there was a decrease in the proportion saying they had not head of the Alcohol Guidelines, from 31 per cent to 20 per cent and from 30 per cent to 14 per cent respectively), as shown in Table 12.

Table 12: Familiarity with NHMRC Alcohol Guidelines

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Have not heard of these	31	20 ↓	15	20	30	14 ↓	24	19
Have heard of them but not familiar with the content	38	51 ↑	49	48	36	43	42	48
Somewhat familiar with the content	29	26	35	31	30	35	31	30
Very familiar with the content	3	2	1	1	4	8	2	3
Familiar (net)	**32**	**28**	**36**	**32**	**34**	**43**	**34**	**33**
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q13: How familiar would you say you are with the 2009 National Health and Medical Research Council's *Australian guidelines to reduce the health risks from drinking alcohol*?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Those who reported being 'familiar' or 'very familiar' with the Alcohol Guidelines were asked how strongly they thought the evidence supported Guideline 4a, "For women who are pregnant or planning a pregnancy, the safest option is not to drink alcohol". Again, there was no significant change between the benchmark and the post-project results. Overall, one in 20 (five per cent) believed that the evidence does not support this advice, for any level of alcohol consumption.

Table 13: Views on strength of evidence for Alcohol Guideline 4a, "For women who are pregnant or planning a pregnancy, the safest option is not to drink alcohol"

	GPs		Midwives		Specialists[29]		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Evidence strongly supports this for all levels of consumption	56	59	78	73	29	45	60	61
Evidence strongly supports this for higher levels of consumption but weakly supports this for lower levels of consumption	28	28	19	12	65	36	32	24
Some evidence exists to support this for all levels of consumption	9	7	3	9	6	18	6	11
Evidence does not support this for any level of consumption	3	7	-	6	-	-	1	5
Don't know	3	-	-	-	-	-	1	-
Unweighted n	*32*	*29*	*36*	*33*	*17*	*22*	*85*	*84*

Q14a. In your view, how strongly would you say the evidence is that supports the following guidelines?

Unweighted base: n=84 for pre-intervention survey and n=85 for post-intervention survey, those familiar or very familiar with the Alcohol Guidelines

The same question was also asked in relation to Guideline 4b, "'If you are breastfeeding, the safest option is not to drink alcohol". There was no significant change from the benchmark survey, and four per cent believed that the evidence did not support this guideline for any level of consumption. Midwives were the group most likely to believe that there is strong evidence supporting the breastfeeding guideline for all levels of consumption (64 per cent).

[29] As this question was asked only of those health professionals who reported being 'familiar' or 'very familiar' with the Alcohol Guidelines the sample size is relatively small, particularly for specialists, so the percentage results should be interpreted with caution.

Table 14: Views on strength of evidence for Alcohol Guideline 4b, "If you are breastfeeding, the safest option is not to drink alcohol"

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Evidence strongly supports this for all levels of consumption	47	34	56	**64**	6	32	42	45
Evidence strongly supports this for higher levels of consumption but weakly supports this for lower levels of consumption	25	41	31	21	82	50	39	36
Some evidence exists to support this for all levels of consumption	19	17	14	12	6	18	14	15
Evidence does not support this for any level of consumption	3	7	-	3	6	-	2	4
Don't know	6	-	-	-	-	-	2	-
Unweighted n	*32*	*29*	*36*	*33*	*17**	*22**	*85*	*84*

Q14b. In your view, how strong would you say the evidence is that supports the following guidelines

Unweighted base: n=85 for pre-intervention survey and n=84 for post-intervention survey *caution low base size

Note: The proportion are of those respondents who selected 'somewhat' or 'very familiar' with the 2009 National Health and Medical Research Council's *Australian guidelines to reduce the health risks from drinking alcohol*.

Barriers to discussing alcohol consumption with pregnant women

There was no significant change in the proportion of health professionals citing a range of issues (from the list provided) that make it difficult for them to discuss alcohol consumption in pregnancy with their patients/clients. These included concern about patient discomfort, lack of training, lack of referral options and lack of knowledge about the amount of alcohol that is harmful in pregnancy. The most common concern remained potential patient discomfort (28 per cent), as shown in Table 15.

A lack of training was cited as a barrier more often by midwives than GPs or specialists (15 per cent compared to six and zero per cent respectively).

Table 15: Difficulties discussing alcohol consumption in pregnancy with patients

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Concern about the patient's discomfort when discussing their alcohol intake	23	26	27	34	18	20	24	28
Lack of training in how to initiate the conversation	6	6	11	**18**	-	-	7	10
Lack of referral options for adequately dealing with alcohol use problems once identified	22	18	22	33	14	18	20	24
Lack of knowledge about the amount of alcohol that is harmful in pregnancy	14	12	12	17	10	6	12	13
Other [specify]	6	4	14	12	8	4	10	7
None of these	52	55	41	**29**	56	61	49	46
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q7. What, if anything, can make it difficult for you to discuss alcohol consumption in pregnancy with your patients/clients?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

There was no significant improvement from the benchmark in terms of health professionals' familiarity with the referral pathways available to assist pregnant patients/clients when there were concerns about their alcohol consumption. Unfortunately, the proportion of midwives who felt 'very familiar' with referral pathways decreased from 22 per cent to 11 per cent. Overall, in the post-project survey, just under half (45 per cent) of the health professionals felt 'not very' or 'not at all' familiar with available referral pathways.

Table 16: Familiarity with referral pathways available to assist pregnant patients/client's when concerned about their alcohol consumption

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Very familiar	12	8	22	11 ↓	16	10	17	9
Somewhat familiar	38	47	37	45	34	39	37	44
Not very familiar	30	35	29	28	34	39	30	33
Not at all familiar	19	11	11	14	16	12	15	12
Don't know	2	-	1	3	-	-	1	1
Familiar (net)	**50**	**55**	**59**	**56**	**50**	**49**	**54**	**53**
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q9: How familiar are you with the referral pathways available to you to assist pregnant patients/clients when you are concerned about their alcohol consumption?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Perceived effectiveness of brief intervention

Overall, there was no significant change in terms of health professionals' belief in the effectiveness of brief interventions for alcohol consumption. However, there was an increase in the proportion of GPs that rated brief interventions as 'very effective' (from 59 per cent to 72 per cent).

Based on the post-project survey, overall across all of the health professional groups, half (49 per cent) believed brief interventions were 'very' effective in assisting pregnant patients/clients to modify their alcohol consumption and a further 45 per cent believed they were 'somewhat' effective. However, around one in 20 (five per cent) continued to believe they were 'not very' effective.

Table 17: Perception of effectiveness of brief intervention in assisting pregnant patients/clients to modify their alcohol consumption

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Very effective	59	72 ↑	33	28	46	43	46	49
Somewhat effective	37	27	59	57	48	57	48	45
Not very effective	3	1	3	11	6	-	4	5
Not at all effective	-	-	1	-	-	-	-	-
Don't know	1	-	4	4	-	-	2	2
Effective (net)	96	99	92	85	94	100	94	94
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q15. How effective do you think brief intervention can be in assisting the following patients/clients to modify their alcohol consumption?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Note: The results are for statement 'Pregnant patients/clients'

There was no significant change compared to the benchmark in health professionals' comfort in initiating conversations with women who were pregnant, planning a pregnancy, breastfeeding or of childbearing age. Around nine in ten continued to report that they were comfortable with initiating conversations about alcohol in relation to pregnancy or breastfeeding and around three-quarters were comfortable with initiating these with women of childbearing age, as shown in Table 18. Midwives were less likely than GPs or specialists to feel comfortable in starting conversations about alcohol with women who are pregnant (for the first time) or actively planning a pregnancy.

Table 18: Level of comfort in initiating conversations

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Women who are pregnant for the first time	94	94	92	**89**	96	**100**	94	93
Women who are actively planning a pregnancy	92	95	87	**84**	98	98	91	91
Women who are pregnant a second or subsequent time	90	89	86	87	92	98	89	90
Women who are breastfeeding	88	83	96	85	96	90	93	85
Women of childbearing age	73	68	77	71	80	**88**	76	73
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q5. On a scale from 0 to 10, how comfortable would you say you are with initiating conversations about alcohol consumption with the following patients/clients?

Note: The proportions are based on top three box i.e. score 8, 9 or 10

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Resources to assist health professionals

In the benchmark survey health professionals were asked which of a range of resources would assist them in talking to women about alcohol use in pregnancy. This was mainly to inform the WWTK project, rather than with a view to measuring change. But in any case there was no significant change in the preferences stated at the overall level, as printed resources for clients/patients remained most popular (73 per cent). However, it may be useful to note that the proportion of midwives citing web-based training resources increased from 48 per cent to 61 per cent.

Midwives were more likely than the GPs to report (based on the post-project survey) that they would find a range of resources helpful, including a website with targeted information (58 per cent compared to 41 per cent), online tools (56 per cent compared to 30 per cent), web-based training modules (61 per cent compared to 19 per cent), face-to-face training (53 per cent compared to 35 per cent) and printed resources for them (62 per cent compared to 42 per cent), as shown in Table 19. This relatively high level of interest in, or perceived need for, training and support on this topic among midwives, and relatively low level among GPs, reflects the findings from the qualitative elements of the evaluation (discussed in the next section).

Table 19: Resources that would assist health professionals in talking to women about alcohol use in pregnancy

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Printed resources for patients/clients	66	**57**	81	85	78	80	75	73
Printed resources for yourself	47	**42**	62	**62**	54	49	54	51
A website with targeted information	33	**41**	64	**58**	58	53	50	50
Accredited (CPD) training	50	49	49	60	20	**29**	43	49
Online tools to assess alcohol consumption levels	44	**30** ⬇	53	**56**	42	43	47	43
Face to face training	31	35	45	**53**	14	22	33	40
Web-based training modules	23	19	48	**61** ⬆	36	25	35	37
Something else (please specify)	1	1	1	3	4	4	2	2
Don't know	1	6	0	0	8	0	2	2
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q16. Which of the following would assist you in talking to women about alcohol use in pregnancy?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Pre-post project change in practice

As there was very little significant change in health professionals' attitudes and knowledge in relation to pregnancy and alcohol between the benchmark and post-project surveys (at the overall level) it is not surprising that there was also no significant change in terms of behaviour, as discussed below.

Circumstances in which alcohol consumption is discussed

Health professionals were asked to state the circumstances in which they would talk to women about their alcohol consumption, from a list of possible options. There was no significant change in the proportion mentioning each circumstance, as shown in Table 20.

Looking in more detail at the post-project results, more than eight in ten (84 per cent) health professionals stated that they would discuss alcohol with any patient/client who is pregnant for the first time, which is on a par with the proportion who would discuss alcohol when seeing someone with a condition that may be caused by alcohol use (85 per cent). However, this leaves around one in six (16 per cent) health professionals who, presumably, would not have a conversation about alcohol with at least some of their patients who are pregnant for the first time.

Smaller proportions reported that they would discuss alcohol with any patient who is pregnant for the second or subsequent time (72 per cent), actively planning a pregnancy (67 per cent) or breastfeeding (58 per cent).

Table 20: Circumstances in which health professionals would discuss alcohol consumption

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Seeing or diagnosing someone with a condition that may be caused by alcohol use	86	85	-	-	-	-	35	85
Seeing any patient/client who is pregnant for the first time	89	89	74	79	80	84	81	84
Seeing or diagnosing someone with a condition that may be exacerbated by alcohol use	86	81	-	-	-	-	35	81
Seeing any patient/client who is pregnant for the second or subsequent time	75	68	74	74	60	75	72	72
Seeing any patient/client who is actively planning a pregnancy	79	83	46	**44**	76	78	65	67
Seeing an asymptomatic adult patient/client at risk of chronic disease	55	58	-	-	-	-	22	58
Seeing any patient/client who is breastfeeding	56	57	75	69	34	39	59	58
Prescribing or administering antibiotics or medication that may interact with alcohol	80	68	23	**18**	48	41	51	43
Seeing any patient/client who is a teenager/young adult	46	46	39	35	40	39	42	40
Seeing any patient/client who is a woman of childbearing age	43	**50**	31	**31**	46	39	39	40
None of these	-	-	4	7	4	2	2	3
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q1. Under which of the following circumstances would you talk to women about their alcohol consumption?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Routine conversations with pregnant about their alcohol consumption

When asked directly whether they routinely ask pregnant women about their alcohol consumption, in the post-project survey just over eight in ten (84 per cent) health professionals stated that they did. Again, there was no significant change compared to the benchmark (81 per cent). This leaves around one in seven (15 per cent) who reported that they did not routinely ask pregnant women about this.

Compared to GPs and specialists, midwives were least likely to routinely ask pregnant women about their alcohol consumption (89 per cent of GPs, and 92 per cent of specialists compared to 76 per cent of midwives).

Table 21: Routine conversations with pregnant about their alcohol consumption

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Yes	86	89	74	**76**	86	92	81	84
No	14	11	26	**23**	14	8	19	15
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q2. Do you routinely ask pregnant women about their alcohol consumption?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Initiation of discussion with pregnant women

In both the benchmark and post-project surveys, around seven in ten health professionals stated that they usually initiate discussions with pregnant women about alcohol consumption in relation to pregnancy (70 per cent post-intervention, 66 per cent benchmark). There was no significant change.

One-quarter (23 per cent benchmark, 24 per cent post-project) again indicated that it depends on the circumstances. Midwives were least likely to report that they initiated these conversation (59 per cent, compared to 82 per cent of GPs), as shown in Table 22.

Table 22: Initiating discussion about alcohol consumption in relation to pregnancy

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
I do	76	**82**	53	**59**	70	69	66	70
The patient/client does	3	2	5	6	6	4	4	4
Neither – it doesn't usually get discussed	1	-	1	-	2	2	1	-
It depends on the circumstances	20	**17**	33	**32**	16	20	24	23
Others	-	-	8	3	6	6	4	2
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q4. Who usually initiates discussions about alcohol consumption in relation to pregnancy?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Incidence of alcohol-related discussion with pregnant patients

Health professionals were asked to describe their practice with pregnant patients/clients in terms of how often they discussed a range of alcohol related topics with them. As shown in Table 23, there was no significant change between the benchmark and post-project surveys.

As in the benchmark, a sizeable minority reported that they did not discuss with every pregnant patient whether alcohol is safe to drink when pregnant (30 per cent), how much alcohol they consume (37 per cent), or how much alcohol is safe to drink (37 per cent). Further, only around half (51 per cent) indicated that they discuss the risks to the fetus of drinking alcohol when planning pregnancy with every patient.

Table 23: Incidence of alcohol-related discussion with pregnant patients/clients

	I never do this		I do this only when asked		I do this with some pregnant patients\clients		I do this with every pregnant patients\clients	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Discuss whether alcohol is safe to drink when pregnant	1	0	6	7	24	23	69	70
Assess how much alcohol they consume	2	2	7	8	23	28	68	63
Discuss how much alcohol is safe to drink when pregnant	4	2	10	9	25	25	60	63
Discuss risks to the fetus of drinking alcohol when planning pregnancy	4	3	12	11	31	34	52	51
Unweighted n	*251*	*257*	*251*	*257*	*251*	*257*	*251*	*257*

Q6. Please indicate the option that best reflects your practice with pregnant patients/clients

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Additional analysis of this data, focused specifically on the incidence of health professionals having these conversations with every patient, confirms there was no significant change between the benchmark and post-project survey for any of the health professional groups. These results are detailed in Table 24.

This analysis also shows that midwives were less likely than GPs or specialists to be having conversations with every pregnant patient about whether alcohol is safe to drink when pregnant (56 per cent compared to 81 per cent and 75 per cent respectively) and how much alcohol is safe to drink when pregnant (52 per cent compared to 71 per cent and 71 per cent respectively).

Table 24: Alcohol-related discussion with every pregnant patients/client – by health professional group

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Assess how much alcohol they consume	73	61	63	57	68	76	68	63
Discuss whether alcohol is safe to drink when pregnant	75	81	64	**56**	66	75	69	70
Discuss how much alcohol is safe to drink when pregnant	68	71	52	**52**	60	71	60	63
Discuss risks to the fetus of drinking alcohol when planning pregnancy	57	56	47	45	52	55	52	51
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q6. Please indicate the option that best reflects your practice with pregnant patients/clients

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Note: The proportion are of those respondents who selected "I do this with every pregnant patient/client" code

This lack of significant change in health professionals' behaviour is reflected in a separate survey among women who had recently been pregnant or breastfed a baby, which was conducted by FARE rather than directly as part of this evaluation. That survey found that there had been little change since 2012 in the proportion of women who could recall their health specialist (GP, obstetrician) raising with them the harms associated with drinking alcohol while pregnant or breastfeeding (37 per cent in 2012, and 38 per cent in 2016).

Use of AUDIT-C

Information about the AUDIT-C is provided in one of the WWTK leaflets and recommended as a tool to help assess a pregnant patient/client's level of alcohol consumption. The proportion of health professionals stating that they use AUDIT-C for this purpose has remained low, as in the benchmark survey (one per cent post and two per cent pre, no significant change). The 'CAGE' tool was more likely to be used (16 per cent benchmark and post), especially by GPs (33 per cent).

Table 25: Tools or questionnaires used to assess a pregnant patient/client's level of alcohol consumption

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
AUDIT	13	6	2	4	10	6	8	5
AUDIT-C	4	3	-	-	-	-	2	1
CAGE	36	33	2	1	4	10	16	16
TWEAK	1	2	2	1	-	2	1	2
Some other method	10	9	27	17	10	8	17	12
None of these	43	54	62	65	68	72	55	62
Don't know	3	3	5	12	10	4	5	7
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q8: Which of the following tools/questionnaires do you use to assess a pregnant patient/client's level of alcohol consumption?

Unweighted base: n = 251 for pre-intervention survey and n = 257 for post-intervention survey

Advice given to patients

Health professionals were asked what advice they generally give to women about alcohol consumption during pregnancy, in an open-response question. These responses were coded with reference to the categories used in the benchmark survey. Again, caution should be used when considering change in proportion results based on open-response questions. However, indicatively, there was a decrease (from 20 per cent to nine per cent) in the proportion of midwives giving advice which appeared to be at odds with the Alcohol Guidelines. However, there was also an increase (from two per cent to 20 per cent) in the proportion of specialists advising women to cut down or minimise alcohol consumption, when the message should ideally be to abstain.

More detailed analysis of the post-intervention survey reveals that around one in ten (11 per cent) health professionals were giving potentially inconsistent advice. While they indicated that they generally advised that there is no safe level of alcohol consumption during pregnancy and/or to abstain, these respondents also indicated that they gave advice which would be at odds with the Alcohol Guidelines (for example, to cut down/minimise amount of alcohol, that an occasional small drink is reasonable, no alcohol in first trimester, one standard drink on special occasions, or advice not to binge drink or one standard drink per day).

Table 26: Advice given to women about alcohol consumption during pregnancy (top mentions)

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Abstain	87	82	76	79	74	59	80	76
No safe level of alcohol	6	8	27	28	18	16	17	18
Cut down/minimise amount of alcohol	6	11	6	8	2	20 ↑	5	11
Occasional small amount/drink is reasonable	2	10	8	2	18	18	8	8
Explain/discuss risk to baby/development	8	2	19	9	6	6	12	5
Explain/ discuss FAS/FASD	4	2	6	7	4	6	5	5
Explain that alcohol passes to fetus	0	3	4	5	0	-	2	3
Advice at odds with the 'No alcohol is the safest option' guideline (Net)	**19**	**20**	**20**	9 ↓	**40**	39	**24**	**19**
Not answered	1	-	1	1	0	-	1	-
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q3a. What advice do you generally give to women about alcohol consumption during pregnancy?

Unweighted base: n = 251 for pre-intervention survey, n = 257 for post-intervention survey, asked to all except the ones saying 'don't know' at Q2

Table only shows mentions above two per cent, based on the post-survey

Note: The "Advice at odds with the 'No alcohol is the safest option' (net)" includes: 'Cut down/minimise amount of alcohol', 'Occasional small amount/drink is reasonable', 'No alcohol in first trimester', '1 standard drink on special occasions', 'Advice not to binge drink' and '1 standard drink per day'.

When asked what advice they give to women about alcohol consumption and breastfeeding, also in an open-response question, the only indicative change was an increase in the proportion of midwives stating that they advised breastfeeding mothers to plan their feeds around alcohol consumption (from 14 per cent to 33 per cent). Again, this does not align with the guideline that not drinking alcohol is the safest option.

Looking at the post-project survey results in more detail, while a larger proportion of midwives than other health professionals were (correctly) informing women that alcohol passes through breast milk (25 per cent), a relatively larger proportion were also giving advice that was at odds with the guideline

that the safest option is not to drink alcohol while breastfeeding (59 per cent), such as advice to 'pump and dump' (19 per cent).

Table 27: Advice given to women about alcohol consumption when breastfeeding (top mentions)

	GPs		Midwives		Specialists		Overall	
	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)	Pre (%)	Post (%)
Abstain	70	70	56	50	54	45	61	57
Cut down/minimise amount of alcohol	22	26	6	15	18	31	15	23
Plan your feeds/plan feeds around alcohol consumption	2	2	14	33↑	4	4	7	15
Alcohol passes through breast milk	11	6	26	25	12	10	17	14
Pump/express milk before drinking alcohol	2	3	24	16	4	2	11	8
Pump and dump/if drinking alcohol express and discard	-	1	15	19	6	-	7	8
Occasional small amount is reasonable	5	5	9	4	18	12	9	6
Explain/discuss risks to baby/baby's development	4	6	2	5	2	2	3	5
No safe level of alcohol	-	3	7	5	4	8	4	5
1 standard drink on special occasions	3	5	1	4	2	4	2	4
BAC is equal to the level in breast milk	1	-	6	10	-	-	3	4
Refer to Breastfeeding Association guidelines	-	-	8	7	-	-	3	3
Advice at odds with 'No alcohol is the safest option' guideline (Net)*	**46**	**40**	**66**	**59**	**48**	**47**	**54**	**49**
Not answered	-	-	-	1	2	-	-	-
Unweighted n	*101*	*103*	*100*	*103*	*50*	*51*	*251*	*257*

Q3b. What advice do you generally give to women about alcohol consumption and breastfeeding?

Unweighted base: n = 251 for pre-intervention survey, n = 257 for post-intervention survey, asked to all except the ones saying 'don't know' at Q2

Table only shows mentions above two per cent, based on the post-survey

*Note: "Advice against 'No alcohol is the safest option' net is created off 'Cut down/minimise amount of alcohol', 'Plan feeds around alcohol consumption', 'Pump/express milk before drinking', 'Pump and dump if drinking express and discard', 'Occasional small amount is reasonable' and '1 standard drink on special occasions'

Self-reported impact of the project resources (among recognisers)

The 37 health professionals (12 GPs, 14 midwives and 11 specialists) who could recall having seen any of the WWTK leaflets or videos were asked to report on how effective they thought the resources were and how they had impacted on their knowledge, attitudes, confidence and behaviour. It is important to bear in mind that self-reported 'impact' questions do not provide as robust an assessment of impact as the comparison of benchmark and post-project survey results. These reports are based on only a small proportion of the target population who not only received but also recalled the materials some time later (that is, the best-case scenario). In addition, there can be a form of 'social desirability bias' (a desire to please or to answer questions in a way that will be viewed favourably by others, which can result in the over-reporting of 'positive' behaviours or attitudes and the under-reporting of 'negative' behaviours or attitudes). For the reasons already mentioned, percentage results based on only these 37 'recognisers' should also be interpreted cautiously. Nevertheless, the results show that, at an overall level, the materials were perceived to have a positive impact by most, though not all, of these health professionals, as discussed below.

Health professionals who had seen the leaflets or videos were asked how effective they had personally found the WWTK project resources. All of the 37 stated that they had found them either 'very effective' or 'somewhat effective' in terms of "communicating useful information to health professionals about alcohol consumption during pregnancy" and "providing useful guidance regarding initiating conversations about alcohol and pregnancy". Around four in ten had found them very effective on each of these measures (38 per cent and 36 per cent respectively).

They were also asked the extent to which they agreed or disagreed with a series of statements about the impact of having seen the WWTK materials on their knowledge and attitudes, using a zero to ten scale. Table 28 shows the proportion who agreed (when defined as a score of 0-2) or disagreed (when defined as a score of 8-10) with each of these statements. In summary, around six in ten agreed that having seen the materials they:

- had a better understanding of what advice to give to patients in different situations about alcohol consumption during pregnancy (59 per cent)
- felt more comfortable in talking to patients about alcohol consumption during pregnancy (57 per cent)
- had a better understanding of how to communicate about alcohol consumption during pregnancy (57 per cent).

Around half agreed that they:

- had thought more about the advice I give to female patients about drinking alcohol during pregnancy (51 per cent)
- had more information about who or where to refer patients for additional support in relation to alcohol consumption during pregnancy (51 per cent)
- had a better understanding of the guidelines on alcohol consumption during pregnancy (49 per cent).

However, this means that between four in ten and half did not give a strong indication that the materials had impacted on them in each of these positive ways. Further around one in ten agreed that, having seen the materials they felt:

- felt less confident about talking to patients about alcohol consumption during pregnancy (11 per cent)
- more concerned about how patients might react if I initiate a conversation about alcohol consumption during pregnancy (eight per cent).

Table 28: Self-reported change in attitude

	Disagree (Score 0-2)		Agree (Score 8-10)	
	%	n	%	n
I have a better understanding of what advice to give to patients in different situations about alcohol consumption during pregnancy	-	0	59	22
I feel more comfortable in talking to patients about alcohol consumption during pregnancy	11	4	57	21
I have a better understanding of how to communicate about alcohol consumption during pregnancy	3	1	57	21
I have thought more about the advice I give to female patients about drinking alcohol during pregnancy	3	1	51	19
I have more information about who or where to refer patients for additional support in relation to alcohol consumption during pregnancy	3	1	51	19
I have a better understanding of the guidelines on alcohol consumption during pregnancy	8	3	49	18
I feel <u>less confident</u> about talking to patients about alcohol consumption during pregnancy	84	31	11	4
I am <u>more concerned</u> about how patients might react if I initiate a conversation about alcohol consumption during pregnancy	65	24	8	3
I am <u>more confused</u> about what advice to give patients about alcohol consumption during pregnancy	84	31	3	1
Unweighted n	*37*			

Q38. Having seen the *Women Want to Know* project materials, to what extent do you agree or disagree with each of the following….

Unweighted base: n = 37 for post-intervention survey, asked of those who recall seeing any of the leaflets or videos

When asked if they had changed their practice in a variety of ways after seeing the WWTK project materials, almost three in five (57 per cent) reported that they had initiated conversations or had more conversations with women about alcohol consumption during pregnancy. Just over half (54 per cent) reported that they advised all pregnant women not to drink alcohol during pregnancy, and around four in ten reported that their conversations with women about alcohol consumption during pregnancy were more effective (41 per cent) and/or more detailed/in-depth (35 per cent).

The resources appeared to have had less of an impact in terms of encouraging the use of the 5As and Audit-C tools (14 per cent and five per cent respectively).

Further, one in five (22 per cent) admitted that their behaviour had not changed in any of these ways as a result of seeing the materials.

Table 29: Self-reported change in behaviour

	%	n
I initiate conversations/more conversations with women about alcohol consumption during pregnancy	57	21
I advise all pregnant women not to drink alcohol during pregnancy	54	20
The conversations I have with women about alcohol consumption during pregnancy are more effective	41	15
The conversations I have with women about alcohol consumption during pregnancy are more detailed/in-depth	35	13
I refer more patients to support services related to alcohol consumption during pregnancy	19	7
I refer to the 5A's mentioned in the materials / refer to the 5A's more often	14	5
I refer to the Audit - C mentioned in the materials / refer to the Audit - C more often	5	2
Nothing has changed	22	8
Unweighted n	*37*	
Q37. Which of the following are you doing or have you done as a result of seeing the *Women Want to Know* project materials? Unweighted base: n = 37 for post-intervention survey, asked of those who recall seeing any of the leaflets or videos		

It is difficult to access evaluations of other similar health promotion projects, to put the findings relating to the reach and impact of WWTK into context. For example, the audit of resources conducted for the WWTK project found that formal evaluations had not been conducted (or were not available) for most of the eight resources identified on the subject of pregnancy and alcohol targeted at health professionals.

Among these, the initiative with an available evaluation that is most relevant, in terms of its aims and its approach of providing health professionals with written resources, is the 'Alcohol and Pregnancy Project' (published by ICHR and Healthway). However, the results of the evaluation are not comparable to the results of the WWTK project as the resources were sent directly to a mailing list of 3,348 health professionals in Western Australia and the evaluation survey was conducted with 1,483 of this *same group* of health professionals, meaning that a reach of 96 per cent was achieved. This is very different to the WWTK project which was aiming to reach as many of the relevant health professionals as possible, without access to a comprehensive mailing list.[30]

Appropriateness of project resources - leaflets and videos

Evaluation objective:

- Assess the appropriateness of resources developed during the campaign

Four leaflets were developed and distributed as part of the WWTK project, of which three were aimed at health professionals and one was aimed at patients. The leaflets were developed to contribute to the aims of the WWTK project by:

- engaging with health professionals to increase their motivation to discuss alcohol with patients
- preparing health professionals for initiating conversations by building their confidence in the evidence based underpinning the Alcohol Guidelines and by providing practical and accessible information and resources
- supporting the conversation in the consultation room by providing easy-to-use tools to help structure the conversation effectively (the intention was that the patient leaflet would be used to support, rather than replace, a discussion on the subject of alcohol).

[30] Payne, J.M., France, K.E., Henley, N., D'Antoine, A.D., Bartu, A.E., O'Leary, C.M., Elliitt, E.J., Bower, C., Geelhoed, E. (2011). RE-AIM evaluation of the alcohol and pregnancy project: Educational resources to inform health professionals about prenatal alcohol exposure and Fetal Alcohol Spectrum Disorder. *Evaluation and Health Professionals* 34 (1) 57 80

Eight short videos were also developed, primarily for use as part of the training programs, rather than for wider distribution as standalone resources, although they were made publicly available on the WWTK website and sometimes shown during conference presentations. All of the videos were aimed at health professionals, rather than patients.

To assess the appropriateness of the resources, reactions to them were sought among the target health professionals via a combination of group discussions (three with GPs, one with midwives) and individual interviews (with six specialists and three midwives). The videos were also discussed as part of the online discussion boards with training participants. The analysis in this chapter is based on these sources, along with feedback from stakeholders, where appropriate.

In many ways, the issues and barriers in relation to discussions with women about pregnancy and alcohol (already outlined in the 'Current Behaviour' section) reflect the findings of the research conducted to inform the development of the WWTK project, so it was interesting to be able to observe the extent to which the resources were perceived to, and/or appeared to, address these.

Awareness of the Women Want to Know initiative and resources

As noted, across the depth interviews and discussion groups with GPs, specialists and midwives there was low awareness of the WWTK initiative and only a couple of the research participants in the discussion groups and interviews indicated they had heard of the program or previously seen any of the material or resources. There was some, albeit limited, awareness of FARE.

Overview of reactions to the WWTK materials

Overall, there was a mixed reaction to the WWTK materials when presented in the group discussions and interviews. While most felt the leaflets presented useful information in an appropriate language and tone, many believed that the information needed to be made more succinct and to present the key messages in such a way that they stood out and could be more readily taken on-board by both busy health professionals and pregnant women, who are expected to take on board a lot of pregnancy-related information.

Evidence from these discussions indicates that the materials would, in some cases, have some positive impact on health professionals' propensity and confidence to talk with pregnant women about alcohol

and many felt reassured that it was a topic that women wanted to hear and learn more about. However, this was not universally the case and there is certainly scope for improvements to be made.

In particular, some GPs and specialists continued to express concern over the lack of 'hard' evidence and conclusive research about the impact of lower levels of alcohol on the unborn baby across all of the materials. Some also felt affronted and defensive about the implication they perceived in some of the videos that health professionals were not advising pregnant women about alcohol or giving the wrong advice. They certainly did not feel encouraged to reflect on or alter their own practice. It is feasible that the reaction may have been different if the videos were seen in the context of the training rather than outside of this (as in the group discussions), but, as it was not possible to contact RACGP training participants for this evaluation, this could not be explored.

A number of health professionals suggested that there should also be an awareness raising campaign targeted at the wider population, to help 'back-up' the messages that they were providing/being asked to provide to patients.

Leaflets

Leaflet: 'Information for women about pregnancy and alcohol'

The '*Information for women about pregnancy and alcohol*' leaflet was widely welcomed by health professionals as a much-needed resource they could give to women that presents key information to support the current Alcohol Guidelines, provide links to further information, and reassurance about alcohol consumed in the early stages of the pregnancy. It was noted that, as women are given a lot of information at early appointments, being able to provide printed resources means they have the opportunity to remind themselves of key pieces of advice.

Some of the research participants noted that the 'Hints and tips when out with friends' was a great inclusion, particularly for younger women who may feel pressured into drinking.

> *"The tips are good too – how to manage it, because a lot of things are like habits and you need to know how to change so you can manage it." – Specialist.*

However, others held a different view. One midwife commented that, while the tips were useful, their 'premium' back page positioning made it appear as though advice for pregnant women on how to explain why they are not drinking is a key focus of the leaflet, when the key message should be why alcohol should be avoided. Another felt the hints and tips were unrealistic and not sufficiently helpful.

> *"Gee, they are pushing the hints and tips – it is all about how to get out of drinking alcohol. This information is good and should be contained within the form, but not given a prominent location." – Midwife.*

While the tone and wording of the information contained in the leaflet was seen as appropriate to the target market – not too technical and fairly easy to read – many believed the key messages were 'lost' among the paragraphs of information. It was widely recommended that the information be presented more succinctly to ensure that the key messages could be read at a glance.

> *"It is a bit too wordy, a bit too essay like, it takes me back to school. The key message needs to be at the beginning. Maybe something like 'no alcohol is safest for your baby'." – Specialist.*

One group of GPs in particular felt that the patient leaflet would have been more useful in backing up the evidence underpinning the Alcohol Guidelines if it had contained the same/similar bullet points on the evidence as the '*Information for health professionals*' leaflet, rather than the more wordy paragraph in the patient leaflet, which some seemed to miss altogether.

Most believed it would be effective to distribute these leaflets to women either during a consultation, or along with other printed information in their 'show bag' and/or on display in waiting rooms. In the latter two cases, this would differ from the way the leaflet was intended to be used – as it was designed to be handed to women as a supplement to a brief intervention in the form of a discussion about alcohol, rather than simply made available in waiting rooms or information packs.

Leaflet: 'Information for health professionals on assessing alcohol consumption in pregnancy using AUDIT-C'

The *'Information for health professionals on assessing alcohol consumption in pregnancy using AUDIT-C leaflet'* was generally seen by health professionals as a potentially valuable resource. It was perceived to provide an effective tool to assess alcohol consumption among pregnant women and include relevant and actionable advice, along with a clear definition of standard drinks.

However, it is important to acknowledge that the health professionals did not generally see this as a tool that they were likely to use consistently with all pregnant women to assess their alcohol consumption. Reasons for this included time constraints and competing priorities, the view that similar information could be, or was already being, elicited more naturally through a conversation, and that for many women this level of assessment was unnecessary. It tended to be seen as most useful for those who were at higher risk, especially for follow-up appointments (to assess progress) and for those whose alcohol consumption warranted further investigation or clarification. Reflecting the quantitative findings, very few health professionals participating in the qualitative research indicated they were aware of or currently used the AUDIT-C.

There was one issue that may be worth considering, even though it was discussed by only one specialist. The issue being that the Audit-C labels a score of 0-3 as 'low risk of harm' even though this score includes women who could be drinking regularly during pregnancy. For example, a pregnant woman could indicate that they are drinking alcohol 2-3 times a week (3 points), consuming 1-2 drinks on a typical day when they drink (0 points) and never having more than one alcoholic drink on one occasion (0 points), providing a total score of 3. It was suggested that including any score above 0 in the 'low risk of harm' category could be seen as implying reassurance that was not completely aligned with the campaign message (even though the 'Advice to be given' table does recommend informing women who score between 0 and 3 points that "…it is safest not to drink any alcohol at all during pregnancy" and to "encourage her to stop drinking alcohol altogether during pregnancy and arrange a follow-up session if required"). It was suggested that the table/scoring could be adjusted slightly to address this.

Some health professionals recommended that this leaflet be further developed so it could be more effectively used as a go-to reference that health professionals could reach for or access online in situations that required a more in-depth analysis of a pregnant woman's alcohol consumption. Other participant recommendations focused on developing the leaflet into a single sided card by reducing the introduction and background details, presenting the AUDIT-C tool and 'advice to be given' sections consecutively and providing the information about standard drinks as an infographic.

Health professionals expected this resource to be sent to them in the mail, made accessible online and distributed at in-service training or other education events, particularly those that focus on alcohol in pregnancy.

Leaflet: 'Information for health professionals on pregnancy and alcohol'

The '*Information for health professionals on pregnancy and alcohol*' leaflet was acknowledged as providing a good overview of the current recommendations, evidence about drinking and pregnancy and the need to initiate the conversation about alcohol at all stages of the pregnancy.

Support for the leaflet was stronger among midwives, as well as some GPs and specialists who encouraged their patients to adhere to the Alcohol Guidelines (although not all – see below). This group felt that the recommendations were clear and liked that the leaflet presented research that confirmed they were justified in talking about alcohol in pregnancy. They were also enthused that the initiative was working towards health professionals presenting a consistent view to patients in relation to pregnancy and breastfeeding.

The 5As were particularly well received and seen as new and useful means of addressing alcohol in pregnancy in a comprehensive manner. It was recommended that this section could be improved by the inclusion of details relating to where specialist support for women who are at risk can be accessed (such as major public maternity hospitals).

Most noted, and some had been unaware, that the Alcohol Guidelines recommended women continue to abstain from alcohol if they are breastfeeding.

There was some criticism from some GPs, as well as some specialists (perhaps more so those working in the private sector), that the leaflet fails to provide actual evidence of the risk of drinking alcohol at low-moderate levels in pregnancy. For this reason, this group believed that information in the leaflet felt misguided and should cite any recent research that specifically concludes that even a small amount of alcohol does influence the baby's outcomes.

> *"FASD, this is a distortion of what is known to push the party line. It isn't evidence-based, it is more like a barrister making a certain argument by stringing things together and it is a tad patronising." – Specialist.*

> *"Yes, there exists no evidence that drinking during pregnancy is good, but there is also no evidence that a little is bad." – Specialist.*

In the main, for this group, none of the materials seemed sufficiently compelling to convince them to change their current approach. This may consist of passing on the message that the Alcohol Guidelines advise that the safest option is not to drink, but if pressed, adding their own view that small amounts of alcohol occasionally were unlikely to cause harm or stating that there was no evidence that this would do harm.

Health professionals expected that this leaflet would be distributed at professional development and training events, particularly those which include presentations about alcohol and pregnancy. It was also recommended that the leaflet be revised to one page in length so it could be more easily accessed as a reference, or developed into a poster to be displayed on the wall at antenatal and GP clinics.

Leaflet: 'The *Women Want to Know* project'

While this leaflet was regarded as providing an overview of the project and presenting the resources available to support health professionals, it was generally seen as repetitive and lacking information of real value to health professionals. The general view was that the information could be provided more succinctly with less of a focus on the background of the initiative and the listing of all Working Group members. Most indicated they would not pay much attention to this leaflet, or retain it for future reference.

Videos

Health professionals across the discussion groups and interviews showed some interest in seeing the videos, though most claimed they didn't typically go out of their way to watch videos online and expected to see these presented in waiting rooms or at conferences and other education and training events. Participants stressed the need for videos on topics such as alcohol in pregnancy to be short and

to the point. It was suggested that anything more than two minutes was considered *'too long'* (some of the WWTK videos were up to five minutes long).

> *"It is nice and short, the first thing I do when I turn on a video is see how long it is. If it is under two minutes I will look at it." – Specialist.*

> *"They often have rotating video thing at the beginning of talks, we had a meeting in the city with people who just wanted an update and we talked about alcohol and smoking and we have rotating videos as people were coming in." – Specialist.*

Each of the videos is discussion in detail below.[31]

Video: 'Pregnancy and alcohol – a GP's perspective'

The GPs perspective presented in the video received a mixed reaction from GPs participating in the discussion groups. While some found it interesting to see a peer perspective, many felt it was now inaccurate and even alarmist to present the Alcohol Guidelines as being new or changed. Some had even forgotten that the Alcohol Guidelines once allowed for low-levels of alcohol consumption (prior to being changed in 2009).

> *"When did we say you can drink? I always assumed that you always told people they couldn't drink." – GP.*

Some also believed that this video incorrectly inferred that GPs were not comfortable discussing alcohol with pregnant woman and that they were giving the wrong advice. As such, the video made them feel affronted and defensive, rather than motivated to reflect on their own practice. They certainly did not see themselves as giving the wrong advice, and this applied even to those who would say to pregnant patients that the occasional drink probably wasn't anything to worry about (as there was no evidence of harm from low levels of drinking).

> *"It sounds like GPs aren't ready to talk to patients about not drinking but we are very happy to raise the issue." – GP.*

Video: 'Pregnancy and alcohol – best practice examples of health professionals discussing pregnancy and alcohol with women' (featuring GP)

In the discussion group, GPs had a strong response to the video that included the role-play with the patient as they perceived it to be unrealistic and misrepresentative of the information and recommendations that were provided to patients and of the depth of conversation that could and would be undertaken in relation to alcohol. Most of these GPs contended that the idea of abstaining from alcohol completely, or having very little, during the course of a pregnancy and the guidelines were not something new. Hence, they felt it was wrong for the scenario to imply that the woman had been told in her previous pregnancy that it was ok to drink or that she would argue that it wasn't consistent with other information.

Some also believed that the scenario was inherently unrealistic as women are not under the impression that drinking during pregnancy could be continued 'in moderation'. Again, this highlights a misconception among some health professionals that women are generally already aware of, and

[31] It was not feasible to show all of the videos in every discussion group and interview, so they were rotated to ensure a range of participants were exposed to each.

understand, the Alcohol Guidelines relating to pregnancy. These GPs also commented that they simply did not have enough time, or see a need, to go into a great detail about drinking during pregnancy and that their conversations around this issue tended to be more of a closed question and communication of the Alcohol Guidelines, albeit with some dilution that "a rare or occasional glass would be fine".

GPs also questioned the appropriateness of including the implication that the woman could have hurt the child, or even had an impact on the health of her first child. They felt that this approach would have a negative impact on the consultation and, potentially, on the patient-doctor relationship.

Video: 'Pregnancy and alcohol – a midwife's perspective'

Midwives were generally positive towards the midwife's perspective video and those working in public hospitals saw it as an accurate reflection of how the topic is discussed in antenatal visits and the procedures they follow during booking-in appointments. For this group, they also felt that the video presented a typical scenario, confirmed their current approach and gave them increased confidence to continue to talk about alcohol in detail with their patients.

> *"It reminds us that they do respect us and what we say." – Midwife.*

For midwives working in private hospitals, when combined with the impact of the leaflets that they had already seen (and the accompanying discussion), they felt that this video had provided them with more concrete and up to date information. This would make them feel a little more confident in having such conversations with pregnant women, and led them to consider that there was an expectation for them to bring up the topic of alcohol with their patients. Indeed, some midwives seemed to feel an element of guilt for not having had this conversation more frequently. However, a number of practical barriers to acting on these feelings remained. In particular, the issue that they only tended to see pregnant women prior to birth who had come in due to complications and because they still felt that they would need to be given permission to initiate discussions about alcohol by the hospitals in which they worked and the obstetricians.

Video: 'Pregnancy and alcohol – best practice examples of health professionals discussing pregnancy and alcohol with women' (featuring midwife)

This video, which provided a role-play of a conversation with a pregnant woman who had been binge drinking prior to finding out she was pregnant, was seen as an accurate reflection of a real life scenario and provided midwives with improved confidence to have a more detailed conversation with patients at the booking-in interview when required. The video was seen as informative and interesting as it provided an example of how to address the scenario without being judgemental, including making it feel like the questions were simply part of a standard set of questions that all women were asked and that each women is presented with the same information regarding the impact of drinking early in the pregnancy.

> *"I think it is helpful to see how someone else does it and what language they use – builds confidence, conversation and builds rapport." – Midwife.*

However, it was felt that this video was too long for general usage, and more appropriate to show midwives during their studies or training.

Video: '*Women Want to Know* – a woman's perspective' ('Verity', 'Olivia' and 'Alex')

GPs, specialists and midwives were generally interested in hearing a patient's perspective and most felt that the women in the videos spoke well and made interesting comments.

However, a number of GPs in the discussion groups again indicated they felt the videos were accusatory and rejected the notion that women generally aren't told about alcohol and pregnancy.

> *"I disagree with the video. It sounds like GPs aren't ready to talk to patients about not drinking but GPs are very happy to raise this issue." – GP.*

> *"Is she living in a vacuum?" – GP.*

Specialists and midwives tended to be more positive about the women's perspective represented in the videos and were more likely to feel it accurately reflected their experience that women aren't necessarily clear about the guidelines or given as much advice as they would like in relation to alcohol. The midwife group also felt reassured that patients would welcome and believe advice from midwives.

> *"What she is saying is pretty spot on, that she was told a bit in the beginning but since she hadn't been told anything more." – Specialist.*

> *"I'm always interested to see what patients think, particularly to find out what rubbish they have heard." – Specialist.*

As a note of caution, one midwife stated that 'Verity's video' connoted that it would be too late to have a conversation about alcohol after 20 weeks, which is when midwives in private hospitals typically see pregnant women.

Video: 'The Australian Medical Association's perspective'

Having a perspective provided by the AMA about the WWTK initiative was considered important by GPs and specialists. However, again, some GPs were critical of the information presented, particularly the references made to new research.

> *"It is unconvincing, we [still] don't know what safe levels are. They should be honest and say we think it is probably harmful – it would be OK to say that." – GP.*

Some also felt that the video was too long and could be further edited to provide a succinct overview of the initiative and the support given to it by the AMA. It was also recommended that the WWTK website link be always shown at the bottom of the screen, for those interested in finding out more.

> *"It is a bit long, but I think that it is good that it focuses on a reluctance to talk about it, that it is socially acceptable and a lot of people don't really talk about their drinking." – Specialist.*

Perspectives on the videos from training course participants

There was also some discussion of the videos as part of the online discussion boards with midwives and specialists who had participated in the online training, although there was not time to discuss each in detail.

There were again mixed views in relation to the videos. Some thought that the information presented was relevant and useful and that offering these along with the reading material provided a well-balanced and more engaging mix of learning formats. It was suggested that a key benefit of the videos was being able to see the different interview techniques recommended in the training being demonstrated in practice and to see that conversations about alcohol could be relatively quick and simple.

> *"Videos are very useful. I found the videos stimulating and presented more information in a clear manner." –Training participant (specialist).*

> *"...the videos were really good examples of how to approach women and motivational interviews techniques." – Training participant (midwife).*

However, there were criticisms. Some felt that they were too staged or stilted and others perceived them as too tedious, slow, and repetitive, resulting in some disengagement with the videos among both groups. Some specialists were frustrated that they couldn't choose to skip the videos.

> *"I didn't enjoy the videos, they seemed very staged and I felt the power imbalance between health professional and client uncomfortable." – Training participant (midwife).*
>
> *"I don't know if I found any of the videos particularly useful as they seemed a little choreographed and things aren't like that in real life interviews." – Training participant (midwife).*
>
> *"I did view the videos though, should cut them short as I found them very tedious." – Training participant (midwife).*

Online training program(s)

Evaluation objectives:

- Assess effectiveness of online training course content in improving health professionals' knowledge on the subject of alcohol and pregnancy and influencing future behaviours in this area.
- Assess effectiveness of offering continuing professional development (CPD) points as an incentive for enrolment and completion of the free online courses.
- Assess effectiveness of the promotional strategies used in attracting enrolments to the CPD courses.

This section evaluates the online pregnancy and alcohol training offered by the colleges in terms of its (self-reported) impact on knowledge and future behaviour. It also assesses the effectiveness of the offer of CPD points as an incentive and of the promotional strategies used to attract enrolments. This analysis takes into account course take-up data (enrolment and completion data collated by each of the colleges), data from the standardised training feedback forms distributed by the colleges (where available), evaluation survey data (awareness of the training courses among health professionals), reactions to the course descriptions among participants in the health professional discussion group (GPs and midwives) and interviews (specialists), as well as the findings from the two online training discussion boards conducted for this evaluation, comprising midwife and specialist course participants.

Note, that while many of the opinions and take outs from the training were similar across both midwife and specialist discussion boards, they did differ in some respects. Where this is the case, these differences are drawn out. The references to 'specialists' in this section includes registrar and resident obstetricians/gynaecologists who participated in the RANZCOG training discussion boards.

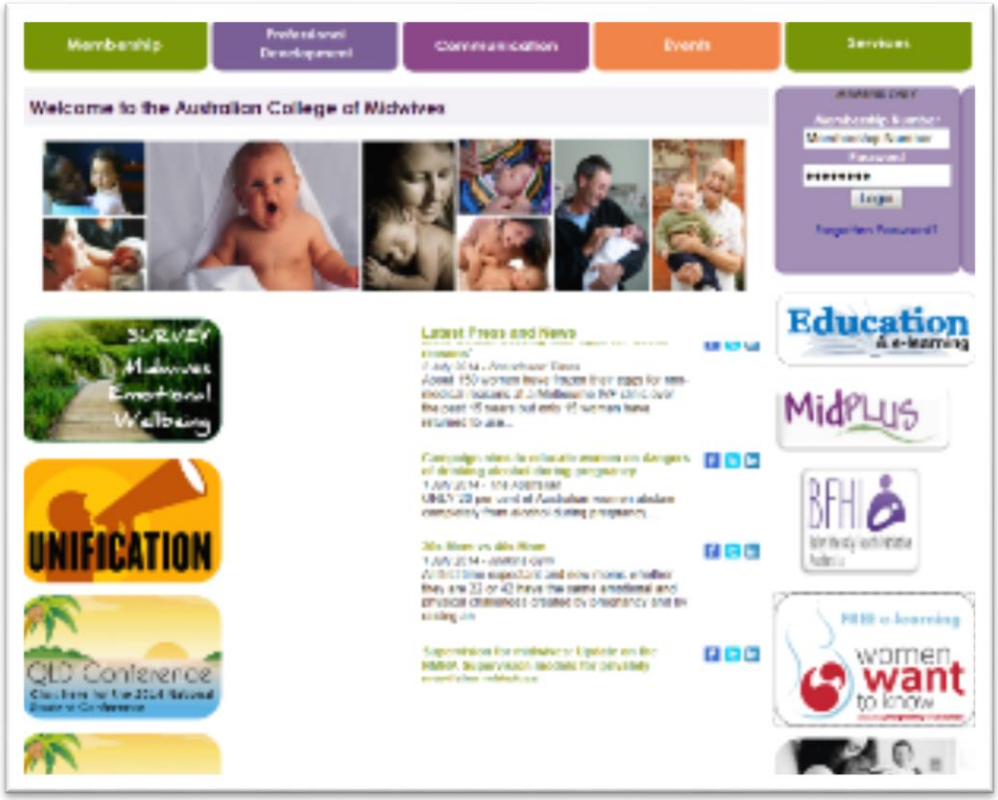
Take-up – enrolments and completions

The take-up findings are primarily based on analysis of the available enrolment and completion data collected by the three colleges (which is more detailed in some cases than others).

ACM training

The training course run by ACM was open to both members and non-members. Between its launch in July 2014 and March 2016, 922 individuals had enrolled in the course. Indicatively, this equates to

approximately four per cent of the 21,140[32] practicing midwives.[33] Of the 922 enrolments, 290 (31 per cent) had completed the full course. ACM CPD accreditation is claimed on an hourly basis, so CPD hours could still be claimed without completing the full course.



The number of completions was reportedly broadly on par with other standalone courses made available via the ACM (courses with a fee apparently tend to attract fewer enrolments, but a higher completion rate, so the actual number of completions tends to be similar). Up until April 2015 (when self-enrolments were introduced), the ACM was documenting whether enrolments were by ACM members or non-members. Up to this point, the majority (76 per cent) of enrolments were by members, but a significant minority (24 per cent) were non-members.

The ACM enrolment data was not broken down by whether training participants were fully qualified or students (or in any other role). However, based on indicative analysis based on those who volunteered for the online discussion boards and identified themselves as either student midwives or midwives, approximately one in eight were students.

RACGP training

The RACGP training was only available to members. As noted, take-up of this course was relatively low in comparison to the ACM course, with around 275 enrolments. Indicatively, this equates to

[32] According to the 2014 workforce report by the Australian Institute of Health and Resources.
[33] This proportion is indicative only, as the workforce figure is based on 2014 data and course enrolments were not limited to practicing midwives only (students and people in other health-related roles have reportedly participated in the training).

approximately one per cent of the 26,885[34] practicing GPs.[35] Of the 275 enrolments, there were 126 completions (46 per cent) between its launch on 6 August 2014 and 6 April 2016. Enrolments peaked in the first five months following the launch of the course (over which time, 124 members enrolled) and have remained fairly steady since then. The RACGP enrolment data was not broken down by whether training participants were fully qualified or students.

RANZCOG training

The training course run by RANZCOG was open to members and non-members. Between the launch of the course on 1 July 2014 and 31 March 2016, there were 261 member enrolments. Indicatively, this would equate to approximately 17 per cent of the 1,516[36] specialists *practicing* in 2014. However, as discussed below the majority of member enrolments were trainees rather than fellows. Based only on course enrolments by RANZCOG fellows, this equates to one per cent of practicing specialists.

[34] According to the 2014 workforce report by the Australian Institute of Health and Resources.
[35] This proportion is indicative only, as the workforce figure is based on 2014 data.
[36] According to the 2014 workforce report by the Australian Institute of Health and Resources.

Of the 261 member enrolments, there were just eight 'completions', defined as the completion of all six activities that make up the training resource. This equates to just three per cent of all members enrolling in the course.

There were also 650 guest (non-member) 'views' of the course (visits to the training page/s). However, as non-members were not required to enrol it is not possible to say how many actually participated in the course or to establish how many of these 'views' were unique visitors (as opposed to repeat visitors). Guest access to the training resources had two peaks: one at the time of release of the course and another in November 2014. Since then guest views have dropped slightly with minor peaks in February 2015, April 2015 and October 2015.

RANZCOG also collected completion data for each of the course modules (for member enrolments only), which shows that participants were most interested in accessing the aspects of the course covering, 'complex patient referral' (n=85) and 'alcohol consumption and breastfeeding' (n=92), as well as the course 'overview and objectives' (n=137). The modules on 'facilitating discussions about alcohol consumption with pregnant women' and the 'conclusions and more information' were somewhat less popular (n=60 and n=68 respectively). The least visited module was on 'the effects of alcohol consumption during pregnancy' (n=23). The qualitative research conducted for the evaluation indicated that health professionals were most motivated to do training in areas where they believed they had knowledge gaps and/or where there was new evidence and that specialists and GPs in particular tended to feel they understood the evidence about the impact of alcohol during pregnancy (discussed further below).

The majority of member enrolments were by RANZCOG trainees (n=193) and doctors undertaking the certificate of Women's Health, RANZCOG Diploma or RANZCOG Advanced Diploma (n=43), rather than

Fellows (n=9).[37] Further, analysis of the number of 'views' by members also reveals a peak approximately every six months (August 2014, February 2015, June 2015, January 2016). RANZCOG have suggested this may reflect the course being accessed more frequently when trainees are preparing for exams. This aligns with feedback from the discussion board participants – where the four registrars who contributed to the board reported that they had done the training as a study aid and as part of their revision process.

It is encouraging that the course attracted trainees, as it suggests that the content was viewed as useful and relevant to this audience. Further, once they become qualified the information and messages conveyed will hopefully impact on their practice as specialists.

However, going forward it will be important to encourage more practicing specialists to participate in the course by convincing this group of health professionals that WWTK is a valuable resource and that the content will be relevant and useful to them (as discussed below). This should help to ensure that the advice currently being given to patients aligns with the Alcohol Guidelines.

Effectiveness of training promotional strategies

Clearly the first step in encouraging take-up of training is raising awareness of its availability. Beyond this, health professionals must be convinced of the importance and utility of the training to them personally and/or incentivised to participate via other means (as discussed in the next section).

A variety of activities was undertaken to promote the training to the three key health professional groups. In summary, in the first phase of the WWTK project (from the launch of the training in July 2014 to September 2014) the training was primarily promoted by the colleges. In the second phase of the WWTK project (from mid-2015 to 2016), the three partner colleges again undertook promotional activities for their respective courses. In this phase, FARE also increased its focus on promoting the training specifically, in particular, producing two versions of a new creative focused solely on this, advertised via the Medical Journal of Australia during February-March 2016 and via Facebook from 8 March to 4 April 2016.[38]

The timing of these additional promotional activities means they are likely to have contributed somewhat to the levels of awareness of the training observed in the survey results described below (survey fieldwork commenced 11 March 2016), but it may be too early to assess the (full) impact of these activities on take-up.

The health professionals who participated in the online survey conducted for this evaluation were asked if they had "heard about the online e-learning course on Pregnancy and Alcohol with Continuing Professional Development (CPD) accreditation available for Health Professionals through RACGP,

[37] There were a further RANZCOG 16 enrolments stemming from the ad campaign launched on the 11 March but this data was not broken down by professional group.

[38] One version of this creative was advertised via the Medical Journal of Australia during February-March 2016, with two primary and three secondary message variations. The primary message was either 'Free accredited training' or 'Your Move'. The 'Your Move' message replaced 'Free accredited training' in March, to investigate whether the change in the call to action had any impact on click through rates (the ongoing impact of this change is being assessed by FARE). The three secondary message variations were 'She's pregnant, she's drinking', 'The occasional drink is ok, right?' and '1 in 5 continue drinking when pregnant'. Another version of this creative, with different imagery, was advertised via Facebook from 8 March to 4 April 2016 with the primary 'Your move' message along with secondary messages of 'She's pregnant, she's drinking', 'The occasional drink is ok, right?' or '1 in 5 continue drinking when pregnant'.

RANZCOG, ACM and other colleges?" As already mentioned, results show that one-quarter (24 per cent) overall had heard of the training. Awareness was significantly higher among specialists (43 per cent), perhaps as a result of the recent promotion of a prize draw for course completers.

As would be expected, given the relatively small number of enrolments in each course compared to the number of relevant health professionals in Australia, only a small proportion (two per cent) of the n=257 participating in the evaluation survey indicated that they had actually started or completed an e-learning course on pregnancy and alcohol (through RACGP, RANZCOG, ACM or other colleges).

Table 30: Awareness of online e-learning course on Pregnancy and Alcohol with CPD

	GPs (%)	Midwives (%)	Specialists (%)	Overall (%)
No, I have never heard about it	79	83	57	76
Yes, I have heard about it, but have not taken the course	18	16	**43**	22
Yes, I started the course, and I am part way through it	2	0	0	1
Yes, I have completed the course	1	1	0	1
Awareness/participation (net)	*21*	*17*	*43*	*24*
Unweighted n	*103*	*103*	*51*	*257*

Q39. Have you heard about the online e-learning course on Pregnancy and Alcohol with Continuing Professional Development (CPD) accreditation available for Health Professionals through RACGP, RANZCOG, ACM and other colleges?

Unweighted base: n = 257 for post-intervention survey, all respondents

Although promotional efforts appear to have had some success in raising awareness of the training among target health professionals, the majority in the survey could not recall having heard about the training on offer. Based on the promotional approach outlined in WWTK project documentation, health professionals who were not engaged with the colleges (as members or subscribers to the relevant college publications or mailing lists) were less likely to be exposed to this promotion than those who were not. Indeed, all of the RANZCOG training discussion board participants had heard about the training from the RANZCOG website (displayed as a banner) or through emails from RANZCOG. Similarly, midwives who had done the ACM training and participated in the online discussion boards had generally heard about the course through the ACM email updates or website (although, a few also mentioned having been informed the Australian Nursing and Midwifery Federation).

The WWTK communications strategy indicates that most of the target health professionals for the WWTK project are members of a professional college. Looking specifically at the membership of the three colleges that delivered the training, while only indicative due to the sample size, among the GPs or midwives who participated in the qualitative focus groups and interviews conducted for this evaluation only around half of the participants in the GP groups were members of RACGP and none of the ten midwives who took part in a discussion group or interview were members of the ACM. All of the six specialists interviewed were members of RANZCOG. According to the information available on each

organisation's website, RANZCOG membership in 2015 included 1,741 practicing fellows, RACGP has 32,000 members in total, including students, and ACM has around 5,000 members, including associates, graduates, students and consumers. Comparing these figures to the 2014 workforce report by Australian Institute of Health and Resources indicates that most GPs and specialists are likely to be members of RACGP or RANZCOG, as there were 26,885 practicing GPs and 1,516 practicing gynaecologists/obstetricians in 2014 (the 2014 RACGP annual report also indicated that eight out of ten GPs in Australia were members). However, comparing the number of practicing midwives (21,140 in 2014) to the ACM membership indicates that only a minority are members of that particular college.

Some of the stakeholders interviewed suggested that an ideal way to promote the WWTK project was through the engagement of champions and influencers, although they acknowledged that it was resource intensive and challenging to identify and engage potential champions. Therefore, it is encouraging that a few of the midwife training participants who contributed to the discussion boards reported that they had heard of the course from lecturers or clinical coordinators, who had encouraged them to participate.

It seems, however, that at least one opportunity to promote the training among a wider audience within the project scope was not fully maximised as only one of the four WWTK leaflets mentions the accredited training and this information is somewhat hidden away on the back page of the 'About the *Women Want to Know* project' (red) leaflet. There is also no mention that the training is free of charge. Given the importance of the training to the overall strategy, promotion of the training could have featured more prominently in these leaflets.

Motivators and barriers to take-up of training

Effectiveness of offering CPD points as an incentive

CPD points were offered as part of the strategy to encourage participation in each of the training courses. All registered GPs, midwives and specialists must undertake CPD[39] and they can earn CPD credits/points/hours through various sources. The CPD allocation for each of the WWTK training courses was dictated by the way the CPD scheme works for each profession. For example, midwives are required to complete 20 hours of CPD per year and the WWTK training provided by the ACM is expected to require an average of three hours to complete. As such, the certificate for completion of the course is worth three CPD hours. For both the ACM and RANZCOG courses, health professionals could claim CPD points even if they did not complete the course, based on the length of time they spent on it, whereas points could only be collected for the RACGP course upon completion. This may explain why the RANZCOG course description and publicity did not explicitly mention the provision of CPD points (if this applies to all RANZCOG courses).

The finding that fewer than half of those who enrolled for the RACGP course completed it is perhaps one indication that the CPD points were not the primary motivation for participation, given that points for that course could only be collected upon completion. It is apparently not unusual for GPs to use

[39] Australian Health Practitioner Regulation Agency (AHPRA). (n.d). *Continuing professional development*. Retrieved from: https://www.ahpra.gov.au/Education/Continuing-Professional-Development.aspx

training materials to collect the information they need from training without collecting the CPD points, so this is not unique to the WWTK course.

It is worth noting that an additional form of incentivisation was recently introduced by RANZCOG as part of phase two of the WWTK project. On 11 March 2016, the college began advertising a draw where members who completed its course would be entered into a prize draw to win an annual membership subscription. As of 31 March 2016, 16 RANZCOG members had enrolled in the course using the enrolment key provided in the ads and five had completed the course. This is a good result considering that a total of only eight people had completed the course in its entirety since its inception in 2014. As such, there would seem to be potential value in expanding this type of approach to the other two courses if possible, to encourage professionals to complete the whole course, as well as overall take-up. At the time of writing, a similar scheme is in the process of being organised by RACGP.

Among those who had chosen to do the course, factors other than the CPD points certainly seemed to be the primary motivators. Among the 19 midwives who participated in the online discussion boards, only a few indicated that CPD points had been one of their main reasons for doing the course.

> *"I decided to join up to do it last year, when I was keen for some CPD points" – Training participant (midwife).*

The majority of midwives said that the content of the course, and its relevance to their work, had been more motivating, expressing a keen desire to keep up to date with the latest evidence and learning strategies to educate pregnant women.

> *"CPD points did not have an effect on my decisions… I simply wanted to do further self-directed study." – Training participant (midwife).*

Midwives who had been practicing for some time saw the course as an opportunity to refresh and update their knowledge. While midwives who were returning from a break in the career felt that the course would be particularly useful in easing them back into the field and providing them with up to date knowledge of the topic.

> *"I felt the need to keep up to date on the latest evidence and strategies to educate and support women and their families." – Training participant (midwife).*

Others felt that this was an area that they needed to learn more about having had little experience to date. This was especially the case for newly qualified midwives.

> *"I decided to take part as it is an area that I did not have much experience in and wanted to learn more about." – Training participant (midwife).*

Similarly, the six specialists who participated in the online discussion board in relation to the RANZCOG training reported that CPD points had not been a motivator for course completion for them – and some had not chosen to collect the points they could have earned. Rather, four participated in the course to assist with their studies and the remaining two undertook the course because they wanted to get a better understanding of the issues around alcohol and pregnancy. Specifically, one specialist believed that the course would provide them with more knowledge on how to address uncertain areas within this topic for patients and the other did the course in order to make sure they were up to date with the research around the topic. As mentioned above, the challenge now is convincing more practicing specialists that the training content will be relevant and useful to them (see discussion on training content below).

Participants in the general health professional discussion groups (GPs and midwives) and interviews (specialists and midwives), none of whom had completed the training, were asked about their potential

interest in WWTK training on the topic of pregnancy and alcohol. The relevant course description was provided and the availability of CPD points and hours noted.

Reflecting the feedback provided by those who had done the training, there was a sense from the groups and interviews that, while the CPD accreditation for the WWTK training might be expected and/or 'nice to have', it would not be sufficiently motivating *on its own* to prompt health professionals to take up the course, especially for GPs and specialists who seemed to have a wide range of possible training options available to them.

Some of the midwives who participated in the discussion groups were somewhat more attracted by the fact that they could collect 'free' CPD points. This was appealing as they often had to pay for accredited training and their options seemed to be more limited, especially for those working in private settings (compared to one of the midwives working in a public hospital who said she was provided with access to day long in-house training courses run by the hospital). Even so, the prevailing view seemed to be that, regardless of the offer of CPD points or hours, health professionals would generally have to feel that the content of any course made investing their limited time worthwhile.

In terms of the content of the WWTK training, GPs and specialists tended to feel that they already knew as much as they needed to about the Alcohol Guidelines regarding pregnancy. That is, that no safe limit has been established for alcohol consumption during pregnancy and, therefore, the advice to give to pregnant women is that the safest option is not to drink alcohol. They also understood that higher levels of alcohol consumption had been shown to be associated with damage to the fetus. In addition, they were generally confident in their ability to pass on this advice to patients and to deal with any questions that might arise. The Alcohol Guidelines were no longer considered to have changed 'recently'. They explained that, given all this, significant new evidence would need to have come to light to make attending a dedicated training course on this topic worthwhile. In relation to pregnancy and alcohol, they seemed to be particularly interested in any new evidence about the impact of lower levels of alcohol consumption during pregnancy. GPs in particular explained that their knowledge has to be up-to-date across such a wide range of issues, and that they would rather spend their limited time on training where they felt there was real scope for their knowledge or understanding to be increased. One of the stakeholders interviewed for the evaluation felt that health professionals' choice of training (in general) might be influenced by which issues are receiving significant media coverage, as well as the emergence of new evidence and changes to guidelines.

Although the midwives who participated in the discussion group and interviews were also aware of the advice that pregnant women should abstain from drinking alcohol and that alcohol consumption could harm a developing fetus, they tended to be more open to the possibility that there was scope to increase their knowledge and understanding via the ACM WWTK training. They also thought that the training could help them with advice on ways to approach conversations with pregnant women about alcohol, which they felt could be sensitive. It is relevant to note that the discussion about the training occurred towards the middle of the conversation, after the midwives had seen the leaflets and been talking about the issue of alcohol during pregnancy for some time, and there was a sense that, as the discussion progressed, they had become gradually more open to the idea that they could have some role to play in influencing patients' decisions about alcohol during pregnancy (private sector midwives in particular felt this was outside of the scope of their role) and/or that there was more that they could usefully learn on the subject (although some key barriers still remained, as discussed below). Indeed, at the end of the group, the midwives commented on how useful it had been to come together with their peers to discuss an issue that they hadn't really had the opportunity to give much thought to previously, reinforcing the idea that there is an appetite for training on this subject among this group. However, had they simply

come across an advertisement for the training without this discussion around the topic, it is possible that their response may have been less enthusiastic.

> *"Now I feel like I would do it, now that I know more about it." – Midwife.*

In terms of the attractiveness of the online training format, there were mixed views. Some were open to undertaking training independently and liked the idea that they could update their knowledge at a time and a place that was convenient to them via an online course, so the WWTK training was attractive in this respect. Others were less keen on online training in general.

> *"I like multitasking – so if I can go to a lunchtime or evening session and eat when someone is talking to me. I like listening to things – I like the concept of an online course but would I do it… It would be one of those things that sits in my inbox and I just keep saying 'I'm too busy, I'm too busy." – Specialist.*

Some expressed a preference for face-to-face training and professional development events that offered them the opportunity to learn about a variety of topics or new developments, as well as the opportunity to meet others working in the field, rather than a course specifically on alcohol and pregnancy. And purely from the point of view of CPD accreditation, some felt it was easier to attend conferences or events that allowed them to accrue multiple points at a time, rather than many one-off short courses.

> *"I've decided to go to a conference this year so I can get all the points I need in one hit." – Midwife.*

Barriers to take-up of training – survey results

As would be expected, given the relatively low total number of enrolments nationally in the three online WWTK training courses, the majority of the online survey respondents who had heard about the training had not (yet) enrolled in it. When asked why in an open ended question, three quarters (75 per cent) of health professionals gave responses which indicated that they didn't take up the course due to lack of time. Other reasons provided as verbatim comments included professionals suggesting that they already felt comfortable talking to patients about alcohol consumption (six per cent) and feeling that they already had enough knowledge on the topic (12 per cent). A few examples follow below:

> *"Not enough time, since I found out about it, but will be doing so shortly."*

> *"Because of other commitments…I also have a sound knowledge of the dangers of alcohol consumption."*

> *"Haven't had time yet - it has been written on my "to do" list for ages!"*

Effectiveness of the training

As outlined in the methodology section, it was not possible to arrange for RACGP to send course participants an invitation to contribute to the evaluation and, in-line with privacy legislation, contact details could not be passed on directly to FARE or HPOM. In addition, only five GPs had completed a standardised course feedback form to date (too few for meaningful analysis) so it has not been possible to assess the effectiveness of the RACGP training course in a meaningful way as part of this evaluation.

The following analysis therefore relates only to the ACM and RANZCOG courses, based on the findings from the online discussion boards and the college feedback forms (although the latter was only available for the ACM course).

Feedback forms distributed and collected by the colleges

ACM shared the results of feedback from 300 participants who completed a course feedback form. The training was well received by those who responded, with just over a quarter (27 per cent) rating it as an 'excellent' course and a further half (52 per cent) rating it as 'very good'. Almost all (96 per cent) said they were likely to recommend the course to others.

When asked about the course content:

- 53 per cent reported that they will use the information in this package to enhance their practice
- 44 per cent reported that the package contained sufficient information
- 46 per cent reported that the course included sufficient reference to other resources to support their understanding.

However, smaller proportions indicated that the course made them feel more confident about the topic area (35 per cent) or that the content met their learning needs (39 per cent) and only 23 per cent agreed that the CPD activity reflection template assisted them to document their learning.

Self-reported impact on knowledge, attitudes and behaviour

Participants in the online discussion boards with training participants were asked what stood out from the training and what it was encouraging health professionals to do. Both groups felt that the clearest message was that health professionals should talk to patients who are pregnant or planning a pregnancy, as well as breastfeeding women, about alcohol and pregnancy and that this should be the norm.

Some of the reasons *why* it is important for health professionals to have these conservations also stood out as take-outs from the training. In particular, the message that women may not be aware of the Alcohol Guidelines around drinking and pregnancy, or the effects on their baby (and hence that it is up to health professionals to make sure they are equipped with this information). Additionally, the message that there is an expectation among women that health professionals will initiate conversations about alcohol, as this was something these health professionals said they had not generally previously thought about.

> *"Re-iteration of the highly important role that midwives/health professionals have to prompt and engage in open-discussion with women about drinking-habits." – Training participant (midwife).*

Among both the specialists and midwives in these online discussion boards, there were some who had previously believed that women were generally aware of the adverse effects of alcohol consumption during pregnancy. These participants felt that learning that women were not necessarily aware of these adverse effects was one of the most useful elements of the training. Through the training, they had come to feel that they had a responsibility to ensure that women are informed of the evidence that negative consequences may result from alcohol exposure during pregnancy. As illustrated by the comment below, some participants had been encouraged to challenge and reappraise some of their assumptions related to this.

> *"It was remarkable for me to learn that women are not generally aware of the adverse effects of alcohol consumption during pregnancy. It was extremely useful for me to realise that assuming that we are all aware of the risks of alcohol consumption represents a failing in addressing and dealing with the issue on my part… Seldom do women raise the issue themselves, I need to change my practice to include opportunities to discuss alcohol (and other substance use/abuse)." – Training participant (specialist).*

"I now realise how little many women know about the dangers and risks of alcohol in pregnancy/whilst breastfeeding, and how health professionals often neglect providing enough factual information about alcohol to women because possibly they assume the risks should be 'general knowledge' in the community. I know never to 'assume' women know about these risks and always ask the question." – Training participant (midwife).

"I learnt that imparting this information is my duty of care." – Training participant (midwife).

One midwife mentioned that it was particularly beneficial to increase their knowledge about a range of impacts of alcohol consumption, including FASD. Similarly, a specialist noted that it had been useful to learn more about what they described as "the more subtle impacts of [alcohol] consumption" and how these impacts differ from FAS.

"I have gained a great deal of knowledge from this course, specifically I found the following key education points most beneficial…Outline of the negative evidence-based consequences of alcohol consumption in pregnancy to the mother and baby (increased risk of miscarriage, stillbirth, low birth weight, brain damage, defects, and foetal alcohol spectrum disorders) which women are frequently unaware and misinformed about." – Training participant (midwife).

"From the course, I would assume that some women believe that irregular drinking binges are not as dangerous as regular heavy consumption - but it was useful to learn that even occasional heavy binges can have negative impacts. It was also useful to differentiate Fetal Alcohol Syndrome from the more subtle impacts of consumption." – Training participant (specialist).

A few midwives and specialists recalled the advice to use the 5As and/or the AUDIT C assessment and believed that these were great tools to utilise when assessing the level of drinking among pregnant women.

Several also took away the importance of using a non-judgemental open-ended patient counselling approach and indicated that the training had helped to equip them to do this.

"'What stood out is the focus on the importance of information giving, counselling and individual patient assessment." – Training participant (specialist).

"I learnt that imparting this information is my duty of care, and how to be able to ask the questions in a less judgmental way, making it sound far more like routine based care." – Training participant (midwife).

"The approach to asking women the difficult questions and the motivational interviewing was the most useful information, and the standard drinking schedule." – Midwife.

"It was very helpful in guiding me about how to start a conversation with pregnant women. I have no hesitation now and I know a step by step approach." – Specialist.

Among the midwives some had found the information about what constitutes a standard drink helpful, especially those who did not themselves drink alcohol, and felt that there was an existing gap in their knowledge prior to participating in the online training.

"I don't drink alcohol so I am not familiar with what constitutes a standard drink in Australia, so I found this information very interesting and important." – Training participant (midwife).

However, while most of the participants indicated that they agreed with everything that was presented in the training, a few midwives remained unconvinced when it came to the advice that, during breastfeeding, there is 'no safe level of alcohol'. While no one disagreed with the advice in relation to

pregnancy, these midwives still felt that the occasional drink during the breastfeeding stage would not cause any harm.

> *"... I didn't agree with the fact that there was no safe level of drinking when breastfeeding and it should be completely discouraged – this part of the course was too brief." – Midwife.*

> *"I just think that a blanket rule of there is no safe level of drinking whilst breastfeeding will make women feel guilty for having the occasional drink as the baby gets older." – Midwife.*

One specialist also challenged the idea that all 'women want to know'. While they accepted the research that showed 97 per cent of women would like to be informed about alcohol consumption during pregnancy, they felt that there needed to be acknowledgement that this left three per cent who would feel uneasy and not be open to discuss this, hence, to account for these rare cases, health professionals would still need to approach asking the question carefully.

It was suggested by some in the online discussion boards that the WWTK project should ideally be accompanied by a public awareness raising campaign, to counter some of the outdated and conflicting advice being given to women:

> *"It would be great if the public on the whole became more aware of the issues around alcohol in pregnancy so that women weren't being given conflicting advice from their loved ones prior to contact with health professional…. idea about social media is a really good one." – Midwife.*

Self-reported impact on behaviour

Participants in both online boards with training participant said they found the information about the tools available to assist health professionals useful and a number were not aware of the existence of these tools before they had done the online training. One specialist noted that the 5As provided health professionals with a structured framework to support them in having a conversation about alcohol and that the Audit-C tool is useful as it is an objective and validated assessment tool. The examples of advice that could be given to patients who received a score at the higher end of the scale were cited as particularly useful. Some of the midwives commented that the 5As tool was explained and demonstrated so well in the training that they now felt comfortable using the tool in practice.

> *"Most useful for me was Audit-C in practice, it gave me good examples on how to broach the topic for those who score higher on the quiz." – Training participant (midwife).*

Crucially, a number of midwives and specialists indicated that the training had led to them initiating more conversations with pregnant women. This was due to them feeling more comfortable in having these conversations with their patients, after the training gave them the tools, knowledge and the confidence to initiate conversations about alcohol and to carry them through. Advice on how to ask questions about potentially sensitive topics, motivational interviewing techniques, and how to ensure that the patients felt comfortable and empowered (rather than threatened) had contributed to this.

> *"The course encouraged me to systematically ask all ladies about alcohol usage." – Training participant (specialist).*

> *"I now have confidence when asking the information and then feel confident about the education around the topic." – Training participant (midwife).*

> *"I feel that this training has helped me have more confidence and [feel] more prepared to provide brief interventions with women to increase their confidence and readiness for change." – Training participant (midwife).*

"I am now more likely to specifically ask patients [about alcohol] and [to] try to keep it relaxed so that the patient feels comfortable." – Training participant (specialist).

One of the specialists explained that simply being made aware of RANZCOG's endorsement of the message that pregnant women should abstain from alcohol would help them to broach the subject with women and give the message itself greater authority.

"The course is important because I can now say to my patients that the college endorses not [drinking] alcohol" – Training participant (specialist).

A few midwives felt that the training did not lead to any change in their behaviour, because they had always had conversations around alcohol and pregnancy with pregnant women. However, they felt the training provided them with more knowledge and understanding on the topic which in turn increased their confidence in having these conversations.

Finally, one midwife mentioned that, as a direct result of her participation in the training, she had arranged for all women attending a booking-in appointment at the clinic where she worked to be given the patient leaflet on alcohol in pregnancy.

"After I completed the course I arranged for the brochures to be available in our clinics, therefore as a result we give it to all our women when completing the pregnancy booking appointment when discussing the alcohol information." – Training participant (midwife).

In summary, the midwives and specialists who took part in the discussion boards were largely positive about the content of the training, finding at least some of the information useful. Some had been prompted to question their own long-held beliefs about alcohol consumption during pregnancy and a number indicated that they had begun to initiate more conversations as a result of the training and/or felt more confident in having such conversations. Most indicated that they would recommend it to their colleagues. They suggested it would be relevant to a wide range of professionals working with pregnant or breastfeeding women, for example, including: GPs, nurses, midwives, specialists, fertility specialists and any others involved in antenatal or prenatal care, as well as students/trainees in any of those areas and public health and early childhood workers.

Training format

Midwives and specialists were generally happy with the online format, which allowed them to work through the materials at their own pace and they liked the course being broken down into distinct sections, which were easy to navigate.

"I loved that I could do at my own pace and in my own time." – Training participant (midwife).

Related this, as already discussed, usage data collected by RANZCOG indicated that specialists were taking what they felt they needed from the training, by choosing to engage with some sections and not others. However, while this may be convenient, and reportedly not out of keeping with how other training resources offered by the colleges are used, this could potentially result in important information or advice being missed.

Among both specialists and midwives there was feedback that the provision of a range of materials helped to make the course more stimulating, including assessment/screening tools, reflections, questions, and videos, as well as reading materials.

"I think that the module is well branded, with user-friendly layout and engaging content." – Training participant (specialist).

> *"Very useful resource which combines the theory and evidence with practical assessment tools and tips on how to give actual advice in a clinical consultation about perhaps an uncomfortable/taboo topic for some… As far as I know there are no other such resources out there so it's a great imitative and should be strongly encouraged for all health practitioners who are involved in pregnancy counselling and pregnancy care." – Training participant (specialist).*

However, a few issues were raised. The specialists tended to feel that the pace of the training was too slow and suggested that there was potential for some topics to be condensed. There was also some frustration that the format did not allow viewers to move on before all the text was read out, or for videos to be skipped. This reflects feedback from one of the stakeholders that health professionals tend to be quick and targeted learners, having become used to having to absorb information on a wide range of topics in relatively short periods of time.

> *"Easy lay out but some slides were quite slow - certain slides could have been condensed or removed." – Training participant (specialist).*

> *"…[it] takes a long time to go through all modules – I found I could read faster than the modules were spoken..." – Training participant (specialist).*

As already discussed, a number of criticisms of the videos were made, resulting in some disengagement with these among both groups. However, there were those who thought that offering the videos alongside the reading materials provided a well-balanced mix of learning options. It was also suggested that a key benefit of the videos was being able to see the different interview techniques being demonstrated in practice and to see that conversations about alcohol could be relatively quick and simple to execute.

In addition to addressing these issues, a handful of participants offered suggestions for improvements, including:

- making sure a link to download the materials is easily visible and clear
- providing not just WWTK leaflets, but also a summary of the training and dot points to hand out to patients, or a text or PDF version of the training to print out and go through
- add a quiz or revision questions at the end of the training
- greater recognition of culturally and linguistically diverse patients, and how to address cultural and religious differences.

CONCLUSIONS AND RECOMMENDATIONS

This section provides a summary of the key conclusions and recommendations drawn from the evaluation. It may be possible to implement some of these recommendations during the remainder of the current WWTK project. Others will be relevant for informing best practice for other preventive health projects or any future iterations of WWTK.

Objective: assess level of awareness of campaign and engagement with the resources

Administrative data shows that the promotional activities were successful in driving visitors to the website in significant numbers, as well as prompting requests for relatively large number of printed copies of the WWTK leaflets. The direct mail-out should have reached roughly up to half of the practicing GPs in a best-case scenario. There was no equivalent mass mail-out to midwives or specialists but they may have received printed copies via the orders placed by health services and hospitals, as well as through conferences. Health professionals may also have been alerted to the resources on the website by the various journal articles and adverts, although these are presumably more likely to have been seen by professionals who are most engaged with these types of publications.

Overall, 14 per cent of health professionals surveyed for the evaluation recalled having seen the videos or leaflets. Among those who were aware of the leaflets, almost half (48 per cent) indicated that they had personally read at least one of them, which equates to five per cent of all of the health professionals surveyed. Health professionals tend to be time-poor and are bombarded with large volumes of information on a day-to-day basis. As such, it is very challenging for promotional activities to 'cut through' to this audience. Taking this and the scope of the project into account, the reach and engagement achieved by the WWTK project is encouraging.

The gap between the end of the first round of funding for the project (for the period 2012-2014) and a second round of funding being granted in July 2015 meant that there was a significant gap in promotional activities. It took some time to re-engage Working Group members, partners and other stakeholders, who understood that the project had come to an end in 2014, and to get a new round of promotion underway. It should therefore be acknowledged that recall of the WWTK resources (and the leaflets in particular) might have been higher had the evaluation survey been conducted immediately following the completion of the first phase of the project or indeed had the promotional activities been maintained throughout 2015.

Recommendations

1. Funding for similar health promotion projects should ideally allow for the ongoing promotion of any resources developed (from the outset), to allow their full potential impact to be maximised by building up momentum.
2. Continue the phase two approach of focusing promotional efforts on increasing the take-up of training in particular, as the evaluation adds support to the hypothesis that the training is more effective than written resources in isolation.
3. Promotion through conferences should focus on securing speaker places that allow the key messages of the project to be conveyed to an engaged audience (the timing of the additional funding meant that some deadlines for conference abstracts were missed in phase two) – this is likely to be more effective than simply providing health professionals with leaflets, given the amount of written

material that tends to be provided at these events and health professionals' limited time to engage with such resources.

4. Although it was out of scope for the WWTK project, efforts to raise awareness of the Alcohol Guidelines for pregnancy and breastfeeding among health professionals should ideally be complemented by a campaign to raise awareness and understanding of alcohol and pregnancy among the wider population. Such a campaign would help to counter common misconceptions and anecdotal evidence, as well as and reinforce the advice being given by health professionals.[40]

Objective: assess any change in HPs knowledge, attitudes, comfort and behaviour in discussing alcohol with pregnant women

The evaluation survey showed that there were few statistically significant changes between the benchmark and post-project survey in health professionals' knowledge, attitudes, comfort and behaviour in relation to discussing pregnancy and alcohol with patients. One of the positive shifts of note was the decrease in the proportion of GPs and specialists reporting that they were unaware of the NHMRC Alcohol Guidelines (from 31 to 20 per cent and 30 to 14 per cent respectively). As we are not aware of any other national awareness raising campaigns to promote the guidelines among either health professionals or indeed the general population, it seems reasonable to conclude that the WWTK project at least played a role in this. There was also an increase in the proportion of GPs that rated brief interventions as 'very effective' in assisting pregnant patients/clients (in general) to modify their alcohol consumption (from 59 per cent to 72 per cent).

Regardless of the appropriateness of the resources, this lack of significant change was to be expected given the low recall and participation. Only 15 per cent of survey respondents could recall having seen the leaflets, videos, or participating in training on this topic. Although this level of awareness is a positive in the context of the project scope, it is unlikely to be sufficient to show any significant change at the overall target population level.

Although it remains a problem that around one in seven health professionals surveyed admitted that they did not routinely ask pregnant women about their alcohol consumption, the arguably bigger issue is that when advice was given, it did not *consistently* reinforce the Alcohol Guidelines. For example, the qualitative elements of the evaluation revealed that there was a tendency for health professionals who did inform pregnant women of the guideline advice, to (inadvertently) undermine this by indicating that the occasional drink probably isn't harmful, if asked. Similarly, when survey respondents were asked what advice they generally gave to women about alcohol consumption during pregnancy, around one in five (19 per cent) in total had given various types of advice which could potentially undermine the Alcohol Guidelines,[41] including eight per cent that reported they had given advice indicating that a small amount of alcohol occasionally was reasonable. This related to the finding that, just over one in ten GPs and specialists (and three per cent of midwives) still believed that one or two drinks per day could be

[40] A separate survey, conducted by FARE (*Annual alcohol poll 2014*) rather than directly as part of this evaluation, among women who had been pregnant or breastfed a baby, found that 15 per cent of women believed that 'drinking while pregnant is ok in moderation' and a further one percent believed that 'drinking while pregnant is not harmful to the fetus'.

[41] For insatance, to cut down/minimise amount of alcohol, to avoid alcohol during the first trimester, not to binge drink, to limit alcohol consumption to one standard drink per day and a small amount of alcohol occasionally was reasonable.

safely consumed without any risk to the fetus. There was also evidence from both the survey and the qualitative elements of the evaluation that health professionals tend to think about alcohol consumption during pregnancy in the context of the harm that can be caused by high levels of drinking, rather than the possible impact of lower levels of drinking.

Recommendations

5. Continue efforts to raise awareness among health professionals that there is no evidence that low levels of alcohol consumption are safe during pregnancy and that this is the basis for the current guidelines (if evidence emerges which demonstrates that a low level of consumption does cause harm then this should certainly be a key focus of future projects/campaigns).
6. Related to this, focus efforts on convincing health professionals of the importance of giving a message that is always consistent with guidelines, including on occasions when they are asked for their own personal opinion, for example about whether the occasional drink, such as on 'special occasions' is acceptable. Ensuring that correct advice is consistently given is arguably even more important in the immediate future than encouraging health professionals who do not initiate conversations with pregnant women about alcohol to do so.

Objective: assess the appropriateness of resources developed during the campaign

The survey results show that, at an overall level, the WWTK materials were positively received by most, though not all, of the 37 health professionals who recalled seeing them. Almost three in five reported that, as a result, they had initiated conversations or had more conversations with women about alcohol consumption during pregnancy. Just over half reported that they [now] advised all pregnant women not to drink alcohol during pregnancy, and around four in ten reported that their conversations with women about alcohol consumption during pregnancy were more effective and/or more detailed/in-depth. However, the resources appeared to have made less of an impact in terms of encouraging the use of the 5As and AUDIT-C tools (14 per cent and five per cent respectively) and one in five stated that their behaviour had not changed as a result of seeing the materials.

There was mixed reaction to the WWTK materials when presented in the group discussions and in-depth interviews with health professionals. Positively, most felt the leaflets presented useful information and the leaflet for women in particular was seen as a useful tool to support and further explain the advice given by health professionals. These discussions also indicated that the materials would, in some cases, have some positive impact on health professionals' propensity and confidence to talk with pregnant women about alcohol and many, especially midwives, felt reassured that it was a topic that women wanted to hear and learn more about. However, as in the quantitative survey, this was not universally the case (especially among some GPs and specialists) and there is certainly scope for improvements to be made. Many believed that the information needed to be made more succinct and to present the key messages in such a way that they stood out and could be more readily taken on-board by both busy health professionals and pregnant women.

In addition, some GPs and specialists continued to express concern over the lack of 'hard' evidence and conclusive research about the impact of lower levels of alcohol on the unborn baby across all of the materials. Some even felt affronted and defensive about the implication they perceived in some of the videos in particular that health professionals were not advising pregnant women about alcohol or giving the wrong advice. They certainly did not feel encouraged to reflect on or alter their own practice. It is feasible that the reaction may have been different if the videos had been seen by GPs in the context of the training, but, as it was not possible to contact RACGP training participants for the evaluation, this could not be explored.

It is important to note that while feedback on the WWTK resources was sought from the Working Group as part of the first phase of the WWTK project, this comprised senior and highly engaged health professionals and the resources were not formally 'concept tested' with the broader target audience of health professionals (this was reportedly discussed but not pursued due to budgetary constraints).

Recommendations

7. Given that the various target groups for the WWTK project tended to react differently to the resources (with midwives in particular tending to react more positively than GPs and specialists), any future campaigns should consider developing separate materials that specifically target the needs of each of the main target groups of health professional groups.
8. Draft materials should be tested with their target audience – in this case 'grassroots' health professionals and women of childbearing age, to make sure they are as effective as possible. This important stage of resource development should also be taken into account when projects are funded).
9. In future projects, given the high volume of written materials that health professionals need to process in their day-to-day practice and the understanding that such materials can only achieve so much when received as standalone resources, written materials should ideally be condensed to fit into one resource. This should focus on conveying: the most important message(s), clear call(s) to action and clear motivator(s) for the call(s) to action, along with a few key pieces of information, plus signposts to additional information. More specifically, it is suggested that a condensed leaflet could most usefully include the following (these suggestions would require further development and testing among the target audiences – and the messaging ideas are for illustrative purposes only):

    - Key message territories – a significant proportion of women believe that drinking while pregnant is ok in moderation and/or are not aware of the Alcohol Guidelines, and the vast majority want and expect health professionals to discuss alcohol with them.
    - Call to action – always advise women that the safest option is not to drink any alcohol when pregnant or trying for a baby: "don't mix your messages like people mix their drinks – even occasional drinking is never ok". This could possibly also be coupled with the direct advice to initiate a conversation about alcohol with all women who are pregnant or planning a pregnancy.
    - Call to action – sign up for free CPD accredited training, which will provide even experienced practitioners with more information about the evidence underpinning the Alcohol Guidelines, and help them hone their skills in talking to women about this potentially sensitive issue.
    - Information:
        - summary of the 5As
        - summary of evidence underpinning the Alcohol Guidelines – ideally split into the evidence relating to low (for instance, no evidence that this is safe), moderate and high levels of consumption (evidence of harm)
        - brief explanation of and link to an online version of the AUDIT-C tool, positioning it as an assessment tool for all pregnant women (not just 'problem drinkers').
10. It is suggested that the WWTK videos are best retained for use within the context of training or conference presentations and perhaps only promoted more widely to midwives (as the videos were best received by this group).

11. Consider whether the AUDIT-C questions could be built into the standardised questionnaires/checklists often used by health professionals to collect info about a range of lifestyle factors. And/or consider whether health professionals could be remunerated for assessing an individual's alcohol consumption and delivering a brief intervention, via MBS payments. This latter option was assessed as unfeasible within the budget and time constraints of the WWTK project as part of the early development process.

Objectives: assess the effectiveness of offering continuing professional development (CPD) points as an incentive for enrolment and completion of the free online courses and the effectiveness of the promotional strategies used in attracting enrolments

Promotional efforts have had some success in raising awareness of the training among target health professionals, as around one-quarter of the survey participants could recall having heard about the training on offer.

There were also 922 enrolments in the ACM course and 290 completed it. However, there were fewer enrolments in the other two courses: around 275 enrolments for RACGP (which was only available to members) and (126 completions) and 261 member enrolments for RANZCOG, with just eight member completions. Although in the case of RANZCOG there were also 650 guest (non-member) 'views' of the course (that is, visits to the training page/s). Most participants in the RANZCOG course were trainees rather than fellows.

However, as the training is core to the WWTK strategy take up would ideally be higher. In terms of the promotion activities, it is notable that only one of the four WWTK leaflets mentions the accredited training and this information is somewhat hidden away on the back page rather than being front and centre. Also, in phase one of the project the training appears to have been mainly promoted by the three professional colleges, making it more likely that members of these colleges would have heard about the training than non-members. While analysis of available health professional workforce and college membership data indicates that the majority (though not all) GPs are likely to be members of RACGP, only a minority of midwives are likely to be members of ACM. It is noted that the training is, in phase two, already being promoted directly by FARE as well as the colleges. Also, an additional form of incentivisation for course completion, introduced by RANZCOG in March 2016, in the form of a prize draw for membership, appears to have already had some success in boosting the number of enrolments and completions.

Feedback from course participants and other health professionals who participated in the evaluation, as well as analysis of completion rates, indicates that although CPD points/hours might be expected by health professionals and/or considered 'nice to have' (especially among midwives), this form of incentivisation was not sufficiently motivating on its own to prompt most health professionals to take up the WWTK training.

The perceived relevance and importance of the overarching topic for day-to-day practice and for study purposes (for trainees) was more important. The challenge is that practicing GPs and specialists who took part in the discussion groups and interviews tended to feel that they already knew as much as they needed to about the Alcohol Guidelines and the evidence underpinning them and were sufficiently confident in their ability to pass on what they saw as a relatively straightforward message to patients. Given this and the wide range of topics they needed to understand (especially GPs), they did not feel that there was a real need for them to take part in a dedicated course on pregnancy and alcohol, unless there was significant new evidence about its impact.

Midwives in the focus group and interviews tended to be much more open to the possibility that there was scope to increase their knowledge and understanding of issues related to pregnancy and alcohol via training. These findings were also reflected in the quantitative survey results. For example, a lack of training was more often cited by midwives than GPs or specialists as an issue which cited made it difficult for them to discuss alcohol consumption in pregnancy with their patients/clients.

While CPD accreditation on its own did not appear to be sufficiently motivating to prompt health professionals to take up the WWTK courses, it was suggested that endorsement from the professional college gave the key WWTK message (that pregnant women should abstain from alcohol) greater authority.

Recommendations

12. Encourage more practicing health professionals (as well as trainees) to participate in the WWTK training course by convincing them that the content will be relevant and useful to them. For example, by utilising the emergence of any significant new evidence as a motivator.
13. Where possible, consider tailoring materials to promote the training specifically towards the training needs and motivators of midwives and GPs/specialists separately. For example, midwives may be more motivated by promotional materials for training which focus on increasing understanding of alcohol and pregnancy, and advice on having conversations about this with pregnant women about alcohol. While GPs/specialists may be more motivated by a focus on staying up-to-date with new research findings relating to the impact of alcohol during pregnancy.
14. Ensure promotional activities aimed at midwives are targeted to reach as many midwives as possible who are not members of the ACM, as well as members. For example, this might include continuing and expanding efforts to engage directly with representatives from relevant hospital departments and healthcare settings to promote the importance and utility of the training and, if feasible within the available budget, via direct communication with health professionals (for instance, via relevant mailing lists, if available).
15. If budget allows, continue to investigate and utilise options to offer some face-to-face training to supplement the online training as and when opportunities arise. Ideally this would include events where training on multiple topics is provided, such as conferences and in-hospital training sessions, to reach health professionals who are less likely to choose to take part in a standalone course on this topic or who prefer a face-to-face approach.
16. Continue to offer CPD accreditation for course completion, but also investigate the addition of other incentives, such as the competition recently introduced for participation in the RANZCOG training.[42]
17. Continue to offer the training free of charge (this was particularly attractive to midwives).

[42] At the time of writing a similar scheme was also being developed by RACGP.

Objective: assess the effectiveness of online training course content in improving health professionals' knowledge on the subject of alcohol and pregnancy and influencing future behaviours in this area

Analysis of the feedback forms shared by ACM and the findings from the discussion boards with RANZCOG and ACM training participants indicates that the training was well received.[43] These participants generally felt that the training had increased their knowledge and gave responses which indicated that key messages had been effectively communicated. Some had been prompted to question their own long-held beliefs about alcohol consumption during pregnancy and a number indicated that they had begun to initiate more conversations with pregnant women as a result of the training and/or felt more confident in having such conversations. Most also indicated that they would recommend it to their colleagues.

While some suggestions for improvements were made, there was also feedback that the provision of a range of materials helped to make the course more stimulating, including assessment/screening tools, reflections, questions, and videos, as well as reading materials.

Module completion data collected by RANZCOG indicated that specialists were taking what they felt they needed from the training, by choosing to engage with some sections and not others. However, while this may be convenient, and reportedly not out of keeping with how other training resources offered by the colleges are often used by busy health professions, this approach could potentially result in important information or advice being missed.

Recommendations

18. Ensure that any new evidence is incorporated into the WWTK training course materials as swiftly as possible, especially about the effects of low level and/or moderate levels of alcohol consumption in particular. Not only is it important for health professionals to be made aware of new evidence as it arises, but this would also provide motivation for participation in the training.
19. In future health promotion projects, aim to ensure that relevant permissions are in place from the outset to allow all relevant target audiences to be taken into account in evaluation findings. In this case, it was not possible to arrange for RACGP to send course participants an invitation to contribute to the evaluation and, in-line with privacy legislation, contact details could not be passed on directly to FARE or HPOM, without the relevant permissions having been sought from participants.
20. Investigate the possibility of offering additional incentives, such as the RANZCOG prize draw, for full completion of training, as already noted.

[43] It is important to note that the views of participants in the RACGP training are not represented in this analysis, as they could not be included in the evaluation.

APPENDIX

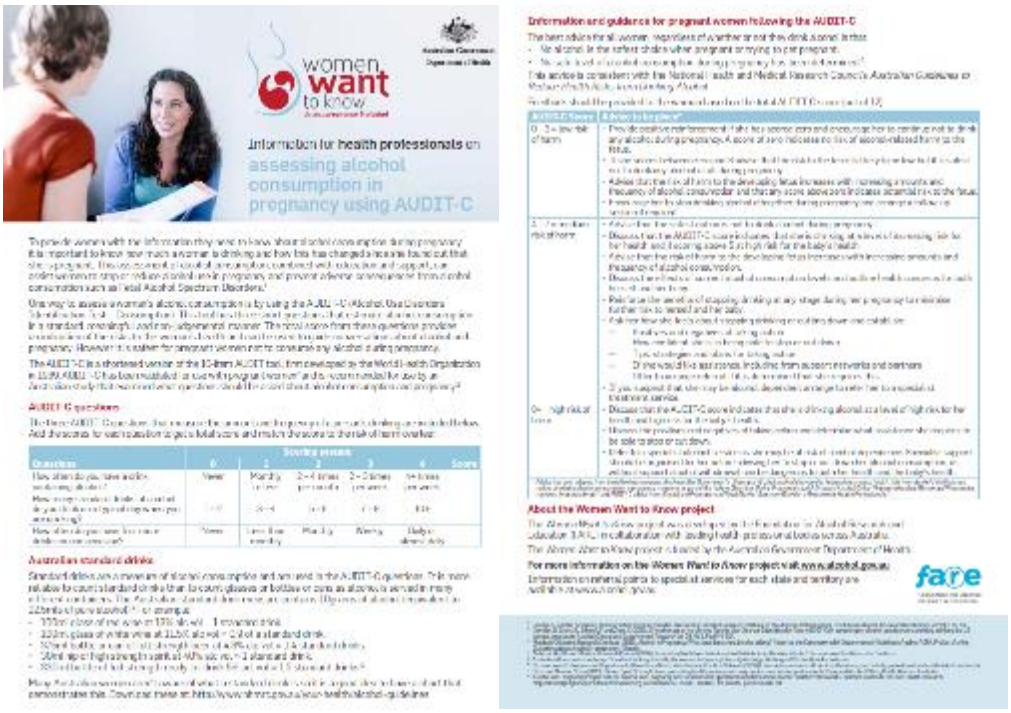
WWTK resources

This section includes all the resources evaluated as a part of the WWTK evaluation project.

- **Print resources**
- **Video resources**
- **Online training resources**
- **Post –intervention survey questionnaire**

PRINT RESOURCES

1. A leaflet on assessing alcohol consumption in pregnancy using AUDIT-C



2. A leaflet for health professionals on pregnancy and alcohol

3. A leaflet for women on pregnancy and alcohol

Pregnancy is an exciting time. It's a time when many women want to know what they can do to ensure that they and their baby are healthy.

One thing that is known to be key in keeping you and your baby healthy is to avoid drinking alcohol while pregnant, planning pregnancy or breastfeeding. This leaflet will help you make an informed choice and provide the best advice for you and your baby.

This advice is consistent with that provided by the National Health and Medical Research Council, Australia's leading expert organisation on the development of national health advice and guidance.

When you are pregnant or planning pregnancy, not drinking alcohol is the safest option.

The National Health and Medical Research Council recommends that for women who are pregnant, planning pregnancy or breastfeeding not drinking alcohol is the safest option.

This is because no studies have found a safe level of alcohol consumption during pregnancy where damage may not occur.

Drinking alcohol during pregnancy can affect the unborn baby and increase the risk of miscarriage, lower birth weight, stillbirth and premature birth. Alcohol can also harm the development of the baby's brain and physical growth and some babies exposed to alcohol may be born with conditions known as Fetal Alcohol Spectrum Disorders or FASD. This is a term used to describe a group of conditions caused by alcohol use in pregnancy. Most children with FASD don't look different but can have a range of problems including brain damage, physical and emotional developmental delays, learning problems such as poor memory, being impulsive and having difficulties in controlling their behaviour.

When you are planning a pregnancy, it is also important to be aware that alcohol can reduce fertility in both men and women. Alcohol can greatly increase the time it takes to get pregnant and affect the quality of men's sperm and women's eggs. If you are trying to get pregnant you should consider not drinking alcohol at all.

If you have consumed alcohol while pregnant and are concerned, or are having trouble stopping drinking, you should talk to your doctor, midwife or obstetrician.

Many women don't know exactly when they become pregnant and many pregnancies are not planned and so it is possible that you might have been drinking alcohol before you were aware of your pregnancy. It is important to remember that it is never too late to stop drinking alcohol during pregnancy and the safest option is to be alcohol free during pregnancy or when breastfeeding. If you are finding it difficult to stop drinking or are concerned you should speak to your doctor, midwife or obstetrician for support and advice.

Speaking to a health professional about your drinking may seem daunting. It is important to remember that health professionals speak to lots of people about these issues. Ultimately, they want the best for you and your baby. It is also important to talk to someone if you think you might be struggling with depression, stress or anxiety. Your health professional can refer you to services in your area to support you and your baby to be healthy.

Not drinking alcohol is also the safest option when breastfeeding.

Alcohol enters the breast milk and may stay there for several hours. Alcohol may affect milk production and this can cause babies to eat less and sleep less. Alcohol can also affect the baby's brain and spinal cord development which continue to grow after birth.

The Australian Breastfeeding Association recommends avoiding alcohol in the first month after birth until breastfeeding is well established. When a more regular feeding pattern is established you may be able to have alcohol between breastfeeds if you plan ahead and allow enough time for the alcohol to exit your system.

4. A leaflet on the Women Want to Know project

The Women Want to Know project

The Women Want to Know project encourages health professionals to routinely discuss alcohol and pregnancy with women and to provide advice that is consistent with the National Health and Medical Research Council's Australian Guidelines to Reduce Health Risks from Drinking Alcohol (Alcohol Guidelines).

In 2009 the Alcohol Guidelines were updated and the information on alcohol and pregnancy was revised. The revised Alcohol Guidelines specified that 'Maternal alcohol consumption can harm the developing fetus or breastfeeding baby' and 'For women who are pregnant or planning a pregnancy, not drinking is the safest option' and 'For women who are breastfeeding, not drinking is the safest option'.[1]

Development of the Women Want to Know project

The Women Want to Know project was developed by the Foundation for Alcohol Research and Education (FARE) in collaboration with leading health professional bodies across Australia and was supported by funding from the Australian Government Department of Health.

The project Working Group included the Royal Australian College of General Practitioners (RACGP), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Australian College of Midwives (ACM), the Australian Medical Association (AMA), the Australian Medicare Locals Alliance (AMLA) and the Australian Government Department of Health. A consumer representative from the Maternity Coalition was also involved in the project development.

[1] National Health and Medical Research Council (2009), Australian Guidelines to Reduce Health Risks from Drinking Alcohol, Canberra: Commonwealth of Australia.

The Women Want to Know project includes two main components:

1. Resources to support health professionals to discuss alcohol use and pregnancy with women; and
2. Associated training to provide health professionals with information and tools to enable them to discuss alcohol and pregnancy with women.

Information on each of these is provided in the following sections.

Resources to support health professionals

The Women Want to Know project includes a range of online and print resources to support health professionals in discussing alcohol use and pregnancy.

Women Want to Know Website

The website www.alcohol.gov.au is a consumer site with information about the project, including specific information for health professionals and women. The website also includes links to 'tool' websites that demonstrate ways for health professionals to discuss alcohol use and pregnancy with women and tools for health professionals to use in their practice such as a standard drinking guide and the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C).

Leaflet - Information for health professionals on pregnancy and alcohol

The leaflet for health professionals is a quick reference guide that can be used during the consultation when discussing alcohol use and pregnancy with women. The leaflet provides a brief overview of the evidence supporting the Alcohol Guidelines and includes a framework for discussing alcohol use and pregnancy – the 5As: Ask, Assess, Advise, Assist and Arrange. The leaflet can be downloaded from www.alcohol.gov.au or hard copies can be ordered from the website.

Leaflet - Information for women about pregnancy and alcohol

The leaflet for women provides information on alcohol use and pregnancy. The leaflet provides information on why it's best to avoid alcohol consumption during pregnancy, hints and tips for 'saying no' to alcohol when out with friends and information on where to go for further information or advice. The leaflet can be downloaded from www.alcohol.gov.au or hard copies can be ordered from the website.

VIDEO RESOURCES

1. General Practitioner discussing alcohol with pregnant woman who drank in her previous pregnancy

2. Midwife discussing alcohol with pregnant woman who had a binge drinking occasion

3. General Practitioner reflecting on the conversation with the pregnant woman who drank in her previous pregnancy

4. Midwife reflecting on the conversation with the pregnant woman who had a binge drinking occasion

5. A pregnant woman (Verity) outlining what information she wants to receive from health professionals about alcohol consumption during pregnancy

6. A pregnant woman (Olivia) outlining what information she wants to receive from health professionals about alcohol consumption during pregnancy

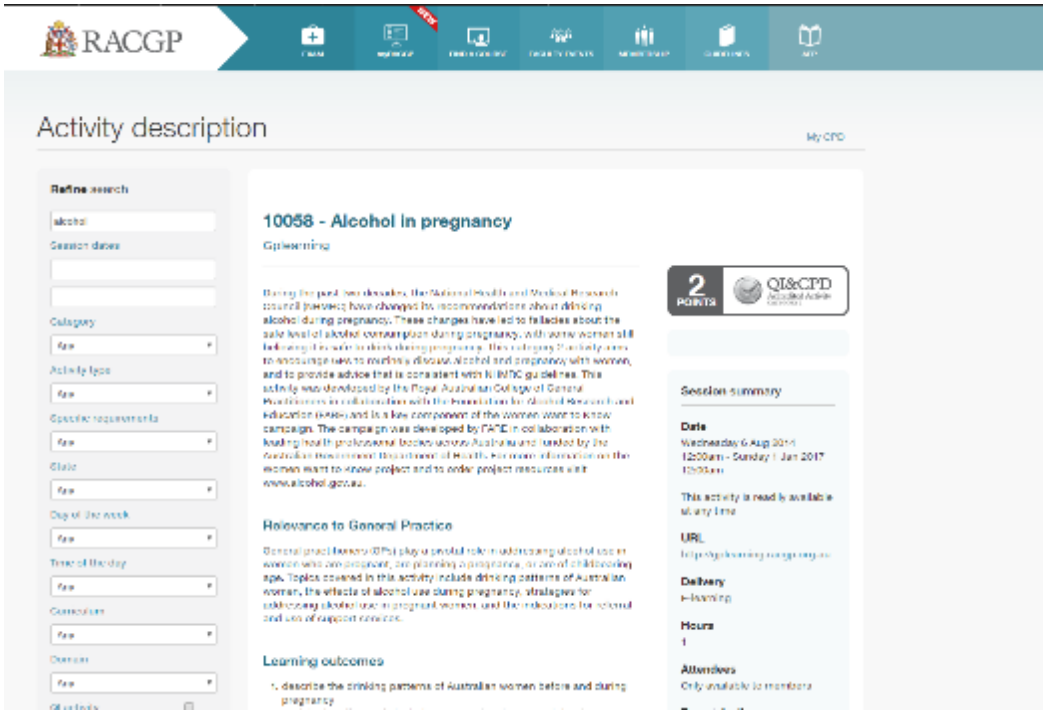
7. A new mother (Alex) outlining what information she wants to receive from health professionals about alcohol consumption during pregnancy

8. Dr Steve Hambleton, President of the Australian Medical Association outlining the importance of the Women Want to Know project

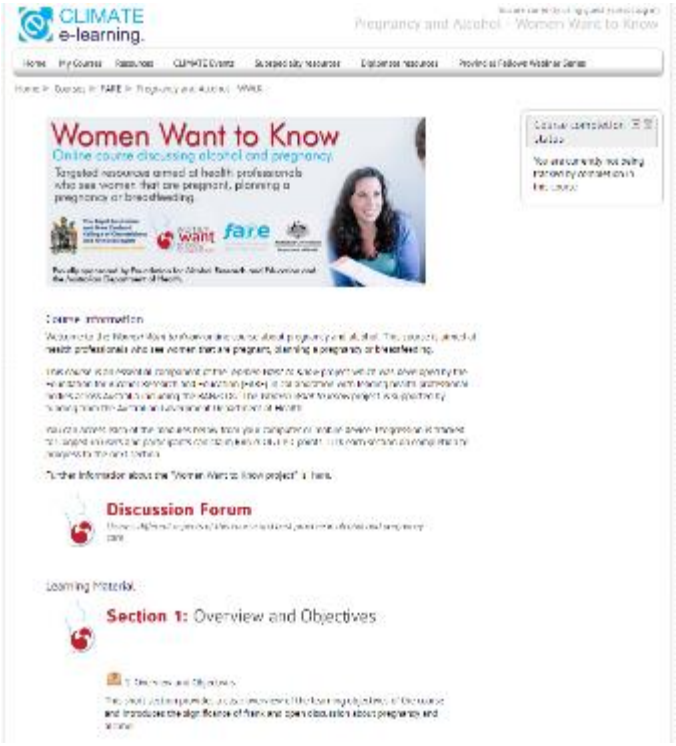
ONLINE TRAINING RESOURCES

There are three FREE online e-Learning courses with Continuing Professional Development accreditation available for Health Professionals through the following colleges:

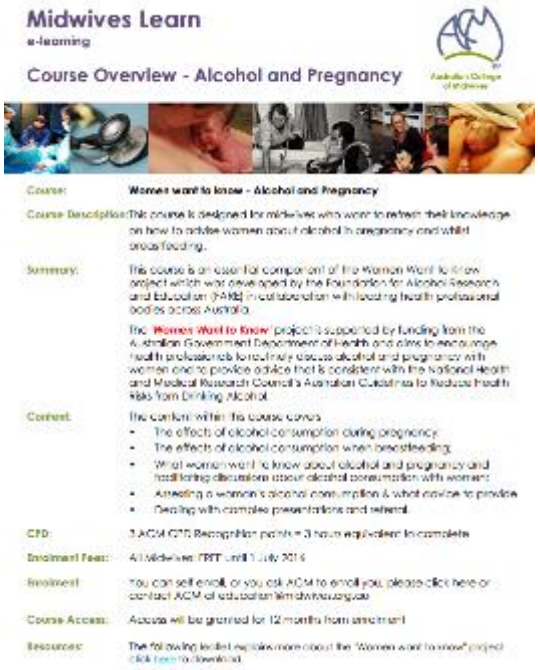
1. RACGP



2. RANZCOG



3. ACM



Post –intervention survey questionnaire

Survey Topic

To evaluate the Women Want to Know (WWTK) project

Quotas

Segment	Sample size (n)
GPs	100
Midwives	100
Obstetricians/gynaecologists	50
Total	250

Colour code key

Question routing	**Ask if**
Programming instructions	**Randomise codes**
HPOM note	Changes

Introduction

Thank you for agreeing to participate in this survey about alcohol use during pregnancy. It is being conducted by TKW Research and Hall & Partners|Open Mind on behalf of a not-for-profit health organisation.

The survey will take approximately **15 minutes** to complete.

The results of this study will be reported in aggregate and your responses will be anonymous.

Your participation in this survey is voluntary. Please be assured that this is a genuine research project, the information and opinions you provide will be used only for research purposes.

Note: The Australian Market and Social Research Society's Surveyline on 1300 364 830 is available for you to call if you would like confirmation of Hall & Partners|Open Mind recognition by the society as a bona fide research company.

Instructions:

Please DO NOT USE the 'Back' and 'Forward' buttons in the browser. Doing so means you may have to start the survey again. Please use the buttons at the bottom of each screen.

SECTION A: SCREENER QUESTIONS

ASK ALL

SQ1. Which of the following best describes your current role?

{SINGLE RESPONSE}

GP	1
Midwife	2
Obstetrician	3
Gynaecologist	4
Aboriginal health worker	5 (TERMINATE)
Other health professional	6 (TERMINATE)
Health professional in training	7 (TERMINATE)
Not working or retired	8 (TERMINATE)
I'd prefer not to say	99 (TERMINATE)

ASK ALL

SQ2. In a typical week, approximately how many patients/clients do you see that are pregnant?

{SINGLE RESPONSE}

I never see pregnant patients	0 (TERMINATE)
Fewer than 1 a week	1
1 – 5	2
6 – 10	3
11 – 15	4
16 – 20	5
More than 20	6
Don't know	99

Termination script:

Thank you for agreeing to take part in the survey but unfortunately we are looking for other groups of health professionals for this survey.

SECTION B: DISCUSSION OF ALCOHOL WITH PATIENTS

ASK ALL

Q1 Under which of the following circumstances would you talk to women about their alcohol consumption?
{MULTIPLE RESPONSE EXCEPT FOR CODES 98 AND 99}

[GPS only] Seeing or diagnosing someone with a condition that may be caused by alcohol use	1
[GPS only] Seeing or diagnosing someone with a condition that may be exacerbated by alcohol use	2
[GPS only] Seeing an asymptomatic adult patient/client at risk of chronic disease	3
Seeing any patient/client who is a teenager/young adult	4
Seeing any patient/client who is a woman of childbearing age	5
Seeing any patient/client who is actively planning a pregnancy	6
Seeing any patient/client who is pregnant for the first time	7
Seeing any patient/client who is pregnant for the second or subsequent time	8
Seeing any patient/client who is breastfeeding	9
Prescribing or administering antibiotics or medication that may interact with alcohol	10
None of these	98
Don't know	99

ASK ALL

Q2 Do you routinely ask pregnant women about their alcohol consumption?
{SINGLE RESPONSE}

Yes	1
No	2
Don't know	99

ASK ALL EXCEPT DON"T KNOW 99 AT Q2

Q3a. What advice do you generally give to women about alcohol consumption during pregnancy?
{OPEN RESPONSE}

Q3b. What advice do you generally give to women about alcohol consumption and breastfeeding?
{OPEN RESPONSE}

ASK ALL

Q4 Who usually **initiates** discussions about alcohol consumption in relation to pregnancy?

{SINGLE RESPONSE}

I do	1
The patient/client does	2
Neither – it doesn't usually get discussed	3
It depends on the circumstances	4
Other, [specify]	97

ASK ALL

Q5 On a scale from 0 to 10, how comfortable would you say you are with **initiating** conversations about alcohol consumption with the following patients/clients?
[Please provide one response per row]

{SINGLE RESPONSE PER ROW}

	0 – not at all comfortable	1	2	3	4	5	6	7	8	9	10 – Extremely comfortable	Don't know
A. Women of childbearing age	0	1	2	3	4	5	6	7	8	9	10	99
B. Women who are actively planning a pregnancy	0	1	2	3	4	5	6	7	8	9	10	99
C. Women who are pregnant for the first time	0	1	2	3	4	5	6	7	8	9	10	99
D. Women who are pregnant a second or subsequent time	0	1	2	3	4	5	6	7	8	9	10	99
E. Women who are breastfeeding	0	1	2	3	4	5	6	7	8	9	10	99

ASK ALL

Q6 Please indicate the option that best reflects your practice with pregnant patients/clients.[Please provide one response per row]

{SINGLE RESPONSE PER ROW}

		I do this with every pregnant patient/client	I do this with some pregnant patients/ clients	I do this only when asked	I never do this	Don't know
A	Assess how much alcohol they consume	4	3	2	1	99
B	Discuss whether alcohol is safe to drink when pregnant	4	3	2	1	99

C	Discuss how much alcohol is safe to drink when pregnant	4	3	2	1	99
D	Discuss risks to the fetus of drinking alcohol when planning pregnancy	4	3	2	1	99

ASK ALL

Q7 What, if anything, can make it difficult for you to discuss alcohol consumption in pregnancy with your patients/clients?
{MULTIPLE RESPONSE EXCEPT CODE 98}

Concern about the patient's discomfort when discussing their alcohol intake	1
Lack of training in how to initiate the conversation	2
Lack of referral options for adequately dealing with alcohol use problems once identified	3
Lack of knowledge about the amount of alcohol that is harmful in pregnancy	4
Other [Specify]	97
None of these	98

ASK ALL EXCEPT THOSE WHO GIVE A RESPONSE OF 1 AT Q6A

Q8 Which of the following tools/questionnaires do you use to assess a pregnant patient/client's level of alcohol consumption?
{MULTIPLE RESPONSE EXCEPT CODES 98 AND 99}

AUDIT	1
AUDIT-C	2
CAGE	3
TWEAK	4
Some other method (SPECIFY)	97
None of these	98
Don't know	99

ASK ALL

Q9 How familiar are you with the referral pathways available to you to assist pregnant patients/client s when you are concerned about their alcohol consumption?
{SINGLE RESPONSE}

Very familiar	1
Somewhat familiar	2
Not very familiar	3
Not at all familiar	4
Don't know	99

ASK ALL

Q10 What are the main risks associated with someone consuming alcohol…
{OPEN RESPONSE}

(a) while pregnant?

(b) while breastfeeding?

ASK ALL

Q11 How many drinks of alcohol per day can **a pregnant woman** consume without any risk to the fetus?
{SINGLE RESPONSE}

None	1
One or two	2
Three or four	3
More than four	4
Don't know	99

ASK ALL

Q12 Where do you obtain information about alcohol consumption during pregnancy and breastfeeding?
{MULTIPLE RESPONSE EXEPT 99}

Training	1
Clinical experience	2
Journal articles	3
Communication from professional bodies (e.g. AMA, RANZCOG, RACGP, RCNA, ACM, ACN)	4
Communication from relevant peak organisations	5
National Health and Medical Research Council's *Australian guidelines to reduce the health risks from drinking alcohol*	6
Other government guidelines	7
Government guidelines from other countries for alcohol consumption	8
Other [Specify]	97
Don't know	99

ASK ALL

Q13 How familiar would you say you are with the 2009 National Health and Medical Research Council's *Australian guidelines to reduce the health risks from drinking alcohol*?
{SINGLE RESPONSE}

Have not heard of these	1
Have heard of them but not familiar with the content	2
Somewhat familiar with the content	3
Very familiar with the content	4

ASK IF SOMEWHAT OR VERY FAMILIAR, CODES 3 AND 4 AT Q13

Q14 In your view, how strong would you say the evidence is that supports the following guidelines? [Please provide one response per column]

{SINGLE RESPONSE PER ROW – FORMAT AS RADIO BUTTONS ALLOW ONE RESPONSE PER COLUMN}

	NHMRC GUIDELINE 4a: For women who are pregnant or planning a pregnancy, the safest option is not to drink alcohol	**NHMRC GUIDELINE 4b:** If you are breastfeeding, the safest option is not to drink alcohol
Evidence strongly supports this for all levels of consumption	1	1
Evidence strongly supports this for higher levels of consumption but weakly supports this for lower levels of consumption	2	2
Some evidence exists to support this for all levels of consumption	3	3
Evidence does not support this for any level of consumption	4	4
Don't know	99	99

ASK ALL

Q15 How effective do you think brief intervention can be in assisting the following patients/clients to modify their alcohol consumption? [Please provide one response per column]

{SINGLE RESPONSE PER COLUMN}

	A. Patients/clients in general	B. Pregnant patients/clients	C. Breastfeeding patients/clients
Very effective	1	1	1
Somewhat effective	2	2	2
Not very effective	3	3	3
Not at all effective	4	4	4
Don't know	99	99	99

ASK ALL

Q16 Which of the following would assist you in talking to women about alcohol use in pregnancy?

{MULTIPLE RESPONSE EXCEPT 99}

A website with targeted information	1
Online tools to assess alcohol consumption levels	2
Web-based training modules	3
Face to face training	4
Printed resources for yourself	5
Printed resources for patients/clients	6
Accredited (CPD) training	7

Something else (SPECIFY)	97
Don't know	99

SECTION C: COMMUNICATION EVALUATION

ASK ALL

Q26 In the last 12 months, have you come across any materials or resources for healthcare professionals about alcohol consumption during pregnancy? Materials or resources might be in the form of videos, articles, leaflets, presentation / stands at a conference etc.

{SINGLE RESPONSE}

Yes	1
No	2
Not sure	99

ASK IF CODE 1 AT Q26

Q27 As you have come across materials or resources for healthcare professionals about alcohol and pregnancy, please describe the content, format and name (if recalled) of those materials or resources and approximately how long ago you came across them.

{OPEN REPSONSE}

ASK ALL

Q28 Before today, had you heard of the "Women Want to Know" project?

{SINGLE RESPONSE. SHOW THE STIMULUS AS BELOW}

Yes	1
No	2
Not sure	99

SECTION INTRODUCTION

We would now like to show you some materials from the 'Women Want to Know' (WWTK) project, including video clips, so please make sure that the speakers on your computer/device are working…

Q29 AND Q30 TO BE RANDOMISE, SUCH THAT WITHINT EACH SEGMENT "GP'S", "MIDWIVES" AND "OB&G" HALF SEE Q29 FIRST AND OTHER HALF SEE Q30 FIRST.

ASK ALL

Q29 Here are short clips from 6 longer videos. Do you recall seeing any of these videos before?

Please view every clip and select those that you recall seeing before. The proceed button (>>) will only appear when the video has finished screening.

{MULTIPLE RESPONSE}. SHOW THE 6 VIDEO CLIPS WITH A RADIO BUTTON NEXT TO EACH. SHOW A 'HAVENT SEEN ANY OF THESE'. STIMULUS TO BE SHOWN IS IN THE PPT DOCUMENT. DON'T ALLOW RESPONDENTS TO GOTO NEXT QUESTION UNLESS THEY HAVE VIEWED ALL 6 CLIPS

Yes	1
No	2

ASK ALL

Intro: We will now show you 4 leaflets.

Q30 Below is a screenshot of a leaflet from the Women Want to Know project, do you recall seeing this specific leaflet before today?

{SINGLE RESPONSE} REPEAT QUESTION FOR THE 4 LEAFLETS. SHOW THE CODES BELOW THE IMAGE. STIMULUS TO BE SHOW IS IN THE PPT DOCUMENT.

Yes	1
No	2

ASK IF CODE 1 AT Q30

Q31 Which of the following best describes what you did with this specific leaflet?
{SINGLE RESPONSE PER COLUMN, RANDOMISE LIST EXCEPT CODE 99} IN COLUMNS SHOW THE LEAFLETS THE RESPONDENT HAS SELECTED AT Q30. THIS QUESTION IS ASKED TO EACH OF THE LEAFLET THAT THEY RECOGNISE. DO NOT RANDOMIZE

Glanced at it, but didn't read it	1
Didn't read it, but kept it on the file	2
Read it but didn't keep it	3
Read it and kept it on file	4
Handed on to a patient or client [SHOW ONLY FOR LEAFLET 3 AND 4]	5
Shared it with colleagues	6

Something else (Specify)	7
Don't remember	99

ASK IF CODE 1 AT Q29 OR Q30

Q32 And how did you come across the resources (videos and/or leaflets) from the Women Want to Know (WWTK) project? Please select all the places you think you have seen or heard about the resources

{MULTIPLE RESPONSE PER COLUMN, RANDOMISE LIST EXCEPT 97 AND 98}

SHOW IN COLUMNS

Videos	1
Leaflets	2

SHOW IN ROWS

An online training course provided by RACGP, RANZCOG and ACM	1
Through a training course provided by another source(s) [KEEP THIS OPTION BELOW CODE 1]	2
At a conference	3
From colleagues	4
An article in journal, newsletter or magazine	5
Communication from professional bodies (e.g. AMA, RANZCOG, RACGP, ACM, ACN)	6
Communication from relevant peak organisations [KEEP THIS OPTION BELOW CODE 6]	7
Australian Government Department of Health website - www.alcohol.gov.au	8
In a practice pack from InfoMed	9
In a show bag at a conference	10
Downloaded resources from Foundation for Alcohol Research & Education (FARE) website – www.fare.org.au	11
Somewhere else [Specify]	97
Don't know	99

ASK IF CODE 1 AT Q30

Q33 What key messages were conveyed through the leaflets?

{OPEN REPSONSE. THE BOX SHOULD BE 15 LINES DEEP}

ASK IF CODE 1 AT Q29

Q34 What key messages were conveyed through the videos?

{OPEN REPSONSE. THE BOX SHOULD BE 15 LINES DEEP}

ASK IF Code 1 at Q29 or Q30

Q35 Which of the following statements best describe what these Women Want to Know project materials (videos or leaflets) were trying to convey? Please select all that apply.

{MULTIPLE RESPONSE PER COLUMN, RANDOMISE LIST EXCEPT CODE 99}

SHOW IN COLUMNS

Videos	1
Leaflets	2

SHOW IN ROWS

For women who are pregnant or planning pregnancy, not drinking is the safest option	1
For women who are breastfeeding, not drinking is the safest option	2
The 5As can make it easier to discuss alcohol consumption with pregnant women or women planning pregnancy	3
Health professionals should ask all women planning a pregnancy about their alcohol use	4
Health professionals should ask all pregnant women about their alcohol use	5
Health professionals should ask all breastfeeding women about their alcohol use	6
One way to assess a woman's alcohol consumption is by using the AUDIT-C (Alcohol Use Disorders Identification Test – Consumption)	7
Women expect healthcare professionals to raise the topic of alcohol consumption during pregnancy	8
Women who are pregnant or planning pregnancy should drink no more than 2 standard drinks in a week	9
Women are often willing to make changes to their lifestyle during pregnancy if advised	10
None of the above	99

ASK IF CODE 1 AT Q29 OR Q30

Q36 How effective did you personally find the **Women Want to Know** project resources in…?

{MULTIPLE RESPONSE}

	Very effective	Somewhat effective	Not very effective	Not at all effective	Don't know
Communicating useful information to Healthcare professionals about alcohol consumption during pregnancy					
Providing useful guidance regarding initiating conversations about alcohol and pregnancy					

ASK IF CODE 1 AT Q29 OR Q30

Q37 Which of the following are you doing or have you done as a result of seeing the **Women Want to Know** project materials?

Please provide one response per row

{MULTIPLE RESPONSE. RANDOMISE EXCEPT CODE 8 AND 9}

As a result of seeing the materials…

I initiate conversations/more conversations with women about alcohol consumption during pregnancy	1
The conversations I have with women about alcohol consumption during pregnancy are more effective	2
The conversations I have with women about alcohol consumption during pregnancy are more detailed/in-depth	3
I refer to the Audit - C mentioned in the materials / refer to the Audit - C more often	4
I refer to the 5A's mentioned in the materials / refer to the 5A's more often	5
I advise **all** pregnant women not to drink alcohol during pregnancy	6
I refer **more** patients to support services related to alcohol consumption during pregnancy	7
Others (specify)	8
Nothing has changed	9

ASK IF CODE 1 AT Q29 OR Q30

Q38 Having seen the Women Want to Know project materials, to what extent do you agree or disagree with each of the following….

Please provide one response per row

{SINGLE RESPONSE PER ROW. RANDOMISE STATEMENTS}

As a result of seeing the materials…	0 – Strongly disagree	1	2	3	4	5	6	7	8	9	10 – Strongly agree
I have thought more about the advice I give to female patients about drinking alcohol during pregnancy	0	1	2	3	4	5	6	7	8	9	10
I feel more comfortable in talking to patients about alcohol consumption during pregnancy	0	1	2	3	4	5	6	7	8	9	10
I have a better understanding of how to communicate about alcohol consumption during pregnancy	0	1	2	3	4	5	6	7	8	9	10
I have a better understanding of what advice to give to patients in different situations about alcohol consumption during pregnancy	0	1	2	3	4	5	6	7	8	9	10
I have a better understanding of the guidelines on alcohol consumption during pregnancy	0	1	2	3	4	5	6	7	8	9	10
I am more concerned about how patients might react if I initiate a conversation about alcohol consumption during pregnancy	0	1	2	3	4	5	6	7	8	9	10
I am more confused about what advice to give patients about alcohol consumption during pregnancy	0	1	2	3	4	5	6	7	8	9	10
I feel less confident about talking to patients about alcohol consumption during pregnancy	0	1	2	3	4	5	6	7	8	9	10
I have more information about who or where to refer patients for additional support in relation to alcohol consumption during pregnancy	0	1	2	3	4	5	6	7	8	9	10

ASK ALL

Q39 Have you heard about the online e-learning course on Pregnancy and Alcohol with Continuing Professional Development (CPD) accreditation available for Health Professionals through RACGP, RANZCOG, ACM and other colleges?
{SINGLE RESPONSE}

No - I have never heard about it	1
Yes - I have heard about it, but have not taken the course	2
Yes - I started the course, and I am part way through it	3
Yes - I started the course, but did not complete it	4
Yes - I have completed the course	5

ASK IF CODE 4 AT Q39

Q40 And, why didn't you complete the online course on Pregnancy and Alcohol?
{OPEN REPSONSE. THE BOX SHOULD BE 15 LINES DEEP}

ASK IF CODE 2 AT Q39

Q41 And, why did you decide not to take up the online course on Pregnancy and Alcohol?
{OPEN REPSONSE. THE BOX SHOULD BE 15 LINES DEEP}

SECTION D: DEMOGRAPHICS

Now we have just a few questions to help us analyse the results.

ASK ALL

Q17 Are you…?
{SINGLE RESPONSE}

Male	1
Female	2
I'd prefer not to say	99

ASK ALL

Q18 What is your age?
{SINGLE RESPONSE}

18-24 years	2
25-34 years	3
35-44 years	4
45-54 years	5
55-64 years	6
65+ years	7
I'd prefer not to say	99

ASK ALL

Q19 Which of the following areas best describes where you live?

{SINGLE RESPONSE} #LOCATION#

Sydney	1
New South Wales - other	2
Melbourne	3
Victoria - other	4
Brisbane	5
Queensland - other	6
Perth	7
Western Australia - other	8
Adelaide	9
South Australia - other	10
Hobart	11
Tasmania - other	12
Australian Capital Territory	13
Northern Territory	14

ASK ALL

Q20 What is your postcode?

Don't know – code 99

ASK ALL

Q21 Which employment type best describes your current situation?
{SINGLE RESPONSE}

Working full-time	1
Working part-time	2
Locum	3
Other [SPECIFY]	97

ASK ALL

Q22 Which best describes your main area/place of practice?
{SINGLE RESPONSE}

Solo private practice	1
Group private practice	2
Medical centre / clinic	3
Super clinic	4
Private hospital	5
Public hospital	6
A combination of private clinic and public hospital	7
A combination of private clinic and private hospital	8
Community-based	9

Other [SPECIFY]	97

ASK ALL

Q23 How many health professionals are there in the main facility in which you work?
{SINGLE RESPONSE}

None	0
1	1
2	2
3	3
4-5	4
6-10	5
More than 10	6
Don't know	99

ASK ALL

Q24 Would you say the patients/clients that you see are primarily from higher income households, middle income, or lower income households?
{SINGLE RESPONSE}

Higher income	1
Middle income	2
Lower income	3
Don't know	99

ASK ALL

Q25 Roughly what proportion of your patients would you say are from…
{INTEGER 0-100. ONE RESPONSE PER LINE}

	%	Don't know
Aboriginal and/or Torres Strait Islander backgrounds	*0-100*	99
Non-English speaking backgrounds	*0-100*	99

ASK IF [SQ1 = 3 OR 4]

Q42 We would like to invite you to take part in a follow up telephone interview (around 30 mins) to discuss your feedback and experience in a little more detail. As an appreciation for your time and valuable feedback, we will provide $250 on completion of the telephone interview. If you are interested in participating, we will get in touch to provide further details and to arrange a time that is convenient to you.

Please note we will take into account your responses to the survey when selecting participants for the telephone interviews to ensure a range of experiences are represented.

Yes, I might be interested in participating please tell me more	*1*
No, please count me out	*2*

[EXIT SCRIPT – Thank you for taking the time to complete this survey.]

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discuss pregnancy & alcohol

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fare
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