Title: Women's Experiences of Messages Relating to Alcohol Consumption, Received During Their First Antenatal Care Visit.

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Abstract

Background: Despite greater awareness of the adverse effects of fetal alcohol spectrum disorders, including increased research into diagnosis and treatment, there has not been similar attention paid to preventing fetal alcohol spectrum disorder. Amongst the extant prevention research, assumptions implicit in the formulation and administration of standardised measurement instruments have tended to limit and define factors that contribute to women's choices around antenatal alcohol consumption in ways that may not necessarily be shared by women themselves. Although a few studies have incorporated qualitative data on women's experiences of antenatal care, there have been no specific studies on the messages women receive during their first antenatal care visit, relating to alcohol consumption.

Aims: To explore and interpret the messages women receive during their first antenatal care visit, relating to alcohol consumption.

Findings: An Interpretative Phenomenological Analysis (IPA) applied to interview transcripts identified two superordinate themes: 1) *Messages Received About Alcohol Consumption*, and 2) *Ways of Interpreting Messages Relating to Alcohol Consumption*. Messages received by participants about alcohol consumption were generally consistent with national guidelines, stating that there is no safe level during pregnancy. Women interpreted this message; however, within a broader, personal and

socio-cultural context, leading to choices about alcohol consumption being informed by their individual understanding of risk. In order to facilitate open discussions about sensitive topics such as alcohol consumption, participants expressed a preference for antenatal support that is tailored to their individual needs.

Conclusion: Strategies to prevent fetal alcohol spectrum disorder need to include messages encouraging women to abstain during their pregnancy, whilst at the same time, providing the type of individualised antenatal care that best enables this to be accomplished.

Keywords: fetal alcohol spectrum disorder; prevention; antenatal alcohol use

Statement of significance

Problem

Fetal alcohol spectrum disorder results in lifelong neurodevelopmental impairments, however, there is a paucity of research on the prevention of this condition.

What is Already Known

There is a large amount of heterogeneity among pregnant women and subtle differences in the way they experience health messages regarding alcohol consumption.

What this Paper Adds

This research adds to our understanding of how women receive and interpret messages relating to alcohol consumption, allowing deeper meanings of their experiences to be illuminated in order to inform more effective strategies to support the reduction or abstinence of alcohol use during pregnancy.

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1. Introduction

Alcohol consumption plays a significant role within Australian culture and is considered integral to many social situations. Alcohol use is pervasive with 80% of people over the age of 14 reporting having consumed alcohol during the 2013 calendar year.¹ Most Australians consume alcohol in moderation; however, a large proportion drink to excess, leading to increased risk of injuries, diseases and negative social and financial consequences.² Research into trends associated with alcohol use in Australia suggest that overall consumption may be rising, with the increase in women's use of alcohol greater than that of men's.³ Reducing or stopping alcohol consumption, however, may be problematic for many people, as research has found that alcohol consumption is linked to particular social norms, the violation of which, may lead to social stigmatisation.⁴

Given the complex relationship with alcohol evident more widely within Australian society, it is unsurprising that alcohol consumption amongst women who are pregnant has been the subject of increasing research. Health guidelines state that no alcohol during pregnancy is the safest option.¹ However, it was only in 2001 that the National Health and Medical Research Council (NHMRC) guidelines stated that for pregnant women, *'over a week, [women] should have less than 7 standard drinks, AND, on any one day, no more than 2 standard drinks'*.⁵ Furthermore, there are mixed findings in the literature regarding the effects of low levels of alcohol exposure during pregnancy. Consequently, it is understandable that there is confusion for health professionals and women regarding what is the correct stance to take and therefore, some women continue to consume alcohol while pregnant.⁶ However, recent studies have found increased risk of neurodevelopmental problems and preterm birth following exposure to 30 – 40 g per occasion and as little as 70 g per week, which is equivalent to approximately 3 to 4 standard drinks once or twice per week. This indicates that at most, there is only a small margin before there is increased risk to the fetus.⁷

Determining the frequency and quantity of antenatal alcohol consumption is particularly relevant due to increasing awareness of fetal alcohol spectrum disorders (FASD). FASD is a

continuum of physical, social, behavioural and intellectual effects associated with antenatal exposure to alcohol.⁸ Effects of FASD are pervasive and often result in lifelong disadvantage for individuals, including over-representation in foster care, higher rates of unemployment, and reduced educational attainment.⁹ Although there are no national data on the prevalence of FASD in Australia,¹⁰ rates of alcohol consumption during pregnancy have been reported to be as high as 47% on a national level.¹¹

Whilst there is substantial research into the diagnosis and treatment of FASD, the limited research into prevention has not yet yielded a coherent approach to reducing harm from antenatal alcohol exposure. Individual studies into prevention have found a range of factors that may influence the choices pregnant women make regarding alcohol consumption. Education level has been found to be a predictor of knowledge about alcohol consumption during pregnancy.¹² Surprisingly, however, pregnant women with higher levels of income have been found to have less accurate knowledge of the effects of alcohol consumption during pregnancy¹² suggesting that socio-economic status (SES) does not equate to health knowledge. An association has also been found between poor mental health and alcohol consumption during pregnancy. Elevated symptoms of anxiety or depression early in pregnancy may lead to an increased risk of binge drinking, defined as having four or more standard drinks on a single occasion.¹³ Significant alcohol use during pregnancy has also been found to reflect impulsive personality traits rather than alcohol dependence, and to be correlated with additional risk behaviours.¹⁴

The absence of a conceptually and pragmatically coherent prevention strategy for FASD has been further highlighted in research with women who self-reported being screened for risk factors in line with Australian antenatal care recommendations.¹⁵ Whilst 92% of women were asked about alcohol consumption during antenatal care visits, only 10% of those women who indicated that they needed support, were provided with the support they required.¹⁵ This suggests that whilst initiatives to detect antenatal risk factors may be being implemented, the application of appropriate interventions to manage those risk factors may not be adequate.

Much of the extant prevention research, therefore, displays methodological shortcomings and also tends to emphasise observable, measurable phenomena such as education, SES, mental health, and self-reports on usage, in order to examine possible determinants of antenatal alcohol consumption

and isolate some of the predictors for FASD. Traditional experimental designs such as RCT's; however, are not able to control for all explanatory variables and may, therefore, provide insufficient detail of the context or circumstances that contribute to women's choices regarding antenatal alcohol consumption.¹⁶ Pawson and Tilley¹⁷ argued that a complex interplay between attitudes, motivations, and circumstances determines whether an individual chooses to participate in social interventions, suggesting that the prevention of FASD requires a more sensitive approach.

A small number of qualitative approaches have helped provide a more nuanced picture. Women who experienced discrimination directed towards them after disclosing alcohol use during pregnancy were less likely to subsequently engage in honest discussions with care providers, resulting in an absence of appropriate support.¹⁸ Honest, non-judgmental interactions were more likely to establish trust and a willingness to incorporate healthier behaviours into their lives.¹⁸ Hotham et al.¹⁸ also draw attention to the differing levels of provider advice women found most supportive, and the influence of family and friends on some women's choices around antenatal substance use. Some women have also indicated a preference for having established a relationship of trust prior to discussing potentially emotive topics such as alcohol consumption.^{16,19} Qualitative research highlights the more complex and subtle influences on women's choices in relation to alcohol consumption that may challenge traditional forms of research that aim for objectivity.^{20,21}

2. Rationale

Gaining insight into women's experiences, beliefs and understanding of the messages they receive in relation to antenatal alcohol use, is necessary in order to inform targeted prevention strategies for FASD. There is a paucity of research on the prevention of FASD relative to the amount of research conducted into diagnosis and treatment. Assumptions implicit in the formulation and administration of standardised measurement instruments in some previous prevention research, has tended to limit and define influences on women's choices about alcohol consumption in ways that are not necessarily shared by women themselves. The few qualitative studies in the literature that incorporate women's experiences of antenatal care, draw attention to the diversity of influences on women's choices relating to alcohol consumption, and nuanced differences in the way they perceive and interpret their experiences of the messages received about alcohol consumption.²¹⁻²³ Further

research is required to allow deeper meanings of pregnant women's experiences to be illuminated. This research sought to complement and inform the numerical comparisons and statistical inferences of quantitative measurements, providing a more holistic understanding of women's experiences of the messages they receive about alcohol consumption during their first antenatal care visit. Consequently, the objectives of the current study were to explore and interpret women's experiences of the messages about alcohol consumption they received during their first antenatal care visit, in order to better inform targeted prevention strategies for FASD.

3. Participants and Methods

3.1. Participants

The current study comprised a purposive sample of 12 female participants who were included if they had attended an initial antenatal care visit within the previous two years. All participants were from the Northern Rivers region of New South Wales or South East Queensland (S.E. Qld), Australia, and ranged in age from 22 to 41 years (mean age 33.26 years). Table 1 provides further information about the participants.

Table 1

Participant Demographics

<i>Pseudonym</i>	<i>Age</i>	<i>Geographical Location</i>	<i>Initial Antenatal Care Provider</i>
<i>Claire</i>	<i>33</i>	<i>Northern Rivers</i>	<i>Hospital-based Midwife</i>
<i>Jane</i>	<i>41</i>	<i>Northern Rivers</i>	<i>Private Midwife</i>
<i>Mae</i>	<i>28</i>	<i>Northern Rivers</i>	<i>Hospital-based Midwife</i>
<i>Sarah</i>	<i>35</i>	<i>S.E Qld</i>	<i>Hospital-based Midwife</i>
<i>Amelia</i>	<i>34</i>	<i>S.E Qld</i>	<i>Hospital-based Midwife</i>
<i>Natalie</i>	<i>30</i>	<i>S.E Qld</i>	<i>General Practitioner</i>
<i>Shell</i>	<i>35</i>	<i>S.E Qld</i>	<i>General Practitioner</i>
<i>Samantha</i>	<i>34</i>	<i>S.E Qld</i>	<i>Obstetrician</i>
<i>Maya</i>	<i>33</i>	<i>S.E Qld</i>	<i>General Practitioner</i>
<i>Kiz</i>	<i>33</i>	<i>S.E. Qld</i>	<i>General Practitioner</i>
<i>Ivy</i>	<i>22</i>	<i>S.E. Qld</i>	<i>General Practitioner</i>
<i>Lea</i>	<i>40</i>	<i>Northern Rivers</i>	<i>General Practitioner</i>

Note: All names are pseudonyms and information was accurate at time of interview.

3.2. Ethical Considerations

Prior to recruiting participants, ethics approval was obtained from the Griffith University Ethics Committee (Ethics Reference number: 2017/470). Participants were assured that confidentiality would be maintained at all times. To reduce any potential bias, the researcher did not have any clinical relationship with any of the participants prior to recruitment. All participants were given an information sheet outlining the aims of the study, provided written consent and chose a pseudonym. The researcher's contact with participants was informed throughout by sensitivity to context.²⁴ This acknowledges the interactional nature of data collection in Interpretative Phenomenological Analysis (IPA), where the quality of information gathered can depend to a large extent on the quality of the relationship established between the researcher and the participants.²⁵ The researcher sought additional ethical guidance throughout by consulting with colleagues, and by accessing literature relating to the ethics of interpretation²⁶ and research with vulnerable groups.²⁷

3.3. Data Collection Methods

A semi-structured interview schedule was developed, (see Appendix A for full interview schedule) which included questions about the participants' experiences of the health messages they received during their first antenatal care visit, with particular emphasis on messages relating to alcohol consumption; (for example: "If alcohol consumption was discussed, were you given any specific advice about the amount of alcohol, if any, that would be safe for you to drink during your pregnancy?"). Construction of the main research question and the interview schedule was an iterative process as ideas were developed and revised in consultation with the interviewer's supervisors. Including collaborative consultation is consistent with Yardley's²⁴ principles of rigour and transparency in conducting quality qualitative research.

The interview schedule contained questions and prompts based on participant responses in order to facilitate the collection of rich data whilst also allowing the interviews to extend to unexpected areas of interest. Consistent with IPA methods, recruitment was via referral from local health services, day-care centres, pre-schools, primary schools, undergraduate university students,

work colleagues, friends and acquaintances. Attempts were made to recruit from substance abuse treatment centres, psychology, psychiatry, and obstetrician practices, and through flyers displayed in shopping centres, libraries and community noticeboards, however, no participants were recruited via these methods. Recruitment was also attempted through snowballing, where participants were asked if they knew anyone who conformed to the selection criteria, however, no participants were recruited via this method. The interviews were conducted by the researcher between December 2017 and April 2018, either in person or via telephone and took between 15 and 40 minutes to complete.

3.4. *Data Analysis*

Data were analysed by the primary researcher, a middle-aged male with an honours degree in social science (psychology), and followed the method of J.A. Smith, P. Flowers and M. Larkin²⁸ for Interpretative Phenomenological Analysis. IPA is strongly influenced by phenomenology, a term used for a number of psychological approaches concerned with subjective experience. The phenomenological aspect of IPA acknowledges that people can provide meaning to their experiences.²⁵ The interpretative aspect of IPA acknowledges that access to meaning is achieved by the researcher via an interpretative analysis of the participant's personal accounts, which are based both on the researcher's own experiences and by consulting the extant literature.²⁸

In qualitative research, rigour and credibility are employed to ensure findings are 'trustworthy'. In the current study, trustworthiness of the findings was enhanced by ensuring that reflexivity was intrinsic to the research process. Reflexivity seeks to recognise and acknowledge the influence of preconceptions, experiences and social and cultural identity that are held by the researcher.^{29 30} Accordingly, the primary researcher for the current study, kept a research journal throughout, in order to explore thoughts, feelings and motivations for undertaking this research, and to document experiences and viewpoints that may have influenced his interpretation of the data.

The analytical procedure itself began with each interview being transcribed verbatim. Including verbatim evidence also contributed to the trustworthiness of findings by enabling the reader to determine the adequacy of the interpretation provided by the author.²⁸ During transcription, all potentially identifying information was removed. Analysis continued with an initial reading of the

transcripts followed by another reading during which notes and descriptive comments were made in order to obtain a thorough familiarisation with the data. Continued reading of the transcripts involved examining each in greater detail so as to capture and code the unique experiences of each participant, as well as shared patterns of experiences across the transcripts. Interpretive and descriptive codes from each transcript were recorded on a master list that was then scrutinised to determine codes that might be meaningfully grouped together. As a means of further enhancing trustworthiness of the analysis, the primary researcher regularly consulted and discussed his coding with his two research supervisors in order to ensure that the interpretations presented were justified by the data.^{28,29} Eighteen clusters were reduced through continued analysis into five subthemes and finally, into two superordinate themes.

Findings

4.1. Results of Interpretative Phenomenological Analysis

Two superordinate themes were explicated in narrative form with verbatim extracts from the transcripts in order to capture participants' experiences. These were: 1) *Messages Received About Alcohol Consumption*; and, 2) *Ways of Interpreting Messages Relating to Alcohol Consumption*.

Theme 1. Messages Received About Alcohol Consumption

The first theme encompassed two perspectives: verbal messages received and written messages received.

Verbal messages received. The majority of participants reported receiving verbal information at their first antenatal care visit, that not drinking alcohol during pregnancy is the safest option, as there is no safe limit:

And as far as alcohol goes she just said it's safest not to drink during pregnancy... (Amelia)

Whilst others received more definitive messages:

...it was less a recommendation and more of 'you can't do it'. (Maya)

However, for Claire, it was a recommendation to reduce rather than abstain:

230 *The message with smoking seemed to be, don't smoke because it can affect your fetus, but the*
 231 *message around alcohol seemed to be less clear-cut and [was] mainly just about reducing*
 232 *your consumption.*

233 One participant (Ivy) reported that she received no information regarding alcohol consumption during
 234 her first antenatal care visit.

235 Whilst participants' experiences of messages about alcohol consumption were generally
 236 consistent, some women spoke about how the information they received, differed from information
 237 their friends had received.

238 *...the information that you have access to, it is so contrasted often. I was surprised with the*
 239 *level of difference of opinion when it comes to antenatal health and the things that you can do*
 240 *and, you know one of my friends is a GP and... her obstetrician was quite relaxed about*
 241 *everything, he was like you know you can eat soft cheese and you can have wine every now*
 242 *and then, it was just that sort of a dichotomy... (Maya)*

243 Kiz's care provider for her current pregnancy recommended that she not drink any alcohol at all;
 244 however, this contrasted starkly with information she had been given during her first pregnancy, two
 245 years previously:

246 *...when I was in Sydney with the midwifery unit, ... they told me to drink a Guinness a day*
 247 *because it has iron in it, if that makes sense.*

248 Maya and Kiz's comments reveal the confusion some participants felt when verbal messages they
 249 received about alcohol consumption during their initial antenatal care visit, differed from those they
 250 had received from other sources or those messages they had previously received from health
 251 professionals.

252 ***Written messages received.*** Although most women found the written information they were
 253 provided with to consistently communicate the message that there is no known safe amount of alcohol

254 that can be consumed during pregnancy, a number of women commented on the sheer volume of
 255 written information they were given:

256 *You get this like bounty bag or info pack, which I'm sure there were all sorts of things in*
 257 *there, and there would have been stuff in there about alcohol and health... It was pretty much*
 258 *here you are so go through all this in your own time and that's a bit why I'm unclear about*
 259 *what was in it and what wasn't. I remember the picture on the front of the alcohol and*
 260 *pregnancy one... but I just never went through it because you kind of get it and you get home*
 261 *and you chuck it in the cupboard. (Amelia)*

262 For Amelia, the amount of written information relating to maintaining a healthy pregnancy seems to
 263 have been overwhelming. Natalie also received a large amount of written information, but took a
 264 different approach:

265 *It was just that the (name deleted) Hospital gave a lot of information... that I was supposed to*
 266 *fill in and the GP was supposed to fill in, but they didn't and so I just did that on my own. So,*
 267 *in the information it just asked what was my relationship with smoking and what was my*
 268 *relationship with alcohol and all that sort of thing and so I've gone through all that on my*
 269 *own, but they haven't really sat down with me...*

270 Despite diligently completing the documentation given to her at her first antenatal care visit, Natalie
 271 was not provided with any follow-up to either submit or discuss her responses to the questions that
 272 were asked of her.

273 This theme explored the verbal and written messages participants received during their first
 274 antenatal care visit, relating to alcohol consumption. The next theme explores some of the ways in
 275 which participants interpreted those messages.

276 **Theme 2. Ways of Interpreting Messages Relating to Alcohol Consumption**

277 The second theme elucidated two perspectives: understanding of risks; and, preferred models
 278 of care.

Understanding of risks. Participants identified differing understandings of risk relating to alcohol consumption during pregnancy, both in response to messages received during their initial antenatal care visit, as well as those assimilated from a broader socio-cultural context:

...I know the general advice is that it's really dangerous to drink any alcohol during pregnancy, especially at the start as that's when the brain cells are developing. (Mae)

... alcohol consumption in the first trimester, if it's not excessive, isn't going to be a huge risk. (Claire)

These extracts from Mae and Claire, highlight differing interpretations of the messages they received about the potential negative effects alcohol may have during different stages of pregnancy.

Participants' interpretation of risk also included differing understandings relating to the amount of alcohol consumed. Natalie's understanding was that any amount of alcohol could be a risk:

So yeah with alcohol... I'm even so careful that I don't like to have alcohol in food because I know that cooking it off takes longer than most people think and doesn't cook off completely. So, I know it might be a minuscule amount in the scheme of things but I'd just rather be overly cautious rather than take a risk.

Samantha chose to abstain, but remained non-judgmental of those who made different choices:

I guess I feel that it's okay to have maybe a little bit.... I know some of my friends who maybe have gone to a wedding and have had like a quarter or half a glass of champagne, so I wouldn't judge someone for doing that especially if it was very much in moderation, but when it came down to it and I was at a wedding, I didn't feel like I wanted to drink anything so I didn't, I chose that.

Others were aware that evidence regarding the potential negative effects of alcohol consumption remains contested and chose to consume some alcohol:

I mean I know it's not recommended to drink, but I did have a couple of glasses of wine over the course of my pregnancy. (Maya)

Providing the message that no alcohol is safest during pregnancy may be sufficient for some women who choose to abstain; however, the narratives of some of the women in this study paint a more complex picture. Some women chose abstinence, whilst others made decisions in terms of their own judgement of risk, and drank at what they considered to be safe levels. Whilst none of the participants described heavy, moderate or frequent drinking during their pregnancy, and those who reported drinking some alcohol did not consider their choices to be risking their baby's health, for some participants who chose to drink, unpleasant feelings arose:

Yes, it was never something that I did regularly or particularly freely, so if I did do it, I always felt a little bit guilty afterwards, so I didn't really enjoy it that much. (Maya)

Whilst feelings of guilt prevented Maya from enjoying small amounts of alcohol during her pregnancy, Natalie's choice of complete abstinence resulted in her meticulously researching the presence or otherwise of alcohol in her diet.

I contacted a women's health information line about nutrition and clarifying questions about that. So, you know things about having alcohol in a Christmas pudding or alcohol on a lemon meringue, something like that, so questions about what's the go here if I wasn't really sure.

Natalie's experience suggests she interpreted messages relating to alcohol consumption, both during her first antenatal care visit, as well as more broadly, which led her to be hyper-vigilant around the consumption of any amount of alcohol.

Preferred models of care. Although none of the participants felt a need to seek support from their initial antenatal care provider or any other services in relation to their alcohol consumption, some indicated that if they had needed to, they would not have felt comfortable talking to their care provider about alcohol:

I think that if I had been drinking, I think I would've been really embarrassed to admit that because I know that it is wrong, and I know that it's against advice. (Mae)

The fact that a number of women reported that they would not have felt comfortable speaking with their care provider about alcohol if they had needed to, suggests something lacking in the antenatal care they received. Claire spoke about the type of antenatal care that she would have preferred:

...it could be good to have a couple of familiar faces, that's when you build the kind of relationship where you feel comfortable talking in-depth ... and asking questions. And maybe have a bit more time to explain, so you can ask, 'Hey remember last time when I had this question about this, can we follow it up?'

Natalie also expressed her preference for a more individualised and integrated approach:

But I think in terms of continuity of care, I think definitely to have someone who has been with you since the start but based on my last pregnancy, I had more antenatal appointments at the hospital and I swear at every appointment I saw a different midwife...

The experiences of Claire and Natalie may be instructive and point to the type of antenatal care that could have produced a more trusting and open relationship with their care provider, which in turn may have resulted in these women feeling more able to discuss sensitive topics such as alcohol consumption, had they needed to.

This theme explored the ways in which participants interpreted messages they received relating to alcohol consumption, both in relation to their understanding of risks and in terms of the models of care that would have best facilitated discussions about alcohol consumption with antenatal care providers.

4. Discussion

The purpose of this research was to explore women's experiences of messages relating to alcohol consumption received during their first antenatal care visit, in order to better inform targeted prevention strategies for FASD. Two superordinate themes were developed, each exploring particular elements of participants' narratives and in combination, they provide an overview of the landscape of these women's experiences.

Theme 1 explored the verbal and written messages women received about alcohol consumption during their first antenatal care visit. Whilst one participant was advised to reduce alcohol consumption and one other participant received no information about alcohol consumption at all, most participants received verbal messages that there is no safe amount of alcohol that can be consumed during pregnancy, which is consistent with findings of previous research that found health professionals routinely enquire about alcohol use at the initial antenatal care visit.²⁰ However, these findings differ from some previous research that has found midwives and general practitioners believed pregnant women already knew not to drink alcohol and consequently, were unlikely to discuss this topic during antenatal care visits.^{23,31}

The influence of the media, in addition to family and friends, has previously been reported to contribute to women's decisions about alcohol consumption during pregnancy.¹⁸ Whilst Hotham's research found these sources were primarily advocating for pregnant women to abstain from consuming alcohol, the current study found that some women were confused about messages received from different antenatal care providers, that abstinence is not required during pregnancy.

Written messages received about alcohol consumption were reported to be consistent by participants who received them. However, the volume of information received appeared to negate the purpose of educating women about alcohol consumption during pregnancy. For some women, messages about alcohol seemed to have been lost amongst all the other information they were expected to assimilate and apply regarding their health and the health of their baby. One explanation for this may be suggested by research, which has found midwives reported that they have too much information to cover in the first antenatal care visit.³² Consequently, for some women in the current study, there appears to be a breakdown between the health messages they are given, and how these messages may be put into practice.

Theme 2 explored the ways in which participants interpreted messages about alcohol consumption during their first antenatal care visit. All of the participants seemed to be aware that stopping or reducing alcohol consumption during their pregnancy was what was expected of them and most received messages during their first antenatal care visit that were consistent with their understanding. The messages about alcohol consumption participants received, therefore, with few

exceptions, generally confirmed what they had already internalised from friends, family, media and previous contact with health care providers.

A more fine-grained analysis of participants' interactions; however, highlighted beliefs, understandings and assumptions that suggest further complexity to their interpretations. Although participants reported that they were aware that the most recent advice about alcohol consumption is that there is no safe amount during pregnancy, their narratives revealed varying interpretations and degrees of acceptance of this message, suggesting differing interpretations of risk. Some participants understood that no alcohol whatsoever during pregnancy was the safest and chose this option, whilst others considered drinking small amounts earlier in the pregnancy or later in the pregnancy to be safe. Some drank small amounts during their pregnancy, whilst others considered drinking small amounts to be generally safe, but chose to abstain during their own pregnancy. This range of responses is largely consistent with research that has found pregnant women contextualised recommendations about drinking during pregnancy and held their own views about its riskiness.^{21,22}

Some women, however, also spoke about their feelings of uncertainty, anxiety and guilt around the subject of alcohol consumption during pregnancy, suggesting that there are both personal and social factors that mediate the messages they are receiving about alcohol consumption during their first antenatal care visit. Participants' experiences support research that has found that health discourses that over-emphasise individual responsibility can be unrealistic and distressing and can exacerbate perinatal anxiety.³³ Fears of being negatively judged by their care provider may have led some participants to report that they would not have felt comfortable discussing alcohol consumption if they had needed to. It seems that socio-cultural influences and expectations regarding alcohol consumption are not absent from the initial antenatal care visit for these women, but inhabit and inform the interactions that occur between them and their health care provider. Consequently, women in this study seemed to be wanting discussions about alcohol consumption to occur within a context of antenatal care that was tailored to their individual needs. A more sensitive and personalised approach to initial antenatal care visits may have helped assuage participants' potential feelings of guilt or fears of opprobrium from health care professionals. This would have allowed participants to report a greater sense of comfort in discussing sensitive topics such as alcohol consumption, had they needed

to. This could be achieved through more Australian women having access to a caseload midwifery model, which ensures that each woman receives care throughout pregnancy, labour, birth, and into the postnatal period from a known midwife.¹⁹

As there is evidence that self-report underestimates alcohol consumption amongst pregnant women,³⁴ individualised care may also provide an environment of trust, where women are more able to safely explore the issues that are relevant to them. Most participants reported being asked about alcohol consumption only once during their pregnancy, which is consistent with previous research.³⁵ However, it may be necessary to revisit this question as the pregnancy progresses, given some participants' differing understandings of risk associated with alcohol consumption during specific stages of pregnancy. Therefore, rather than simply asking whether a woman drinks alcohol or stating that there is no safe limit for alcohol consumption during pregnancy, an initial antenatal care visit could include an opportunity for women to begin a conversation with their antenatal care provider, about their relationship with alcohol and what it means for them both individually and within a broader social context.

Revisiting questions about alcohol consumption; however, requires a continuity of care that many participants found lacking during their pregnancy. Continuity of care may have facilitated a trusting relationship where participants felt more able to speak freely about concerns that they may not have felt comfortable sharing with others. This seems especially important in relation to discussions about alcohol consumption, with previous research indicating continuity of care creates a supportive relationship between women and their antenatal care provider,³⁶ and increased women's feelings of safety in relation to disclosing sensitive information.³⁷ The foundation for creating such a supportive relationship begins with the initial antenatal care visit. The significance of this visit was expressed by Jane:

I feel it's important that women feel listened to and supported and just well-educated around how a healthy birth can happen or how your body or how things work together to move towards that direction rather than towards potential complications, so I think the role of antenatal care is huge and it really influences massively the choices women make, based on that first antenatal visit.

5.1. Limitations

The limitations of the current study include acknowledgement that participants' accounts were retrospective and as such, accuracy and salience of their experiences may have been distorted by memory. It is also important to note that, given the qualitative nature of this research, the results cannot be generalised to the broader population of women attending their initial antenatal care visit. Future research with larger and more diverse samples is needed to determine whether these results apply to other women; however, the current study adds to our understanding of how this cohort of women received and interpreted messages relating to alcohol consumption, during their first antenatal care visit.

5.2. Implications

The findings from this study suggest that verbal and written messages given to women during their first antenatal care visit are largely consistent in communicating current government guidelines that there is no safe level of alcohol use during pregnancy. Not all women in this study, however, received this message, and some reported confusion related to differing messages that they received. This suggests further work is required in order to educate all antenatal care providers about both the existence and the communication of these guidelines. Notable, is the differing ways in which participants interpreted the messages they received about alcohol consumption. Whilst most chose not to consume alcohol during their pregnancy, some reported drinking "infrequently" or in "small amounts". It therefore seems important to continue to promote an abstinence message; however, the message needs to be communicated in a balanced and rational way to avoid unintended negative consequences, which may contribute to feelings of judgement, guilt or anxiety.

Conclusion

Although messages about alcohol consumption during initial antenatal care visits shows some consistency, more important are the ways in which these messages are being interpreted by women. Messages appear to be interpreted within both an individual and socio-cultural context, leading to women's choices about alcohol consumption being influenced by a myriad of factors. Consequently,

465 it is important that antenatal care services provide support that is tailored to the individual needs of
466 women, in order to facilitate open discussions about sensitive topics such as alcohol consumption.

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470 The author has no conflicts of interest in relation to funding to declare.

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