



LJMU Research Online

Schölin, L, Hughes, K, Bellis, MA, Eriksson, C and Porcellato, LA

“I think we should all be singing from the same hymn sheet” – English and Swedish midwives’ views of advising pregnant women about alcohol

<http://researchonline.ljmu.ac.uk/id/eprint/9524/>

Article

Citation (please note it is advisable to refer to the publisher’s version if you intend to cite from this work)

Schölin, L, Hughes, K, Bellis, MA, Eriksson, C and Porcellato, LA (2018) “I think we should all be singing from the same hymn sheet” – English and Swedish midwives’ views of advising pregnant women about alcohol. *Drugs: Education. Prevention. and Policv.* 26 (5). pp. 394-400. ISSN 0968-

LJMU has developed **LJMU Research Online** for users to access the research output of the University more effectively. Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in LJMU Research Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain.

The version presented here may differ from the published version or from the version of the record. Please see the repository URL above for details on accessing the published version and note that access may require a subscription.

For more information please contact researchonline@ljmu.ac.uk

<http://researchonline.ljmu.ac.uk/>

“I think we should all be singing from the same hymn sheet” – English and Swedish midwives’ views of advising pregnant women about alcohol

Many countries have adopted abstinence guidelines for pregnant women, due to uncertainty around the risk of harm caused by small amounts of alcohol. There is a lack of research exploring frontline midwives’ attitudes towards alcohol use during pregnancy and comparisons of practices in different countries. Sixteen semi-structured interviews were conducted with midwives working in Liverpool, England (n=7) and Örebro County, Sweden (n=9). Data were analysed inductively, using thematic analysis with thematic networks. The findings show that all midwives believed pregnant women should be advised not to consume any alcohol during pregnancy and there is a need to tailor their approach to the individual. A key concern among midwives in both countries was how to advise about alcohol exposure that occurs before the pregnancy is known to the woman. English midwives discussed the uncertainty around the risk of consuming small amounts of alcohol, whereas Swedish midwives believed any amount of alcohol was associated with risk. Discussing alcohol was viewed as part of the health professional’s role, but routine questions for all women were perceived to aid discussions about alcohol. Future research should further explore the impact of wider social and political environment on midwives’ attitudes around risks with prenatal alcohol use.

Keywords: alcohol; pregnancy; prevention; antenatal care; qualitative research

“I think we should all be singing from the same hymn sheet” – English and Swedish midwives’ views of advising pregnant women about alcohol

Introduction

Alcohol exposure during pregnancy is associated with risk of harm, relating to negative pregnancy outcomes and foetal development. These include miscarriage, pre-term birth, low birth weight and small for gestational age infants, and foetal alcohol spectrum disorder (FASD) (Bailey & Sokol, 2011; O’Leary, 2004; Patra et al., 2011; Riley, Infante, & Warren, 2011; Sokol, Delaney-Black, & Nordstrom, 2003). Whilst the evidence of harm as a result of high alcohol intake is clear (O’Leary, 2004), there is a paucity of evidence regarding the risk of consuming smaller amounts of alcohol (Mamluk et al., 2017). Uncertainty about the threshold for risk has resulted in drinking guidelines recommending complete abstinence in many countries (Department of Health and Human Services, 2005; NBHW, 2014; NHMRC, 2009). To prevent and reduce harm caused by alcohol exposure, antenatal care is a key arena for prevention. International guidelines, published by the World Health Organization (WHO), recommend that all pregnant women are asked about their alcohol consumption and provided with an intervention if they continue to drink during pregnancy (WHO, 2014).

Prenatal alcohol use is relatively common in Europe. Recent estimates show that a quarter of European women have consumed alcohol at some point during their pregnancy. The rate of drinking, however, varies widely across countries. The UK, for example, has one of the highest prevalence rates (41.3%), while Sweden has one of the lowest (9.4%) (Popova, Lange, Probst, Gmel, & Rehm, 2017). Differences in prevalence may relate to the level of alcohol consumption in the general population, but official drinking guidelines could also have an influence. Recommendations regarding

alcohol use during pregnancy in the UK were revised in the Chief Medical Officers' (CMOs) Alcohol Guidelines in 2016 (Department of Health, 2016). Previous guidelines recommended abstinence as the safest option, though if women choose to drink, they should limit themselves to one to two UK units per week after the first trimester (NICE, 2008). The revised drinking guidelines now advise that alcohol should be avoided completely (Department of Health, 2016) and are aligned with guidelines in many other countries, including Sweden (NBHW, 2014).

Although many countries have adopted abstinence-based policies, research suggests a discord between recommended policy and practice. The proportion of midwives advising abstinence to pregnant women has been reported as 61% in Denmark (Kesmodel & Kesmodel, 2011), 99.4% in Australia (Payne et al., 2014), and 93% in England (Winstone & Verity, 2015). However, 41% of midwives in a study in England reported advising pregnant women to limit their alcohol intake to one to two units once or twice per week, and 27% advised women to not get drunk, which at the time was in line with the existing guidelines (Winstone & Verity, 2015). Studies showing non-adherence to guidelines suggest that some midwives advise that smaller amounts can be consumed due to lack of evidence of harm at low levels of consumption (Crawford-Williams, Steen, Esterman, Fielder, & Mikocka-Walus, 2015; van der Wulp, Hoving, & de Vries, 2013). Furthermore, some midwives diverge from abstinence guidelines by making exceptions for occasional drinking or drinking at special occasions (Kesmodel & Kesmodel, 2011; van der Wulp et al., 2013).

Along with the type of advice given, practices of routinely asking pregnant women about their alcohol use differ between countries. A qualitative study from Australia found that midwives reported addressing alcohol on a routine basis, yet the pregnant women perceived such conversations as brief and only occurring during the

initial appointment (Jones, Telenta, Shorten, & Johnson, 2011). Evidence from England also highlights that not all pregnant women are asked about their alcohol use; a study of 1862 midwives found that 60% of midwives routinely asked about alcohol use and only 29% routinely provided information regarding alcohol and pregnancy (Winstone & Verity, 2015). As international guidelines have set out as a priority that all women are asked about their alcohol use (WHO, 2014), understanding how midwives approach pregnant women about their alcohol use is therefore of importance.

The main aim of the present study was to explore perceptions and practices of providing alcohol advice to pregnant women among frontline midwives in England and Sweden. The study addresses three primary questions: i) how midwives within different policy contexts approach the subject of alcohol; ii) what advice they give to pregnant women; and iii) what their attitudes towards official guidelines are.

Materials and Methods

Data collection

Semi-structured interviews were conducted between October and November, 2014, with midwives working at a local maternity service in Liverpool City (n=7) and regional maternity services in Örebro County (n=9). The Head of Midwifery at each location sent out information about the study via email, and in Liverpool, information was also disseminated through a staff newsletter. Midwives who were interested in taking part in the study contacted the lead researcher (X) directly to arrange for an interview. A total of 17 midwives expressed interest in taking part, however one Swedish midwife withdrew her intention to participate due to lack of time. A £10/100SEK voucher was given to all participants as compensation for their time. Data collection was concluded as data saturation was considered to be reached as no new codes were identified in the

final transcripts analysed.

Prior to the interview, all midwives were provided with an information sheet outlining the purpose of the study. Participants were informed that their data would be treated confidentially and that all accounts would be anonymised. Written consent was obtained from all participants. Interviews were conducted in a place most suitable for the participant, including university premises, their workplace, or their home.

All interviews were conducted in English or Swedish by X, who is fluent in both languages. Swedish interviews were analysed in their original form, to retain accuracy in the interpretation (Temple & Young, 2004). The average time for interviews was 50 minutes. The interview guide was developed based on the existing literature, focusing on three main topics: i) general attitudes towards alcohol use in pregnancy, ii) experiences and practices around alcohol advice, and iii) knowledge of alcohol-related birth defects and views on different approaches to inform pregnant women. In this paper, we focus on the first two topics. The present study was informed by a previous study on perceptions and practices of alcohol use during pregnancy amongst parents (Schölin, Hughes, Bellis, Eriksson & Porcellato, 2017).

Ethical approval was granted from Liverpool John Moores University in England (13/HEA/078 and 14/EHC/027), Uppsala Ethical Review Board in Sweden (2014/132), and local maternity services in England (RE:033).

Data analysis

Open coding of the transcribed interviews was undertaken by X, using NVivo 10 (NVivo, 2012), and the developed coding framework was discussed throughout with another qualitative researcher (Y). Data were analysed thematically, according to the six-step approach developed by Braun and Clark (Braun & Clarke, 2006) and visualised using thematic networks (Attride-Stirling, 2001) (Figure 1). To establish trustworthiness

of the analysis, transcripts from the initial two interviews and the coding framework were cross-checked by Y.

[Insert Figure 1 here]

Participants

Sixteen midwives with experience in addressing alcohol use with pregnant women were interviewed (Table 1). The age of midwives ranged from 32 to 62 years (median=48 years), and years of professional experience from 1.5 to 38 years (median=13.5 years). The English sample included four community midwives and three midwives with specialist practice areas (obesity, substance misuse, and teenage pregnancies). In the Swedish sample, midwives were recruited from local general practices in Örebro County, and no midwife had a specialist area.

[Insert Table 1 here]

Results

Four key themes emerged from the analysis; pregnant women's lifestyles, promoting a healthy lifestyle, antenatal practises, and the midwifery role. The first two themes are here presented together, as there is a great deal of overlap between them. The following sections describes the findings, represented with anonymised quotations.

Pregnant women's lifestyles and promoting a healthy lifestyle

Overall, midwives in both countries noted that the number of pregnant women who report alcohol use is very low.

My general view is probably that I perceive that they are pretty few, in relation to how many who drink alcohol before they get pregnant, so to speak (Swedish midwife 4)

Most of them will say they have stopped drinking (English midwife 7).

However, some English midwives also suggested that women might not be truthful and may underreport alcohol intake due the stigma around drinking during pregnancy.

Swedish midwives did not question the truthfulness of their clients; the low prevalence was viewed as an accurate representation of how uncommon prenatal alcohol use is.

One English midwife specifically suggested she had met “ladies who are general directors and they say that they really long for that glass of wine and they’re not gonna stop or that gin and tonic” (English midwife 5). This excerpt suggested that some alcohol, even specific drinks, may be acceptable among women of higher socioeconomic status (SES). On the other hand, Swedish midwives suggested that any drinking would be an indication of an underlying drinking problem.

There was agreement from English and Swedish midwives that drinking in general, and women’s drinking in particular, is a public health concern.

I actually think that people drink incredible amounts. And it is shocking sometimes when you hear how young women drink. They are wasted (Swedish midwife 8)

In general I think alcohol is just a massive issue for this country and this region in general [...] massive public health issue isn’t it (English midwife 1)

Whilst all midwives stressed the importance of alcohol as a risk factor for adverse outcomes during pregnancy, some argued that information and guidance to pregnant women needs to be streamlined. They therefore argued that focusing on ‘the big things’, such as alcohol, smoking and healthy eating, helps women make the most important lifestyle alterations. A main concern related to the large amount of information given to pregnant women, and potentially conflicting advice from media, relatives, or friends.

So there's a big checklist "don't smoke, don't drink [...] if we can target and say "yeah eat healthily, don't drink alcohol and don't smoke," I think you've got a big section of it sorted then and done [...] That's when they watch on the telly don't they with their mum and they'd go "red wine is good for the cardiac flow" (English midwife 5)

Midwives acknowledged that nine months is a long time for women to abstain, given the centrality of alcohol in many social situations. Midwives were asked specifically about the role of the pregnant woman's partner. In both countries, midwives felt that partners expect women to make changes to their lifestyle but rarely considered changing their own behaviours to support the women. Midwives therefore found it difficult at times to engage with partners around lifestyle changes, as noted specifically by a midwife who specialised in substance misuse.

They're never gonna stop smoking, they're never gonna stop drinking, they're not gonna stop taking drugs. But women are in a really hard position living in that, living that lifestyle with perhaps partners who was doing the opposite of what we want them to do (English midwife 4)

Antenatal practices

All midwives agreed that pregnant women should abstain from alcohol. Swedish midwives were clear on the advice they gave to women, noting that alcohol can cause harm and therefore women should be advised to abstain completely.

I don't think that you should drink alcohol during pregnancy, because it causes birth defects. So that is my recommendation to all pregnant women, that you abstain completely (Swedish midwife 2)

English midwives also recommended abstinence to pregnant women, but felt that changes in guidelines and conflicting information in the media cause confusion for midwives and women about potential safe levels.

The guidelines have changed and every year we seem to be giving them different information about alcohol, what's safe and what's not safe, so I think it's really confused as a professional to be honest (English midwife 4)

A lot of the media sort of information is quite variable a lot of the time. It sort of changes from "a glass of wine is okay" to "avoid alcohol at all costs", but the guidance that we work towards is that we should advise women to not drink at all (English midwife 6)

English midwives were in agreement that women should be advised to not drink any alcohol, even though the NICE guidelines allowed for smaller amounts of alcohol. One midwife called for clarity from the government to explicitly state abstinence as the safest choice, and for health professionals to all give the same advice.

Well we know that the risks are but we don't know what level would be at risk, so I would give the information, I think that we should all be singing from the same hymn sheet (English midwife 7)

However, some English midwives had a different personal opinion compared to the professional advice they dispensed.

In the back of your mind you go "one's not gonna kill ya" but I prefer to say no, no drinking (English midwife 5).

Midwives felt confident in discussing alcohol as part of their professional roles, and generally all midwives felt that routine questions were useful, as they suggest everyone is being asked about their drinking. However, there were differences in the assessment of women's drinking habits in the two countries. In England, booking questions included a section on alcohol, including current drinking and pre-pregnancy drinking in UK units. Whilst all English midwives felt they addressed alcohol adequately with those questions, some believed that other midwives may bypass the section or not ask follow-up questions. One midwife felt that this was an area that needed to be strengthened.

If you ask a yes or no question, I don't think we know because we don't ask the question. I don't know if that happens, I think we should be asking every single time (English midwife 4)

Swedish midwives' experiences were different. They described the introduction of the AUDIT screening questionnaire (Babor, Higgins-Biddle, Saunders, & Montiero, 2001), which they used to assess pre-pregnancy drinking habits, as an important tool. All Swedish midwives used the AUDIT, and several also used it to include the partner in the conversation. English midwives on the other hand did not routinely involve the partner, which one midwife acknowledged was not in line with how she addressed smoking.

And not always, but sometimes I also ask the man to fill out a (AUDIT) form and it might be there that I know since before that there is a problem or something that you might feel that there are interventions needed for both for it to work. And it can be difficult if you have a high AUDIT score and the partner continues to drink and continues with the life that she would like to do herself (Swedish midwife 6)

Not as a general rule, no, no. I mean it's the woman and her baby, but it's, there's a fine line. We don't challenge if they drink but I do with smoking cessation. I say to them "so you smoke. You've got to stop as well because you can't expect her to without support", but never with the alcohol, which is strange really when I think about it (English midwife 5)

Midwifery role

There was a unanimous view by midwives in both countries that discussing alcohol was part of their job. This was included in a wider range of topics that were perceived to be sensitive, but not necessarily difficult to talk about.

I have no problem talking about any of them things, because I feel that I am a midwife and I am a health professional and actually that's what I'm supposed to do (English midwife 2)

Swedish midwives noted that the training they had been given in Motivational Interviewing (MI)¹ had helped them in addressing the topic of alcohol adequately. One midwife however noted that “where there is (alcohol) abuse, I am happy to hand over to those who know” (Swedish midwife 6).

Building a relationship with women was a common theme, and a need for empathy was highlighted. This meant approaching women in a non-judgmental way in order to build and sustain a relationship, which at times meant tailoring advice and guidance to the individual.

I think that my job is to support, I don't really care how bad they are [laughing] because I want them to come back to me for midwifery care (English midwife 4)

My general view is obviously zero tolerance, so [laughing] but at the same time it is about individuals. So just like with the smoking it's not possible to say to everyone “no, no stop” (Swedish midwife 6)

One area that midwives in both countries found difficult was addressing alcohol use that occurred before the women knew they were pregnant. Some called for guidelines on how to deal with such issues, in order to support women in the best way.

I never say that it's not dangerous. I don't think I have ever said that, but you are very tempted. Because you want to do good (Swedish midwife 7)

I would really like to know what advice could be given to somebody say who've done it for about eight weeks. And maybe heavily. So I don't know what the implications of that are. So I should be able to give her that advice, you know, what we do (English midwife 1)

¹ MI is an effective behaviour change method due to the focus on “evoking the client's inherent motivation rather than installing motivation from elsewhere” (p.358) (Moyers, 2014)

One Swedish midwife suggested that the timeline follow back (TLFB) questionnaire is a good resource to, ascertain if the woman was not pregnant at the time she consumed alcohol. However, when TFLB results confirm that alcohol was consumed after conception, the difficulty in advising pregnant women still remains.

Discussion

To our knowledge, this is the first study to adopt a cross-cultural approach to exploring midwives' perceptions of drinking advice in countries endorsing different drinking guidelines for pregnant women. We found that midwives universally advised abstinence, regardless of the official guidelines. However, as we have demonstrated, perceptions of risk differed between the two countries.

Midwives in the study talked about how alcohol use among pregnant women is uncommon; however some English midwives questioned the honesty of the responses and noted some women may continue to drink. Swedish midwives' risk discourse, in contrast to English midwives, was binary: either women stop drinking or they continue because they have an underlying drinking problem. English midwives' views were more nuanced, and the uncertainty around the risk of drinking small amounts was mentioned. This reflects our previous work, which showed a similar binary risk discourse among new parents in Sweden (Schölin et al., 2017). A few midwives mentioned one specific group of women who disputed the abstinence advice: women of higher SES. Interestingly, no midwives explicitly discussed drinking among women of lower SES, despite a higher prevalence of FASD in such populations (Lange, et al., 2017). The general perception that drinking was uncommon might have influenced these experiences, meaning midwives had not come across a range of women who continue to drink. However, their experiences may also indicate a bias in which women may feel comfortable disclosing their drinking.

Women's drinking behaviour in general was a public health concern among midwives. Relating to pre-pregnancy habits, inadvertent exposure before knowing about the pregnancy was perceived as common, and some midwives found it challenging to provide reassurance in these situations. As women seek advice about the impact of alcohol exposure before knowing about the pregnancy (Holland, McCallum & Walton, 2016), guidance for midwives on how to advise women in such circumstances is needed. The UK CMO drinking guidelines state that if a woman has drunk small amounts of alcohol before finding out about the pregnancy, the risk of harm is low. Furthermore, women who have drunk during early pregnancy are reassured that "it is unlikely in most cases that their baby has been affected" (p.5) (Department of Health, 2016). The TLFB was noted as a good method for potentially reassuring women who are worried about unintentional exposure, but clearer guidance on what to advise women was requested by midwives. From a primary prevention perspective, however, reaching women before they get pregnant may reduce the number of women drinking before finding out about the pregnancy. Programs aimed at non-pregnant women have shown promising results in reducing risky alcohol use, to some extent, as well as in increasing the use of contraception (Schölin, 2016).

Findings from this study highlighted three areas of alcohol advise-giving midwifery practice of particular importance. Firstly, establishing and nurturing a good relationship with women is at the core of midwives' practices (Heslehurst et al., 2013; McLeod et al., 2003; Phillips et al., 2007; Schmied, Duff, Dahlen, Mills, & Kolt, 2011). Reluctance to implement advice-giving practices or provide abstinence advice may relate to concerns of causing upset (Doi, Cheyne, & Jepson, 2014; van der Wulp et al., 2013). However, we did not find that midwives were concerned that discussing alcohol would affect the midwife-woman relationship. Secondly, routine questions facilitated

discussions around alcohol, reflecting that screening instruments can be a “pedagogical tool” to engage with patients (Nilsen, Wåhlin, & Heather, 2011) and reduce feelings of stigma (Chang, 2001). Finally, midwives noted that engaging with partners can be difficult and some only addressed the partner’s drinking if they were aware about an existing drinking problem. Inclusion of a partner may enhance outcomes of behaviour change interventions (Chang et al., 2005), and a Swedish study found that partners responded positively to being included in midwife counselling about alcohol consumption (Högberg, Skagerström, Spak, Nilsen, & Larsson, 2016)

The novel cross-cultural design provided further insights into midwives’ approaches to advising pregnant women. We found that midwives in England and Sweden unanimously advocated for abstinence, regardless of the official guidelines in place at the time of the study. Previous research has shown that scepticism towards the evidence for risks of low to moderate alcohol consumption may lead midwives to advise women that some alcohol can be consumed (Crawford-Williams et al., 2015). We found that some English midwives expressed views that small amounts might not cause harm, however they believed that abstinence was the clearest and best advice to give. Swedish midwives’ views, however, appeared anchored in a strong belief that even small amounts could harm the baby, which may be rooted in wider socio-cultural views of risk. We previously demonstrated this in a study of new parents (Schölin et al., 2017), where risk discourses were intertwined with moral judgements of good motherhood and female autonomy. Governmental approaches to construction of risk of alcohol use during pregnancy may reinforce such views. For example, Leppo, Hecksher and Tryggvesson (2014) found that health education materials in Sweden advocate a precautionary approach of abstinence by stating that evidence suggests that even small amounts can harm the baby.

The differences in personal and professional opinions regarding abstinence are interesting when considering wider discussions about alcohol use during pregnancy. Australian research shows that media coverage of alcohol use during pregnancy includes a variety of frames diverging from the abstinence guidelines, by emphasising that evidence of harm from lower levels of drinking has been inconclusive (McCallum & Holland, 2017). Similar framing has also appeared in the two countries included in the current study. In the UK, an article in *The Guardian* suggested that the 2016 CMOs' Alcohol Guidelines unfairly punish pregnant women, as the risk of consuming small amounts remains disputed (Campbell, 2017). A recent article in a Swedish newspaper described the release of a book on pregnancy and parenting, which suggested that women can consume "five to six glasses of wine per week" (one standard glass equals 12g alcohol). The article also included a response from The National Food Agency, which strongly disagreed with the claims of the book (Aftonbladet, 2017).

Our findings offer insights into the provision of advice by midwives, their attitudes to alcohol use during pregnancy, and the differences in risk discourse between countries. The results point to the need for further research into the impact of risk discourse and how it shapes health behaviour in pregnant women. Furthermore, the impact of the wider policy environment and media discourses on health professionals should be explored further.

Limitations and strengths

A number of limitations should be recognized when interpreting the findings of this study. Our qualitative study included a small number of midwives in specific regions in England and Sweden, and the results might not be generalizable to other parts of the countries. Furthermore, the sample is too small to explore differences depending on personal characteristics, such as length of professional experience, age, parity or own

drinking status. Furthermore, midwives who do not provide abstinence advice may have chosen not to take part in the study. Similarly, any Swedish midwives who provided advice other than abstinence may not have disclosed it in the interview, due to the clear abstinence guidelines. Although the method of recruitment, which involved support from the health of Midwifery services, may have potentially biased which midwives took part in the research, the anonymity of the participants and the fact that they expressed their interest directly to the lead researcher mitigated against this. Despite these limitations, this cross cultural study has provided unique insight into practices of advising pregnant women about alcohol, and contributes to an understanding of how wider social and political environment influence midwives' attitudes around risks with prenatal alcohol use.

Acknowledgements

We would like to thank all the midwives who participated in the study and the maternity services in the two locations who supported the recruitment and data collection.

Disclosure of interest

The authors report no conflict of interest.

References

- Aftonbladet (2017, 16 September). Råd till gravida om alkohol sågas [Advice about alcohol to pregnant women discarded] Retrieved from <https://www.aftonbladet.se/nyheter/a/3v08A/rad-till-gravida-om-alkohol-sagas>
- Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, 1(3), 385–405. doi: 10.1177/146879410100100307

- Babor, T. F., Higgins-Biddle, J. C., Saunders, J., & Montiero, M. (2001). *AUDIT: The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care (second edition)*. Geneva: World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/10665/67205/1/WHO_MSD_MSB_01.6a.pdf
- Bailey, B. A., & Sokol, R. J. (2011). Prenatal Alcohol Exposure and Miscarriage, Stillbirth, Preterm Delivery, and Sudden Infant Death Syndrome. *Alcohol Research & Health*, 34(1), 86–91. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3860553/pdf/arh-34-1-86.pdf>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. doi: 10.1191/1478088706qp063oa
- Campbell, D. (2017, May 18). Warning pregnant women over dangers of alcohol goes too far, experts say. *The Guardian*. Retrieved from <https://www.theguardian.com/politics/2017/may/18/warning-pregnant-women-over-dangers-of-alcohol-goes-too-far-experts-say>
- Chang, G. (2001). Alcohol-screening instruments for pregnant women. *Alcohol Research & Health*, 25(3), 204–209. Retrieved from <https://pubs.niaaa.nih.gov/publications/arh25-3/204-209.pdf>
- Chang, G., McNamara, T. K., Orav, E. J., Koby, D., Lavigne, A., Ludman, B., ... Wilkins-Haug, L. (2005). Brief Intervention for Prenatal Alcohol Use: A Randomized Trial. *Obstetrics & Gynecology*, 105(5), 991–998. doi: 10.1097/01.AOG.0000157109.05453.84
- Crawford-Williams, F., Steen, M., Esterman, A., Fielder, A., & Mikočka-Walus, A. (2015). “If you can have one glass of wine now and then, why are you denying that to a woman with no evidence”: Knowledge and practices of health professionals concerning alcohol consumption during pregnancy. *Women and Birth : Journal of the Australian College of Midwives*, 28(4), 329–335. doi: 10.1016/j.wombi.2015.04.003
- Department of Health. (2016). *UK Chief Medical Officers’ Low Risk Drinking Guidelines*. London: Department of Health. Retrieved from <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attach>

ment_data/file/545937/UK_CMOs__report.pdf

Department of Health and Human Services. (2005). U.S. surgeon general releases advisory on alcohol use in pregnancy. Retrieved from <https://wayback.archive-it.org/3926/20140421162517/http://www.surgeongeneral.gov/news/2005/02/sg02222005.html>

Doi, L., Cheyne, H., & Jepson, R. (2014). Alcohol brief interventions in Scottish antenatal care: a qualitative study of midwives' attitudes and practices. *BMC Pregnancy and Childbirth*, *14*(1), 170. doi: 10.1186/1471-2393-14-170

Heslehurst, N., Russell, S., McCormack, S., Sedgewick, G., Bell, R., & Rankin, J. (2013). Midwives perspectives of their training and education requirements in maternal obesity: a qualitative study. *Midwifery*, *29*(7), 736–744. doi: 10.1016/j.midw.2012.07.007

Holland, K., McCallum, K. & Walton, A. (2016) 'I'm not clear on what the risk is': women's reflexive negotiations of uncertainty about alcohol during pregnancy, *Health, Risk & Society*, *18*:(1–2), 38–58. doi: 10.1080/13698575.2016.1166186

Högberg, H., Skagerström, J., Spak, F., Nilsen, P., & Larsson, M. (2016). Alcohol consumption among partners of pregnant women in Sweden: a cross sectional study. *BMC Public Health*, *16*(1), 694. doi: 10.1186/s12889-016-3338-9

Jones, S., Telenta, J., Shorten, A., & Johnson, K. (2011). Midwives and pregnant women talk about alcohol: what advice do we give and what do they receive? *Midwifery*, *27*(4), 489–96. doi: 10.1016/j.midw.2010.03.009

Kesmodel, U. S., & Kesmodel, P. S. (2011). Alcohol in Pregnancy: Attitudes, Knowledge, and Information Practice Among Midwives in Denmark 2000 to 2009. *Alcoholism: Clinical and Experimental Research*, *35*(12), 2226–2230. doi: 10.1111/j.1530-0277.2011.01572.x

Lange, S., Probst, C., Gmel, G., Rehm, J., Burd, L. & Popova, S. (2017) Global prevalence of Fetal Alcohol Spectrum Disorder among children and youth. *JAMA: 171*(10):948–956. doi: 10.1001/jamapediatrics.2017.1919

- Leppo, A., Hecksher, D., & Tryggvesson, K. (2014). 'Why take chances?' Advice on alcohol intake to pregnant and non-pregnant women in four Nordic countries. *Health, Risk & Society*, 16(6): 512–529. doi: 10.1080/13698575.2014.957659
- Lovatt, M., Eadie, D., Meier, P. S., Li, J., Bauld, L., Hastings, G., & Holmes, J. (2015). Lay epidemiology and the interpretation of low-risk drinking guidelines by adults in the United Kingdom. *Addiction*, 110(12), 1912–1919. doi: 10.1111/add.13072
- Mamluk, L., Edwards, H. B., Savović, J., Leach, V., Jones, T., Moore, T. H. M., ... Zuccolo, L. (2017). Low alcohol consumption and pregnancy and childhood outcomes: time to change guidelines indicating apparently “safe” levels of alcohol during pregnancy? A systematic review and meta-analyses. *BMJ Open*, 7(7), e015410. doi: 10.1136/bmjopen-2016-015410
- McCallum, K. & Holland, K. (2017). 'To drink or not to drink': media framing of evidence and debate about alcohol consumption in pregnancy. *Critical Public Health*, 1–12. doi: 10.1080/09581596.2017.1414150
- McLeod, D., Benn, C., Pullon, S., Viccars, A., White, S., Cookson, T., & Dowell, A. (2003). The midwife's role in facilitating smoking behaviour change during pregnancy. *Midwifery*, 19(4), 285–297. doi: 10.1016/S0266-6138(03)00038-X
- Moyers, T. (2014). The Relationship in Motivational Interviewing. *Psychotherapy*, 51(3), 358–363. doi: 10.1037/a0036910
- NBHW. (2014). *Kunskapsstöd för mödrahälsovården*. Stockholm: National Board of Health and Welfare. Retrieved from <http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19328/2014-2-2.pdf>
- NHMRC. (2009). *Australian Guidelines to reduce health risks from drinking alcohol*. Canberra: Commonwealth of Australia. Retrieved from https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf
- NICE. (2008). *Antenatal Care - NICE clinical guideline 62*. London: National Institute for Health and Clinical Excellence. Retrieved from

www.nice.org.uk/nicemedia/pdf/CG062NICEguideline.pdf

Nilsen, P., Wåhlin, S., & Heather, N. (2011). Implementing brief interventions in health care: lessons learned from the Swedish Risk Drinking Project. *International Journal of Environmental Research and Public Health*, 8(9), 3609–27. doi: 10.3390/ijerph8093609

NVivo (2012). NVivo qualitative data analysis software; QSR International Pty Ltd. Version 10.

O’Leary, C. M. (2004). Fetal alcohol syndrome: diagnosis, epidemiology, and developmental outcomes. *Journal of Paediatrics and Child Health*, 40(1–2), 2–7. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/14717994>

O’Leary, C. M. (2012). Alcohol and pregnancy: do abstinence policies have unintended consequences? *Alcohol and Alcoholism*, 47(6), 638–9. doi: 10.1093/alcalc/ags094

Patra, J., Bakker, R., Irving, H., Jaddoe, V. W. V, Malini, S., & Rehm, J. (2011). Dose-response relationship between alcohol consumption before and during pregnancy and the risks of low birthweight, preterm birth and small for gestational age (SGA)-a systematic review and meta-analyses. *BJOG : An International Journal of Obstetrics and Gynaecology*, 118(12), 1411–1421. doi: 10.1111/j.1471-0528.2011.03050.x

Payne, J. M., Watkins, R. E., Jones, H. M., Reibel, T., Mutch, R., Wilkins, A., ... Bower, C. (2014). Midwives’ knowledge, attitudes and practice about alcohol exposure and the risk of fetal alcohol spectrum disorder. *BMC Pregnancy Childbirth*, 14, 377. doi: 10.1186/s12884-014-0377-z

Phillips, D., Thomas, K., Cox, H., Ricciardelli, L. A., Ogle, J., Love, V., & Steele, A. (2007). Factors That Influence Women’s Disclosures of Substance Use during Pregnancy: A Qualitative Study of Ten Midwives and Ten Pregnant Women. *Journal of Drug Issues*, 37(2), 357–375. doi: 10.1177/002204260703700207

Popova, S., Lange, S., Probst, C., Gmel, G., & Rehm, J. (2017). Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis. *The Lancet Global Health*. doi:

10.1016/S2214-109X(17)30021-9

Riley, E. P., Infante, M. A., & Warren, K. R. (2011). Fetal alcohol spectrum disorders: an overview. *Neuropsychology Review*, *21*(2), 73–80. doi: 10.1007/s11065-011-9166-x

Schmied, V. A., Duff, M., Dahlen, H. G., Mills, A. E., & Kolt, G. S. (2011). “Not waving but drowning”: a study of the experiences and concerns of midwives and other health professionals caring for obese childbearing women. *Midwifery*, *27*(4), 424–430. doi: 10.1016/j.midw.2010.02.010

Schölin, L. (2016). Prevention of harm caused by alcohol exposure in pregnancy - Rapid review and case studies from Member States. Copenhagen: World Health Organization Regional Office for Europe.

Schölin, L., Hughes, K., Bellis, M. A., Eriksson, C. & Porcellato, L. (2017). Exploring practices and perceptions of alcohol use during pregnancy in England and Sweden through a cross-cultural lens. *European Journal of Public Health*, cxx208. doi:10.1093/eurpub/cxx208

Sokol, R. J., Delaney-Black, V., & Nordstrom, B. (2003). Fetal Alcohol Spectrum Disorder. *JAMA*, *290*(22), 2996. doi: 10.1001/jama.290.22.2996

Temple, B., & Young, A. (2004). Qualitative Research and Translation Dilemmas. *Qualitative Research*, *4*(2), 161–178. doi: 10.1177/1468794104044430

van der Wulp, N. Y., Hoving, C., & de Vries, H. (2013). A qualitative investigation of alcohol use advice during pregnancy: experiences of Dutch midwives, pregnant women and their partners. *Midwifery*, *29*(11), e89--98. doi: 10.1016/j.midw.2012.11.014

WHO. (2014). *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. Geneva: World Health Organization. Retrieved from http://www.who.int/substance_abuse/publications/pregnancy_guidelines/en/

Winstone, A. M., & Verity, C. (2015). Antenatal alcohol exposure: An East Anglian

study of midwives' knowledge and practice. *British Journal of Midwifery*, 23(3),
180–186. doi: 10.12968/bjom.2015.23.3.180