



REPORT • 2026

on the situational analysis
carried out within the project
**„Opportunities in the prophylaxis of fetal
alcohol disorders in Chisinau municipality”**

UNICEF project „Opportunities in the prophylaxis of fetal alcohol disorders in Chisinau municipality”, implemented by the Public Association „Progres prin Alternativa” with the financial support of the Norwegian government, in partnership with the Ministry of Health, the Gheorghe Paladi Municipal Clinical Hospital and the Riscani Territorial Medical Association.



The project "Opportunities in the prevention of fetal alcohol disorders in the municipality of Chisinau"

(STAF pilot project) was implemented by the Public Association "Progres prin Alternativa" (Progress through Alternative) with the support of the UNICEF Republic of Moldova Country Office and in partnership with *Gheorghe Paladi* Municipal Clinical Hospital and Riscani Medical Territorial Association, between August 2025 and May 2026.



The project aimed to raise public awareness of the risks of alcohol consumption during pregnancy and prevent fetal alcohol disorders by promoting informed decisions and a supportive environment for pregnant women.

Project objectives:

- Generate evidence on knowledge, attitudes and practices related to alcohol consumption in pregnancy to support evidence-based programs and policies.
- Strengthening the capacities of health, education and social protection professionals for prevention, early identification and counselling.
- Increasing the level of information and support for pregnant women in the Riscani sector of the capital for the adoption and maintenance of FASD prevention behaviors.

The program of activities of the STAF project included:

- A quantitative study on the knowledge, attitudes and practices of women who have given birth in municipal maternity hospitals and their partners;
- A qualitative research with mothers and professionals in the fields of health, social work and psychology;
- A pilot intervention to train specialists in the Riscani sector of Chisinau municipality and to assess its impact on the professional practices and behaviors of pregnant women;
- Communication and public education activities by promoting the message "Zero alcohol in pregnancy".
- A national conference entitled "The spectrum of fetal alcohol disorders in the Republic of Moldova: from invisible reality – to responsible approaches", with the participation of experts from Romania, France, Germany and Poland.

The results obtained within the STAF project confirm that prenatal exposure to alcohol presents a real public health problem in the Republic of Moldova, insufficiently recognized and insufficiently addressed within the existing health and social protection systems.

The situational analysis has shown that the prevention of alcohol consumption in pregnancy is not systematically integrated into existing medical services. Screening and counselling depend to a large extent on the individual initiative of professionals, and the use of standardized tools and access to specific training are limited. Gaps were also identified regarding cross-sectoral collaboration, availability of methodological supports and

mechanisms for early identification of children affected by prenatal alcohol exposure. Although most of the women participating in the STAF project studies were aware of the risks associated with alcohol consumption during pregnancy, it was established that mis-perceptions persist in society about the existence of quantities considered "safe". Almost a third of respondents consider it acceptable to drink a small amount of alcohol during pregnancy, and every fifth of them perceive drinking wine as neutral or even beneficial for the baby. The level of knowledge of fetal alcohol syndrome remains low, and the study highlighted an important gap between knowledge of risks and actual behaviors, with almost three out of ten participants reporting alcohol consumption during pregnancy.

At the same time, the project demonstrated that change is possible through relatively simple and effective interventions. The training of professionals (200 specialists: medical workers, psychologists and social workers) has led to a significant increase in the frequency and quality of counseling of pregnant women on alcohol consumption, to the expansion of the use of screening tools and to the improvement of the level of knowledge among the beneficiaries. The most important result was the reduction to elimination of alcohol consumption reported after confirmation of pregnancy in the evaluated group. These findings confirm the feasibility of integrating FASD prevention into existing services, without the need for major restructuring and with insignificant additional resources.

The results of the project demonstrate that the prevention of fetal alcohol disorders can be effectively integrated into existing services, by strengthening professional skills, using standardized screening tools and developing an appropriate regulatory and methodological framework. The data generated provides a solid basis for the development of evidence-based national interventions.

In this context, the Project team requested the examination of the opportunity to include the prevention of FASD in the public health priorities of the Ministry of Health and the initiation of a process of analysis of the measures necessary for the development of a national framework for the prevention of prenatal exposure to alcohol. At the same time, it was proposed to set up an intersectoral technical working group, with the participation of representatives of the Ministry of Health (in the field of primary health care, specialized health care; maternal and child health), medical institutions, academia, professional organizations and development partners, to examine the results of the study and formulate recommendations on the integration of FASD prevention into existing policies, programs and services.

The Public Association "Progres prin Alternativa" is available to provide the complete results of the research, the tools developed within the project, the methodological materials developed and the experience gained in the implementation of the pilot intervention.

The STAF project team,
Dumitru ȘIȘCANU,
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project director

REPORT

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(STAF project)

*(presented at the round table entitled
"STAF Project: Results. Conclusions. Recommendations.", May 26, 2026, Chisinau)*

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BACKGROUND

Alcohol use during pregnancy is a preventable cause with well-documented harmful effects on the health of both the fetus and the newborn. Prenatal exposure to alcohol is linked to a wide range of outcomes, including miscarriage, premature birth, and low birth weight, as well as permanent neurological and behavioral disorders. The most severe and clearly defined consequence is fetal alcohol syndrome (FAS), an irreversible condition marked by distinctive craniofacial abnormalities, growth retardation, and central nervous system dysfunction. More broadly, FAS represents the most serious form within the spectrum of fetal alcohol disorders (FASD), which also includes partial forms characterized by neurodevelopmental deficits without the full set of physical features associated with the syndrome. Clinically, FASD is one of the leading preventable causes of intellectual disability, congenital malformations, and developmental disorders. It can also lead to secondary problems such as poor school performance, mental health issues, substance abuse, and even criminal behavior.

Worldwide, about 10% of pregnant women drink alcohol, and the prevalence of FAS is estimated at 14.6 cases per 10,000 newborns born live – equivalent to roughly 119,000 affected children born each year. Rates of FASD in vulnerable groups such as institutionalized children, individuals in correctional facilities, and students with special educational needs are 10 to 40 times higher. The situation is particularly concerning in the WHO European Region, where alcohol use during pregnancy reaches 25.2% – the highest of all WHO regions – and FAS prevalence is 2.6 times the global average. This places Europe, especially Eastern Europe, at high public health risk. The five countries with the highest rates of alcohol use in pregnancy are all in Europe: Russia, the United Kingdom, Denmark, Belarus, and Ireland.

Studies of adopted children from Eastern Europe, including the Republic of Moldova, confirm this vulnerability: among children adopted from Russia and Ukraine, at least half showed FASD-related features, with 20.4% meeting criteria for full FAS and 17.2% for partial FAS.

A key risk factor is unplanned pregnancy, which is often linked to alcohol exposure during the periconception period. European studies highlight a strong association between pregnancy planning and preventive behaviors, including alcohol avoidance. Multicenter research also shows that alcohol use during pregnancy varies widely by region, and paradoxically, women of older age, higher education, and higher socioeconomic status may be more likely to drink alcohol during pregnancy.

The Republic of Moldova is part of a particularly vulnerable regional context. According to WHO data, it ranks among the countries with the highest per capita alcohol consumption worldwide, estimated at 11.4 litres of pure alcohol in 2024. This level of consumption is most commonly recorded among people of reproductive age (20–44 years), which significantly increases the risk of fetal alcohol exposure.

In the Republic of Moldova, the situation is marked by a significant lack of statistical data. Although medical professionals report cases of alcohol use during pregnancy, there are no official statistics on its incidence among pregnant women. International studies covering Eastern Europe place Moldova alongside Romania and Ukraine as territories

where the prevalence of FAS among institutionalized children has been documented, but they do not provide separate, nationally representative data for each country.

The absence of representative national data makes it difficult to evaluate how effectively public health messages reach the target population, to identify the groups most at risk, and to understand the factors sustaining this behavior during pregnancy. Moreover, the lack of information on trends in alcohol use among pregnant women limits the development of evidence-based public policies and the efficient allocation of resources for interventions.

In this context, research conducted within the UNICEF project "*Opportunities in the prophylaxis of fetal alcohol disorders in Chisinau municipality*" (2025) represents the first comprehensive assessment of FASD in Moldova. The situational analysis aimed to formulate practical recommendations for prevention and was based on three distinct studies:

- **Perceptions and behavior regarding alcohol consumption in pregnancy**, documenting the knowledge, attitudes, and practices of women who had recently given birth in municipal maternity hospitals in Chisinau, as well as their partners, regarding alcohol use during pregnancy.
- **Barriers and opportunities in the prevention of FASD**, a qualitative component based on thematic focus groups with specialists in the medical, psychological, and social fields. It explored perspectives on prevention, current counseling practices, barriers and support needs, and opportunities to strengthen intersectoral collaboration.
- **Impact of training activities for service providers on reducing alcohol consumption during pregnancy**: a survey of pregnant women who were registered for prenatal medical care before and after the training of specialists (medical staff, social workers, and psychologists) on reducing alcohol use during pregnancy and preventing FASD.

The research activities were conducted with the approval of the National Committee for Ethical Expertise of the Clinical Trial (No. 2035, 11.11.2025).

The findings highlight the urgent need for an integrated national policy on the prevention of fetal alcohol spectrum disorders, including:

- primary and preconception prevention,
- systematic screening during pregnancy,
- counseling and motivational communication,
- multidisciplinary professional training,
- development of integrated medical-psycho-social services,
- early intervention for affected children,
- public communication campaigns,
- stigma reduction,
- strengthened cross-sectoral collaboration,
- mechanisms for continuous monitoring and research.

The available evidence confirms that prevention of FASD can become a realistic, feasible, and effective component of existing reproductive and maternal health services, provided that a coherent strategic and operational framework is established.

PERCEPTIONS AND BEHAVIOR REGARDING ALCOHOL CONSUMPTION IN PREGNANCY

(Quantitative study)

Purpose and objectives of the study

The study aimed to document the knowledge, attitudes, and practices related to alcohol consumption during pregnancy among women who gave birth in municipal maternity hospitals in Chisinau, as well as their partners. The findings provide an empirical basis for the development of prevention and counseling interventions.

Specific objectives:

- Provide an overview of the level of information and actual behaviors concerning alcohol use during pregnancy.
- Identify vulnerable groups and the factors associated with alcohol consumption during pregnancy.
- Substantiate targeted prevention and counseling interventions adapted to the national context.

The inclusion of spouses and partners reflects recognition of their role in shaping women's behaviors during the perinatal period and highlights the need to address alcohol consumption as a shared responsibility of the couple, rather than solely an individual issue.

Study methodology

Study design

This study employed a quantitative, cross-sectional design of the Knowledge, Attitudes, and Practices (KAP) type. Research was conducted among women who gave birth in two municipal maternity hospitals in Chisinau: "Gheorghe Paladi" Municipal Clinical Hospital and Municipal Maternity No. 2.

Primary data were collected through a self-administered electronic questionnaire, completed by respondents after discharge from the maternity ward (*Annex 1*).

Participant sampling

The eligible population consisted of women who gave birth in the participating hospitals between June and October 2025. Eligibility required complete contact details recorded in the mother's medical file. Cases of antenatal death and neonatal death occurring during hospitalization prior to the mother's discharge were excluded from the sample.

Sampling was conducted randomly, resulting in 1,063 women selected and invited to participate in the study. Data collection took place between December 2025 and February 2026.

Participation consents were obtained in distinct stages. Specific consent for this study was reconfirmed by telephone at the time of contact by operators, prior to sending the electronic questionnaire.

Participant enrollment

Enrollment was conducted by trained operators, who initiated telephone contact with all 1,063 selected women. Of these, 262 were not reached, either due to lack of coverage or incorrect phone numbers recorded in the medical files. Another 38 women declined participation.

A total of 763 women consented to take part in the study. Each was sent an SMS containing a link to the electronic questionnaire along with a unique identification code. Respondents were also given the option to complete the questionnaire in either Romanian or Russian.

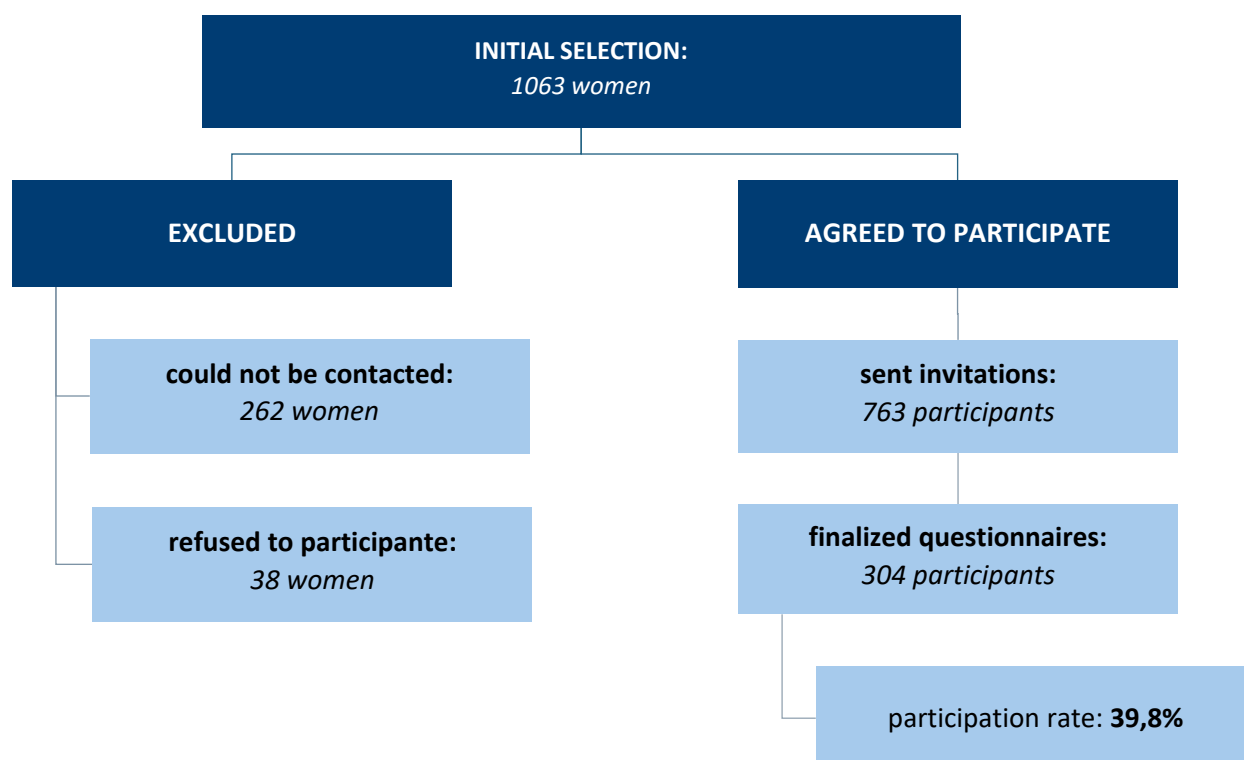


Figure 1. Sampling and enrolment.

The questionnaire was completed by 304 participants, resulting in a final response rate of 39.8% relative to the number of women who had agreed to participate (*Figure 1*). The lower turnout compared to the anticipated 50% may be explained, at least in part, by the influence of social media campaigns warning about digital fraud during the enrollment period.

Spouse/partner questionnaire

At the end of the women's questionnaire, respondents were encouraged to share a link to a separate survey designed for spouses or partners (*Annex 2*). Forty individuals completed the partner questionnaire, representing 13.2% of the total number of female participants.

The low participation rate among partners limits the ability to generalize conclusions for this subgroup. Accordingly, the results from this questionnaire will be presented in an exploratory manner, as complementary data.

Data collection tools

Data were collected through two distinct electronic questionnaires: one for women and another for their partners. Both instruments addressed the three core areas of the study: knowledge, attitudes, and practices regarding alcohol consumption during pregnancy.

The questionnaires were developed by the project team in consultation with specialists in public health, obstetrics, and behavioral research. The development process included a literature review and analysis of tools used in similar KAP studies internationally, ensuring methodological alignment with recognized standards. Questions were structured around the three study dimensions and adapted to the local socio-cultural context to ensure accessibility and relevance for the target population. Prior to data collection, the instruments were reviewed and refined based on expert feedback.

Administration of the electronic questionnaires was carried out via the Microsoft Forms platform, accessible to respondents through a link sent by SMS. The platform provided mobile compatibility, an intuitive interface, multilingual options, and automatic centralized data collection. Conditional branching logic was configured directly within the platform, ensuring that questions were displayed based on prior responses, thereby reducing errors and enhancing relevance for each participant.

Data analysis

Prior to analysis, the data were checked for integrity, including the identification and exclusion of duplicate records from the same respondent.

Descriptive analysis included the calculation of absolute and relative frequencies (percentages) for nominal variables, as well as mean values and standard deviations for continuous variables.

Comparisons between subgroups, defined by pregnancy planning (planned vs. unplanned) and level of education (higher vs. no higher education), were conducted using inferential statistical tests. For the nominal variables, the chi-square test (χ^2) was applied. Comparisons of means were performed by analysis of variance (ANOVA). Differences between groups were considered statistically significant at the $p < 0.05$ threshold.

Privacy and data protection

Before completing the electronic questionnaires, respondents were provided with clear information regarding: the purpose of the study, the voluntary nature of participation, their rights as research subjects, as well as the right to refuse participation or to withdraw at any time, without any consequences.

The separation between identification data and answers provided was ensured by the strict separation of tasks within the team. The operators who contacted the participants by phone and who knew their identity did not have access to the answers provided. In turn, the team members involved in the analysis and interpretation of the data did not have access to the respondents' identifying information. The consolidated database, the only one that allowed contact details to be associated with responses, was managed exclusively by the study coordinator.

The data were used only for research purposes in accordance with the stated objectives of the study, stored and processed under appropriate security conditions, with access restricted to the members of the research team and were not transmitted to third parties.

Results of the women's questionnaire

Socio-demographic characteristics

The sample included participants residing both in Chisinau municipality, as well as in other regions of the country. The proportion of women residing outside the capital was 26.6% ($n = 81$), which reflects the extended service area of the two participating maternity hospitals and gives the sample geographical diversity, but without being representative at the national level.

Of the participants residing in Chisinau municipality, the proportions residing in different sectors were relatively balanced, ranging between 9.2% and 13.8% (*Figure 2*).

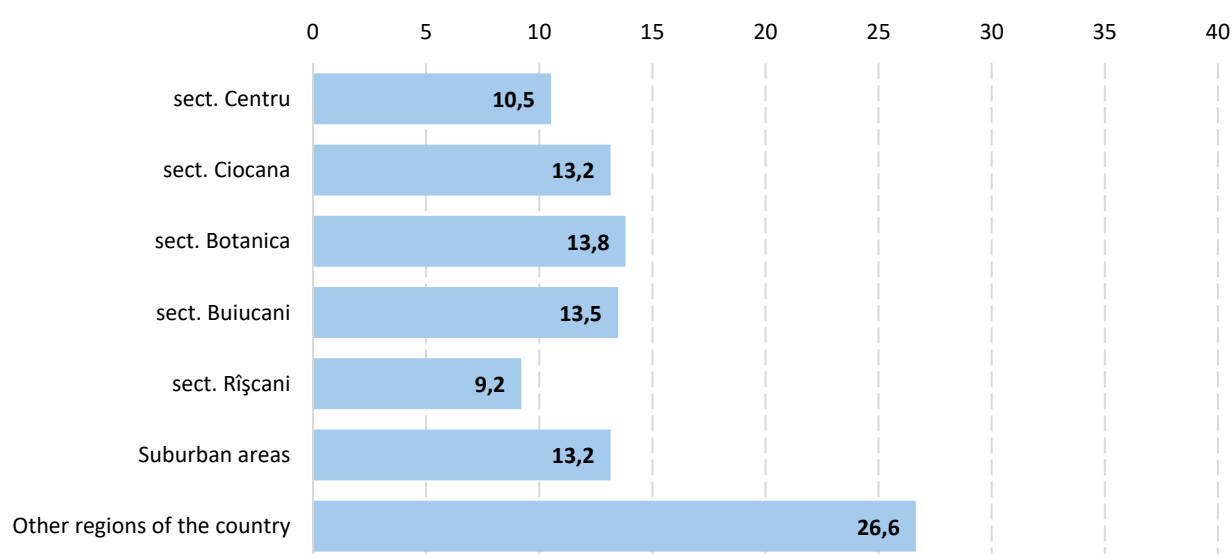


Figure 2. Distribution of participants by place of residence (%)

Distribution by age groups

The participants' ages ranged from 17 to 43 years old. The predominant age group was 26–35 years, representing more than half of the sample (51.3%, $n = 156$), followed by the group under 25 years (30.3%, $n = 92$) and the group of 36 years and older (18.4%, $n = 56$). The distribution by age groups was similar in subgroups defined by the planning of the last pregnancy.

In contrast, it varied significantly by parity: women at first birth were predominantly young, under 25 years old (53.9%, $n = 69$), while women with two or more previous births were older – 60.8% ($n = 107$) in the 26–35 age group and 26.1% ($n = 46$) in the 36 and over group. (*Table 1*)

Most of participants (98.0%, $n = 298$) were married or in stable couple relationships, a distribution that remained uniform in all subgroups analyzed.

The most frequently reported level of education was higher level of education (55.3%, $n = 168$), followed by vocational school, high school, or college (29.9%, $n = 91$) and completed or incomplete general school (14.1%, $n = 43$). Two participants declared the absence of any form of formal education. The distribution by education level was similar in the subgroups defined by pregnancy planning: women with unplanned pregnancies had a slightly higher share of incomplete secondary education (8.4% compared to 4.8%

among those with planned pregnancy), and women at first birth reported more frequently studies at vocational school level, high school or college (35.9%), compared to multiparous women, that had mostly higher-level education (58.5%).

The socio-demographic profile of the spouses/partners by age groups, marital status and level of education was similar to that of women.

Table 1. Socio-demographic characteristics of respondents after load planning and parity

	Total		The last pregnancy was planned				Number of births			
	n	%	Yes		No		1		≥ 2	
	n	%	n	%	n	%	n	%	n	%
Age										
≤ 25	92	30.3	70	33.5	22	23.2	69	53.9	23	13.1
26–35	156	51.3	105	50.2	51	53.7	49	38.3	107	60.8
≥ 36	56	18.4	34	16.3	22	23.2	10	7.8	46	26.1
Marital status										
Married/Couple	298	98.0	205	98.1	93	97.9	126	98.4	172	97.7
Divorced/Unmarried	6	2.0	4	1.9	2	2.1	2	1.6	4	2.3
Highest level of education										
No education	2	0.7	2	1.0	0	0.0	1	.8	1	.6
Incomplete general school	18	5.9	10	4.8	8	8.4	5	3.9	13	7.4
General school	25	8.2	18	8.6	7	7.4	11	8.6	14	8.0
Vocational School/ High School/College	91	29.9	61	29.1	30	31.6	46	35.9	45	25.5
Higher education	168	55.3	118	56.5	50	52.6	65	50.8	103	58.5

Preconception care

In total, 61.8% of participants (n = 188) stated that they have a reproductive plan, personal or as a couple, defined as knowing the number of children they want and the age at which they intend to conceive them. Women with their last pregnancy planned reported having a reproductive plan significantly more frequently (74.2%, n = 155), compared to those for whom the pregnancy was not planned (34.7%, n = 34).

The analysis of the two variables, pregnancy planning and the existence of a reproductive plan, allowed the identification of four categories of participants, with different risk profiles and receptivity to educational interventions (*Figure 3*). The largest category was that of women with a reproductive plan and planned pregnancy (51.0%, n = 155), which represents the most favorable profile from the perspective of preventive behaviors, including alcohol avoidance during the periconception period. At the same time, 20.4% of the participants (n = 62) had the maximum risk profile: the absence of a reproductive plan combined with an unplanned pregnancy – a category associated with a

higher probability of exposure to alcohol and other risk factors before and in the first weeks of pregnancy, often before its confirmation. The other two categories, (a) with an existing reproductive plan but unplanned pregnancy (10.9%) and (b) planned pregnancy in the absence of a reproductive plan (17.8%), suggest either a discrepancy between reproductive intention and behavior, or partial and short-term planning. Thus, these two groups can be considered intermediate risk profiles, characterized by partial or inconsistent intention, which makes them a priority for educational interventions that transform intention into coherent and preventive reproductive behavior.

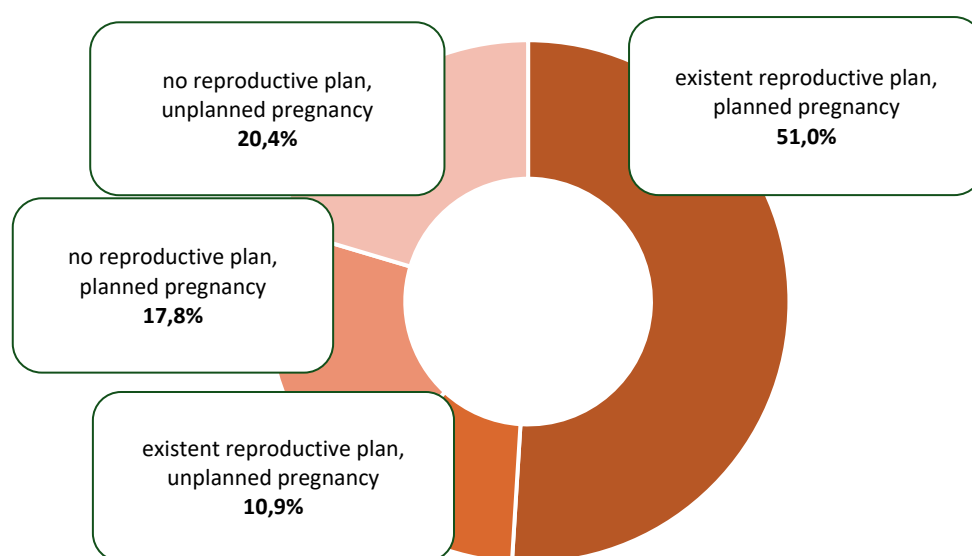
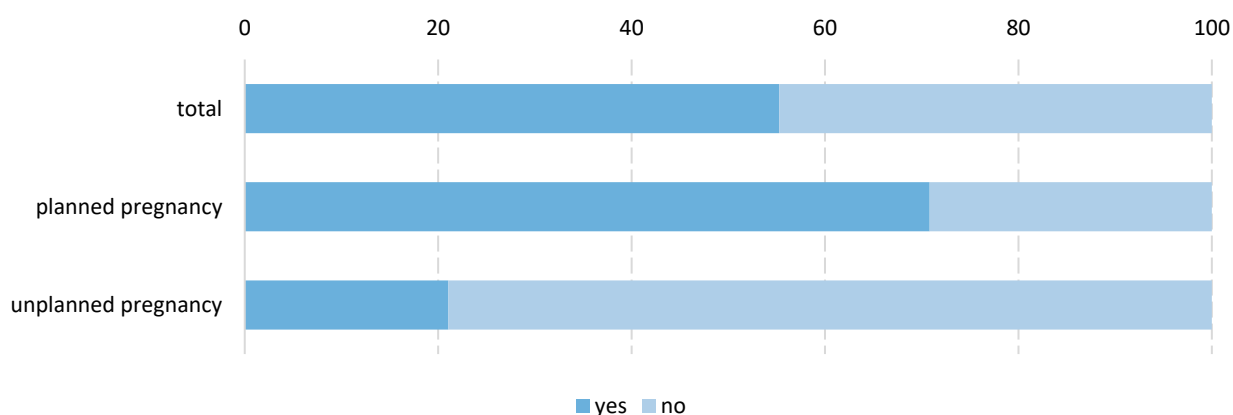
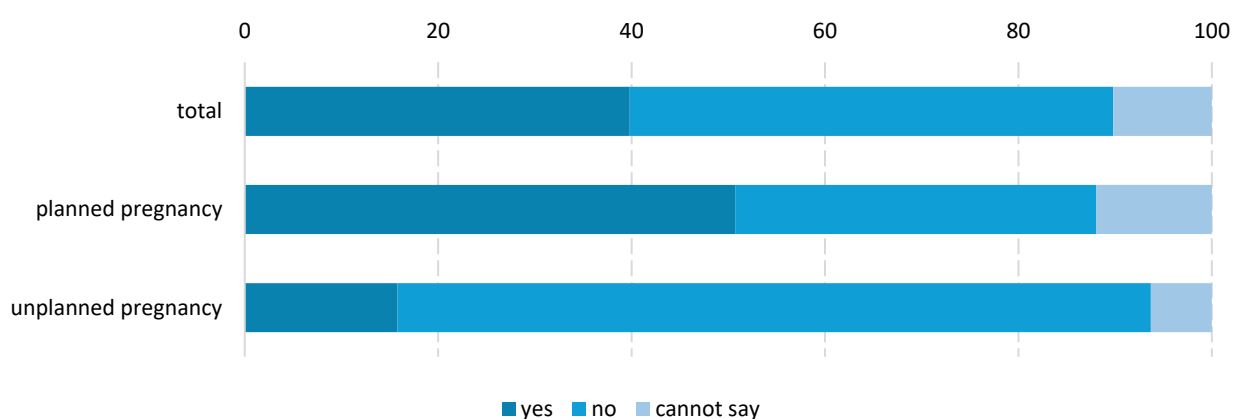


Figure 3. Existence of a reproductive plan and planning of the last pregnancy.

Of the total respondents, 44.7% (n = 136) of the women admitted the absence of systematic planning before pregnancy. At the same time, 55.3% (n = 168) considered that they had preconception education, a significantly higher proportion among women with the last pregnancy planned (70.8%, n = 148) compared to those with unplanned pregnancy (21.1%, n = 20), as well as among those with higher education (60.1%, n = 101) compared to those without higher education (49.3%, n = 67).

The perception of the partner's training was considerably more reserved: only 39.8% of the participants (n = 121) considered that the partner had made plans for pregnancy, while 50.0% (n = 152) appreciated that the partner had no preparation, and 10.2% (n = 31) could not say. The disparity between the proportion of women who perceived their own training as sufficient and the proportion of those who appreciated the same about their partner remained consistent in both subgroups defined after pregnancy planning, with women answering that their partners prepared less than they did in the preconception period (Figure 4).

(A04) Do you consider that you have done preconception training (preparation for pregnancy)?**(A09) Do you consider that your spouse/partner prepared for the upcoming pregnancy?****Figure 4. Women's perception of preconception care.**

The preconception medical visit was done by only 43.1% ($n = 131$) of the participants, while 47.4% ($n = 144$) did not have such a visit, although they were aware of the recommendation that it would be good to do so. A proportion of 9.5% ($n = 29$) were unaware of the existence of this medical practice.

The analysis indicates a notable disparity in preconception behaviors based on pregnancy planning status. In the case of planned pregnancies, 56.0% ($n = 117$) of the participants had a preconception consultation, 37.3% ($n = 78$) were aware of the recommendation but did not follow it, and 6.7% ($n = 14$) were unaware of the importance of a preconception visit to the doctor. The picture is substantially different in the case of unplanned pregnancies: 69.5% ($n = 66$) of the participants were aware of the usefulness of the preconception visit to the doctor, but did not do so, and 15.8% ($n = 15$) were not aware of this recommendation (Figure 5).

These data indicate that the main barrier to preconception care is not the lack of information, but the absence of conscious reproductive intention, a factor that strongly conditions both women's motivation and preventive behavior in the period before conception.

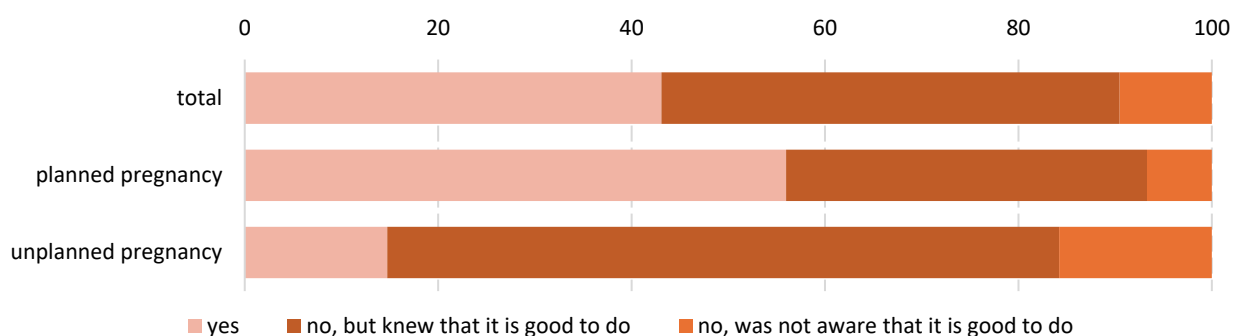


Figure 5. (A05) Before becoming pregnant, did you pay a visit to a medical worker to discuss your plans to become pregnant?

The content of the preconception medical visits was mainly oriented towards general health aspects and routine prophylaxis. The frequently addressed topics were the maintenance of an optimal state of health before conception, the importance of folic acid and multivitamin supplementation, as well as the need to inform the family doctor or specialist early in the pregnancy. These topics reflect the classic agenda of preconception counseling, centered on the body's biological preparation for pregnancy.

In contrast, topics related to behavioral risks were addressed significantly less frequently. The effects of smoking on fetal health were discussed in 61.1% of cases, as was the impact of alcohol consumption during pregnancy, while the risks associated with drug use were mentioned in only 31.3% of visits – the lowest percentage recorded within this indicator. A tiny proportion of participants stated that none of the topics analyzed were addressed during the consultation (*Figure 6*).

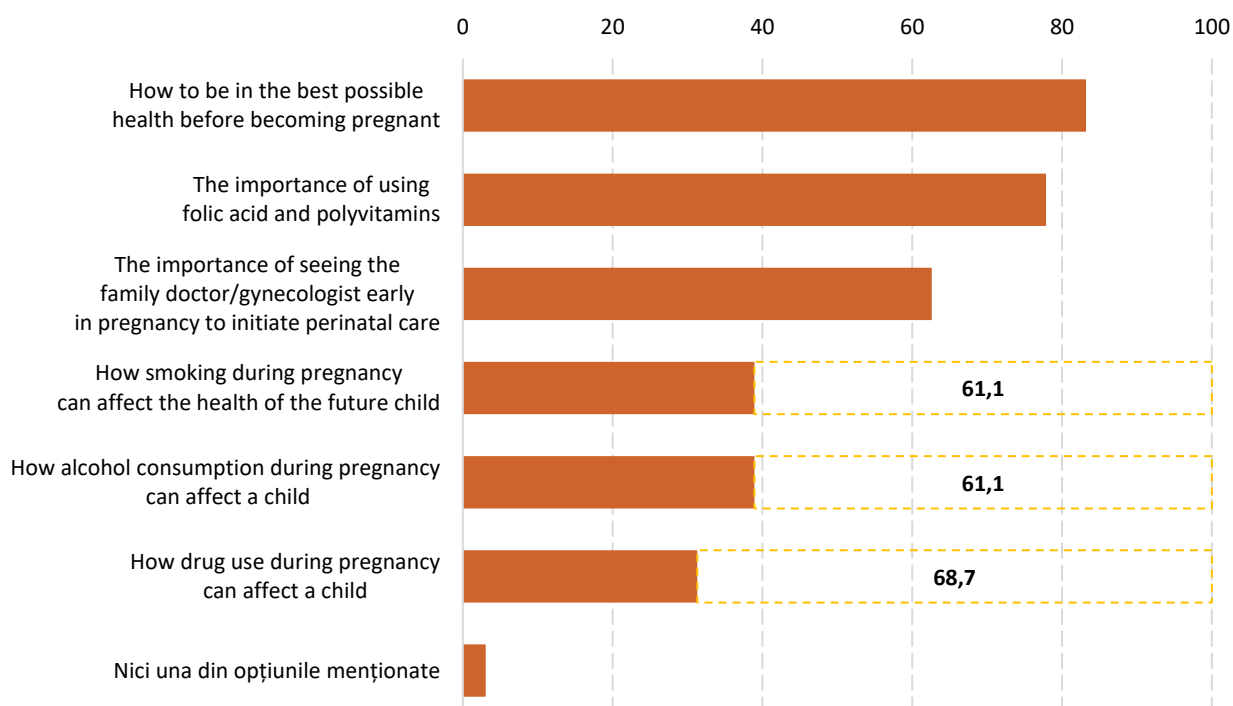


Figure 6. (A06) Has the specialist you contacted for preconception care discussed with you the following?

This asymmetric distribution of the content of preconception counseling signals a systematic gap: topics related to reproductive risk behaviors, although with a documented impact on the evolution of pregnancy and neonatal health, remain underrepresented in current medical practice, which limits the preventive function of the preconception visit.

KAP – Knowledge

Investigating participants' perceptions of the factors that contribute to the birth of a healthy baby, the results indicate a high level of awareness of the main protective and risk behaviors during pregnancy. Most respondents identified as relevant: quitting smoking and avoiding exposure to secondhand smoke, abstinence from or reducing alcohol consumption, avoiding stressful situations, abstaining from the consumption of psychoactive substances, as well as observing a regular schedule of medical visits during pregnancy.

To note that the distribution of responses between the subgroups analyzed is similar: no significant differences were recorded depending on the planned or unplanned nature of the pregnancy or depending on the level of education of the participants (*Figure 7*). This suggests that the normative perception of healthy behaviors in pregnancy is widespread and relatively independent of the socio-demographic variables examined.

Also, the responses of spouses and partners reflected a similar structure to that of the women, who designated in comparable proportions the same factors as important for the health of the child. The convergence of perceptions within the couple is a favorable indicator for the potential for partner involvement in periconceptional and perinatal health behaviors.

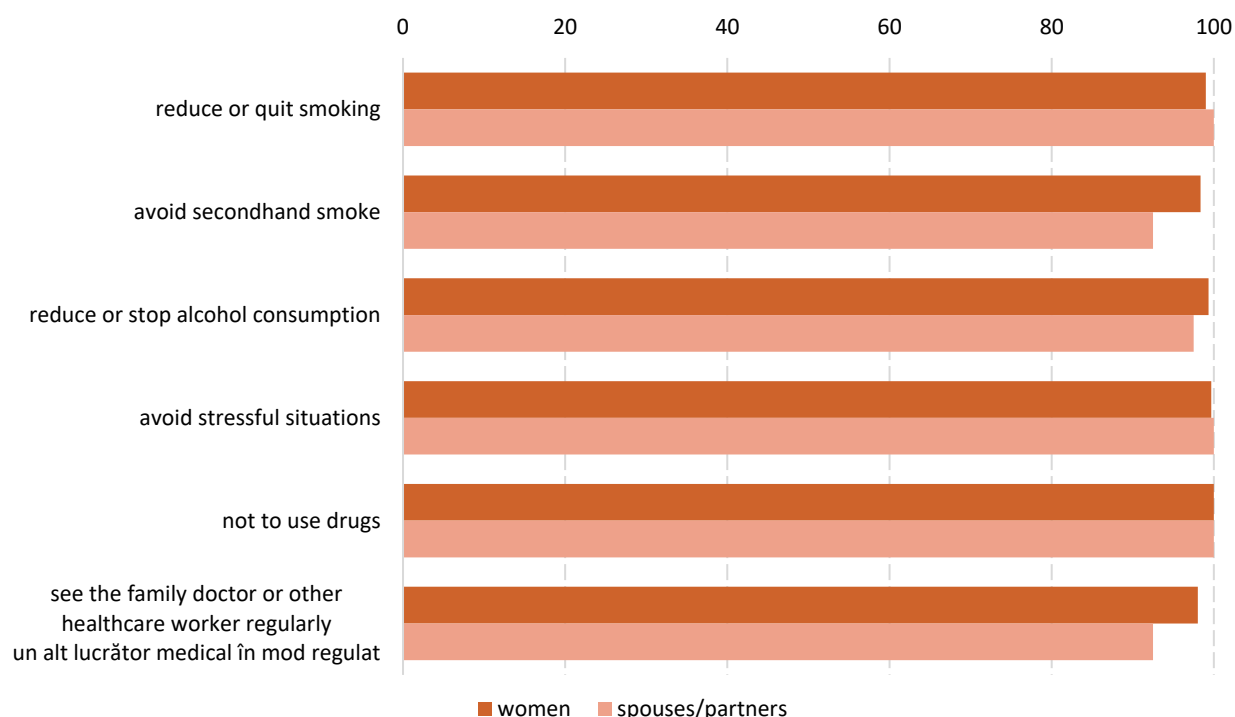


Figure 7. (KAP01) In your opinion, what can a pregnant woman do to increase the chances of having a healthy baby? (very important/important answers)

The analysis of perceptions regarding moderate alcohol consumption during pregnancy reveals a marked differentiation according to the type of drink, both among the participants and their partners.

There is a unanimous consensus on the effects of strong spirits and alcoholic cocktails, both of which are perceived as harmful to the fetus by most respondents. In contrast, perceptions of beer and wine are considerably more nuanced. Beer is predominantly considered harmful, but a notable segment of participants attributes neither benefits nor negative effects to it, reflecting a tolerance towards its consumption. Wine, including homemade wine, registers the highest degree of ambiguity: 21.7% (n = 66) of the participants consider it beneficial for the child, and 17.8% (n = 54) consider that it produces neither benefits nor harms.

Differences in risk perception were identified depending on the level of education: participants with higher education reported significantly more frequently the perception of the harmfulness of beer and wine compared to those with other levels of education, which suggests that the level of formal education mediates the ability to critically assess the risks associated with alcohol consumption during pregnancy.

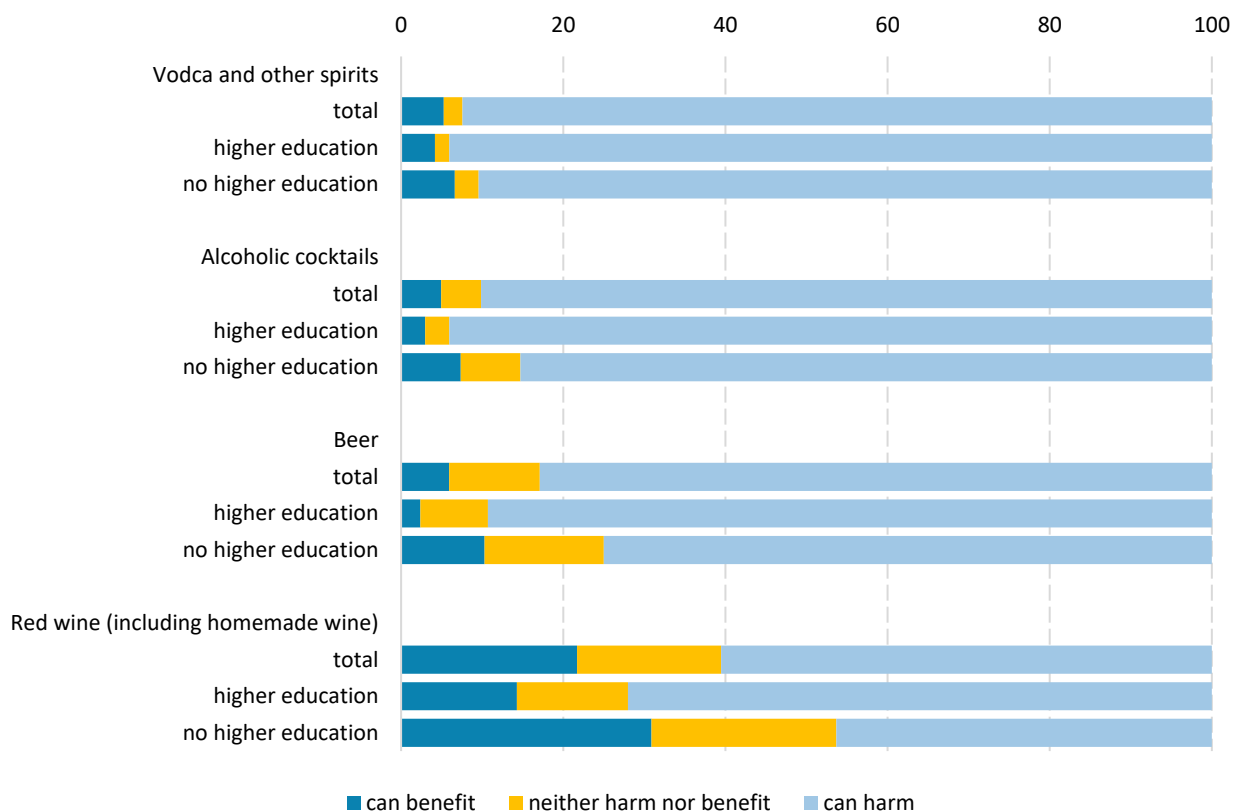
Partners' responses reveal the same trends. Strong spirits (95.0%; n = 38) and alcoholic cocktails (90.0%; n = 36) are perceived as harmful by most of them, while beer and red wine are evaluated by some of the partners as having neutral or even beneficial effects. This convergence between the perceptions of participants and their partners indicates the persistence of permissive social representations towards the consumption of certain types of alcohol during the gestational period, with direct implications for health education interventions addressed to couples (*Figure 8*).

The assessment of attitudes towards alcohol consumption in pregnancy reveals a high level of awareness of the general risk but is accompanied by a perceptual ambiguity regarding low and moderate doses of alcohol.

The consensus is robust: 85.9% (n = 259) of the participants agreed with the statement that any amount of alcohol consumed during pregnancy can harm the baby, and 81.6% (n = 248) rejected the idea that moderate consumption would be safe. Similar proportions are found in the partners' responses, with 80.0% (n = 32) expressing agreement and disagreement with the same statements. At the same time, 95.1% (n = 289) of the participants and 90.0% (n = 36) of the partners confirm the existence of the perception that the risk to the child increases proportionally to the amount of alcohol consumed.

The picture becomes more complex when the statements are aimed at reduced amounts of alcohol. The claim that a small amount of alcohol in pregnancy is safe was rejected by 60.9% (n = 185) of the participants, while 20.1% (n = 61) agreed with it, and 19.1% (n = 58) could express neither agreement nor disagreement. A similar distribution was recorded for the statement that a small amount of alcohol could never harm the child: 54.9% (n = 167) rejected it, while the remaining 45.1% (n = 137) were divided almost equally between those without a firm opinion and those who agreed. Among the partners, the profile of the responses is comparable: 60.0% (n = 24) reject the idea that a small amount would be safe, and 47.5% (n = 19) do not agree that small doses cannot cause harm, the proportion of those without a firm opinion being slightly higher than that of those who agreed.

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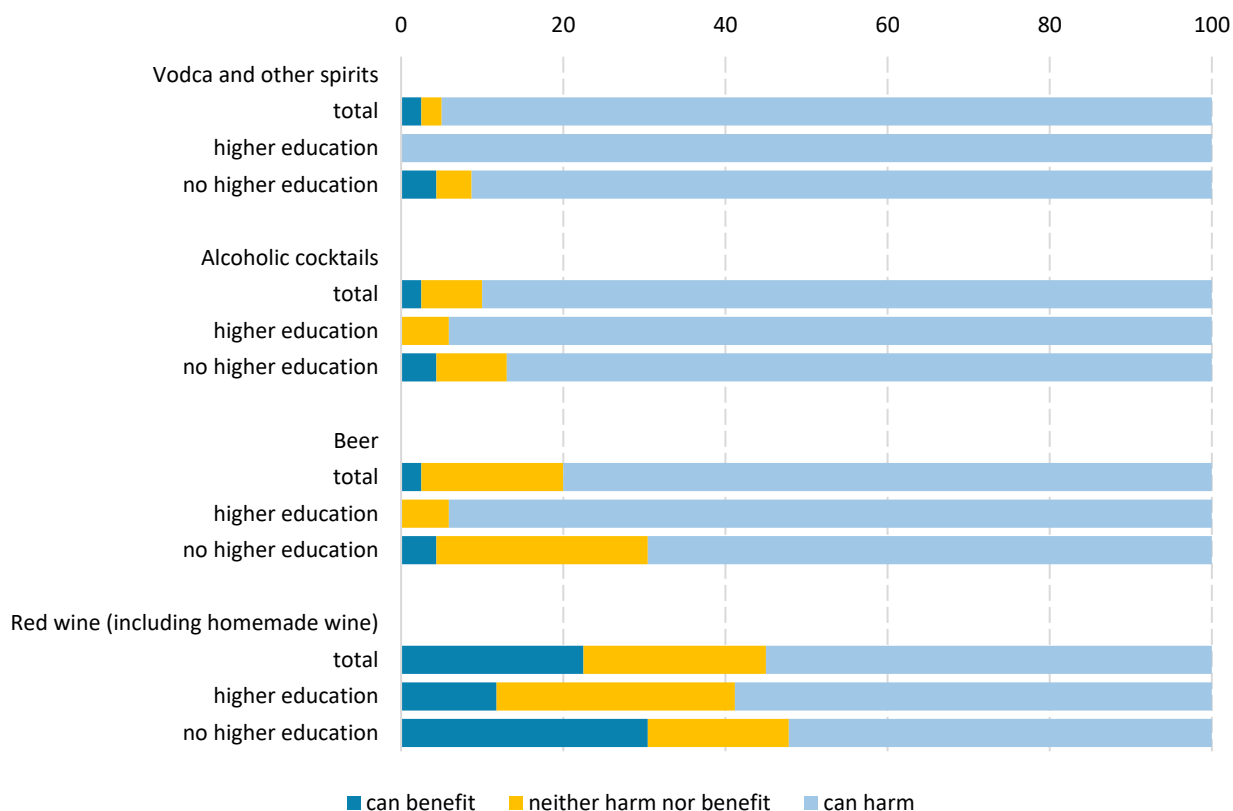


Figure 8. (KAP05) Do you think that moderate consumption of the following alcoholic beverages during pregnancy can be beneficial or harmful to the baby?

From the perspective of socio-demographic variables, the distribution of responses does not differ significantly depending on the planned or unplanned nature of pregnancy. On the other hand, the level of education appears to be a relevant factor, in particular with regard to the perception of the risk associated with low and moderate alcohol consumption: participants with higher education recognize this risk significantly more frequently compared to those with other levels of education (*Figure 9*).

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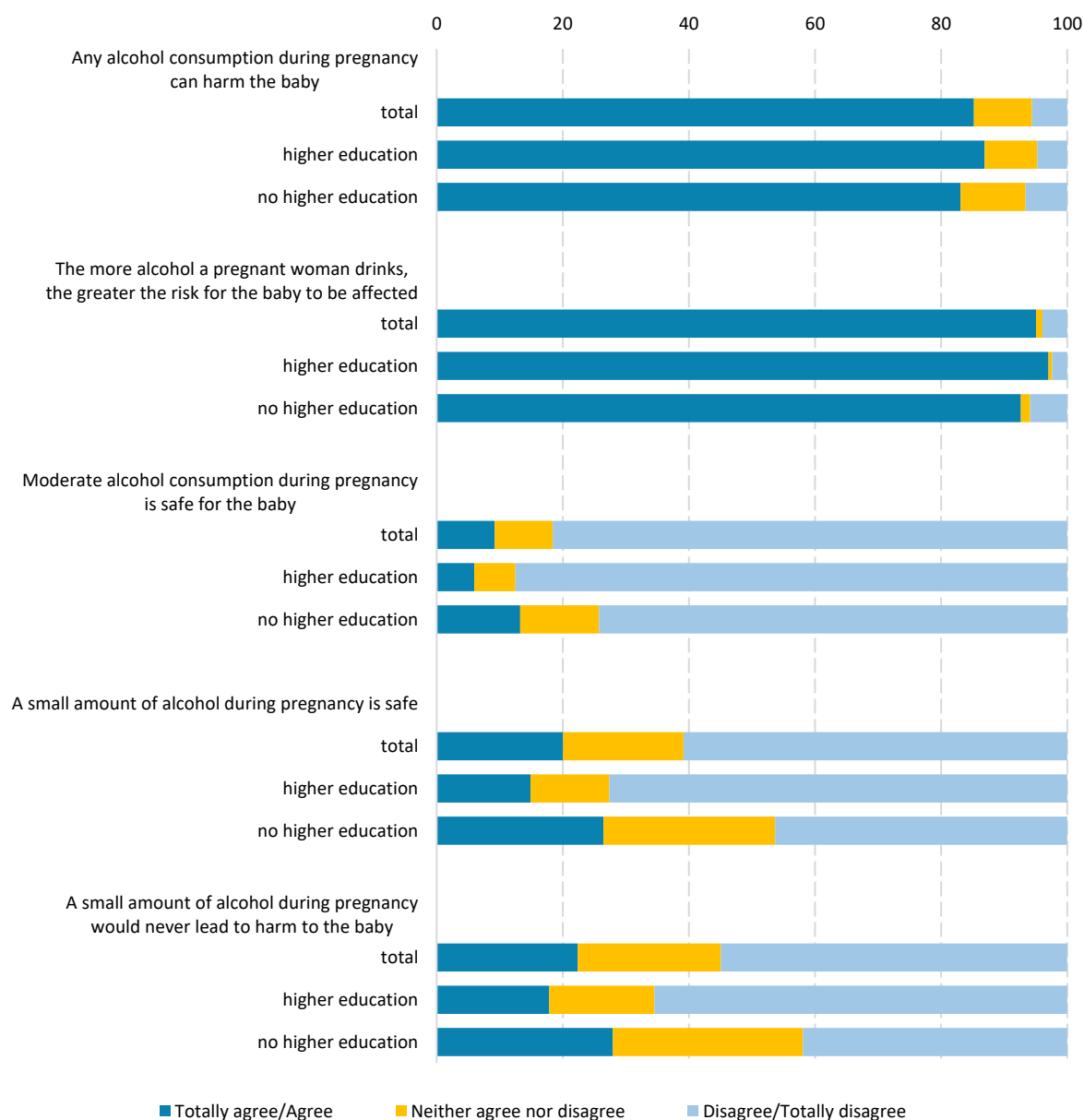


Figure 9. (KAP06) What do you think about alcohol consumption during pregnancy and its effect on the baby?

These results highlight a perceptual dissonance: although the overall risk of alcohol in pregnancy is widely recognized, a considerable proportion of participants and their partners remain unsure or tolerant of reduced doses, signaling the need for health communication interventions that explicitly address the myth of the “safe dose” of alcohol in the gestational period.

In the exercise of ranking risk factors for child development, participants, women and spouses/partners alike, were asked to classify five factors in order of perceived harm, from the most harmful (first place) to the least harmful (fifth place). The responses were converted into a cumulative score with values between 1 and 5, where low scores mean high perceived risk, and high scores indicate low perceived risk.

The analysis of the distribution of rankings highlights areas of consensus and areas of perceptual ambiguity. Thus, drug use was placed in first place, the most harmful, by the majority of participants, regardless of the group, constituting the factor perceived as the most harmful. Coffee consumption was systematically ranked last, being perceived as the least harmful of the factors evaluated.

Active smoking has accumulated rankings predominantly in second and third place, reflecting a relatively consistent perception of its risk, immediately subordinated to drug use. Secondhand smoke was ranked fourth and third most commonly, indicating a moderate recognition of its risk, lower than that attributed to active smoking.

Alcohol consumption presents the most dispersed distribution of rankings, being placed with uniform frequency in the second, third, and fourth places. These results reflect the absence of consensus among participants on the severity of the risk associated with moderate alcohol consumption in pregnancy, confirming the perceptual ambiguity also identified in previous sections of the research.

The differences between the subgroups analyzed, planned versus unplanned tasks, different educational levels – are minimal and without relevant statistical significance, suggesting that the perceived ranking of risk factors is uniform across the sample studied (Figure 10).

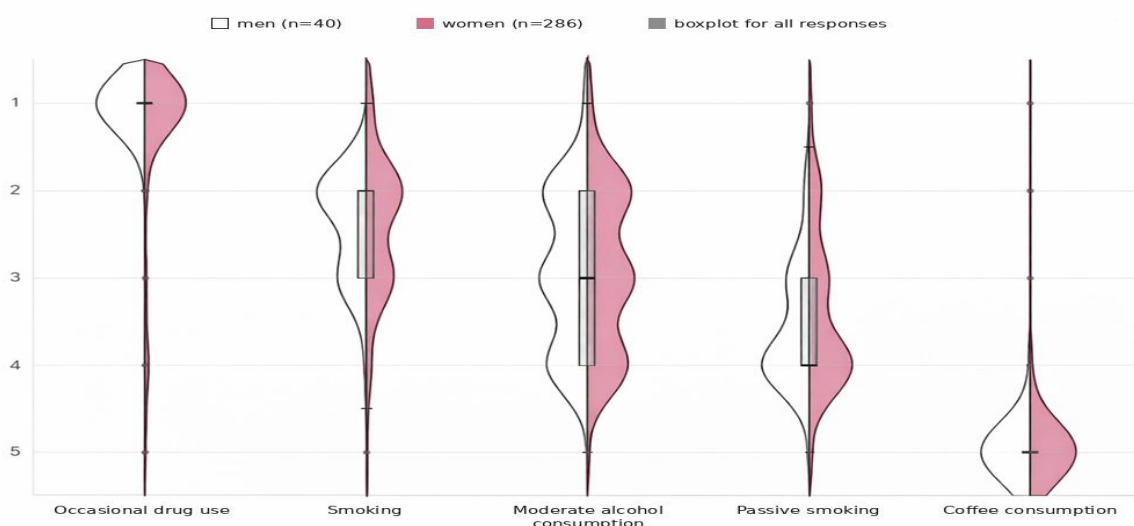


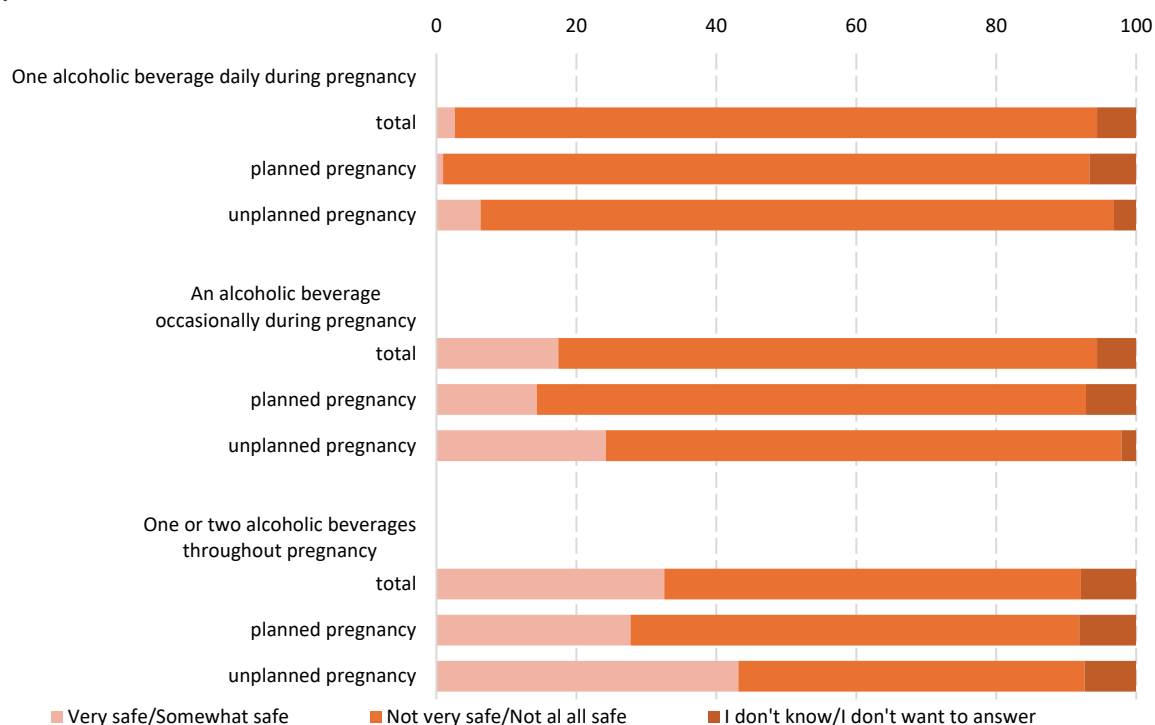
Figure 10. (KAP 7) Rank from most harmful (1) to least harmful (5) for child development, the factors. Distribution of responses

The assessment of perception about the “safe” frequency of alcohol consumption in pregnancy reveals a significant discrepancy between the recognition of risk at the declarative level and the tolerance towards certain consumption patterns.

At the aggregate level, only 2.6% (n = 8) of the participants classified daily alcohol drinking as safe during pregnancy. Occasional drinking was perceived as acceptable by

17.4% (n = 53) of respondents, and consumption limited to one or two drinks throughout pregnancy was considered safe by an even higher proportion, 32.6% (n = 99) (Figure 11). These data confirm that, although the overall risk of alcohol is widely recognized, a third of participants admit a margin of tolerance to minimal exposure, perpetuating the perception that there is a “safe dose” during the gestational period.

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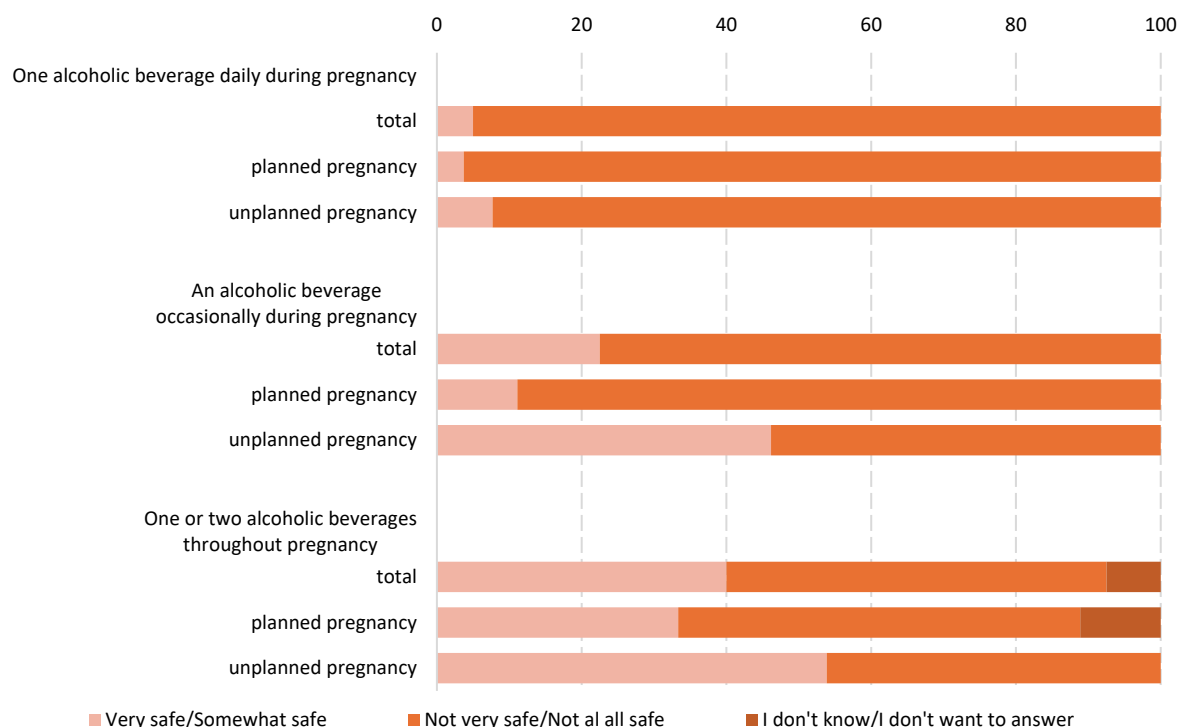


Figure 11. (KAP 08) In your opinion, in terms of the effect of alcohol on the baby, what amounts of alcohol can be considered safe for a pregnant woman?

The analysis according to socio-demographic variables reveals systematic and consistent differences. Participants with planned pregnancies and higher education classified drinking alcohol as unsafe, regardless of the proposed frequency, at a significantly higher rate compared to those with unplanned pregnancies or lower levels of education. This association confirms that both reproductive intentionality and the level of formal education act as protective factors that favor the adoption of a zero-tolerance attitude towards alcohol consumption in pregnancy.

The partners' responses indicate a greater permissiveness towards occasional and infrequent alcohol consumption, with the proportions of acceptance exceeding the values recorded among women. This difference is more pronounced in the case of unplanned pregnancies, suggesting that the absence of reproductive intention also diminishes vigilance towards perinatal behavioral risks for each partner.

Combined with the results from the previous sections, a perceptual profile characterized by the acceptance of the principle of general harmfulness of alcohol is outlined, accompanied by the differentiation of risk as the frequency of consumption decreases – a model with direct implications for preconception and perinatal counseling strategies.

Investigating exposure to information on the effects of alcohol consumption during pregnancy on the child, 69.4% (n = 211) of the participants reported that they had accessed or encountered such content. The prevalence of informational exposure is higher among women with planned pregnancies (72.2%; n = 151) and those with higher education (74.4%; n = 125), confirming the trend, also identified in the previous sections, that reproductive intention and level of education are predictors of active involvement in decisions about health.

An analysis of the sources of information reveals a hierarchy: the internet is the most frequently mentioned source, followed by the traditional media: television, radio, the press, and only thirdly by medical personnel (*Figure 12*). This distribution signals a worrying trend from the perspective of the quality and accuracy of the information received: the sources with the highest level of credibility and clinical personalization, namely health professionals, occupy a secondary place compared to channels with unvalidated or heterogeneous content. The direct implication for medical practice lies in the need to strengthen the advisory role of medical staff in conveying perinatal health messages, including by systematically integrating this topic into routine visits.

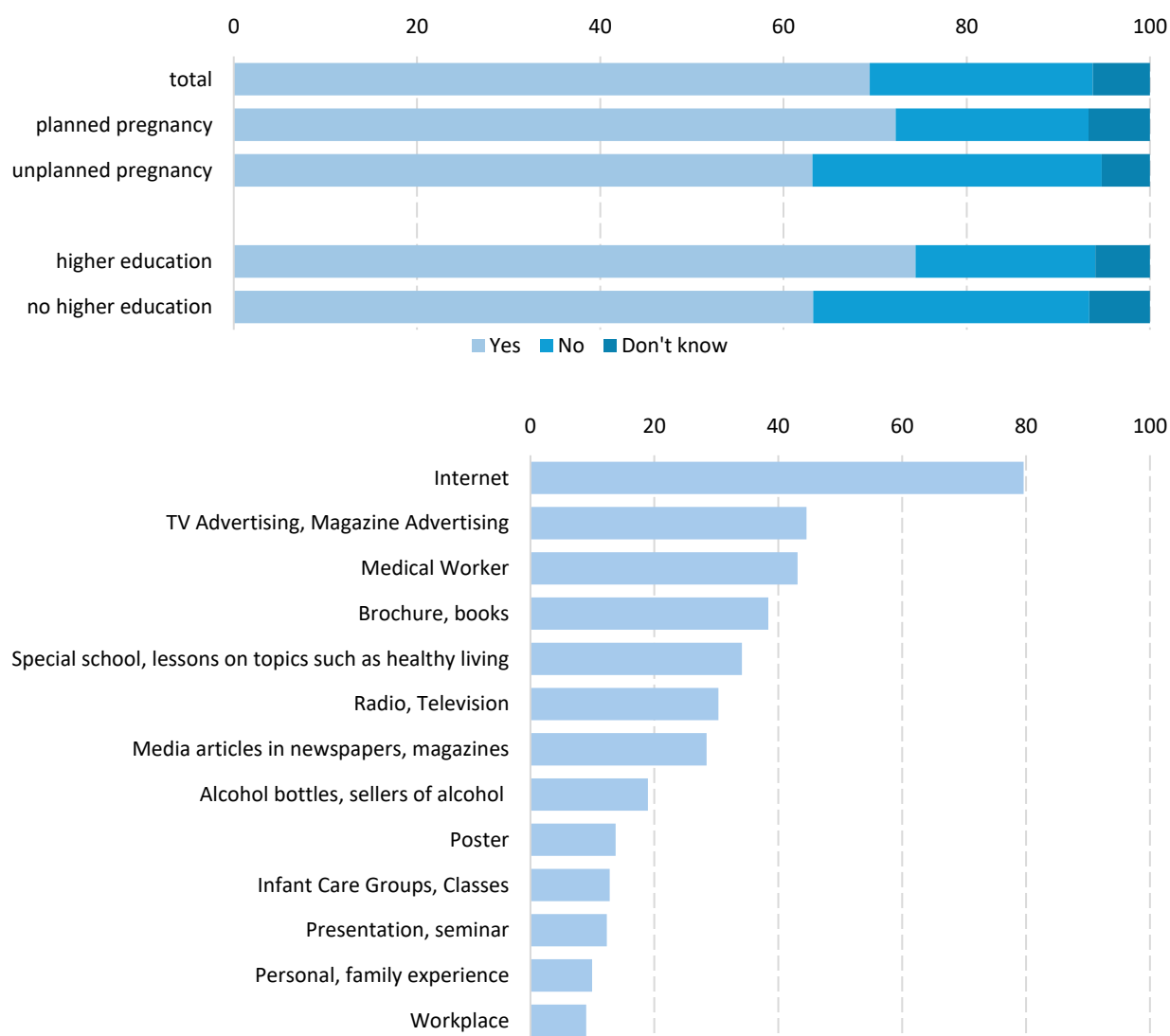
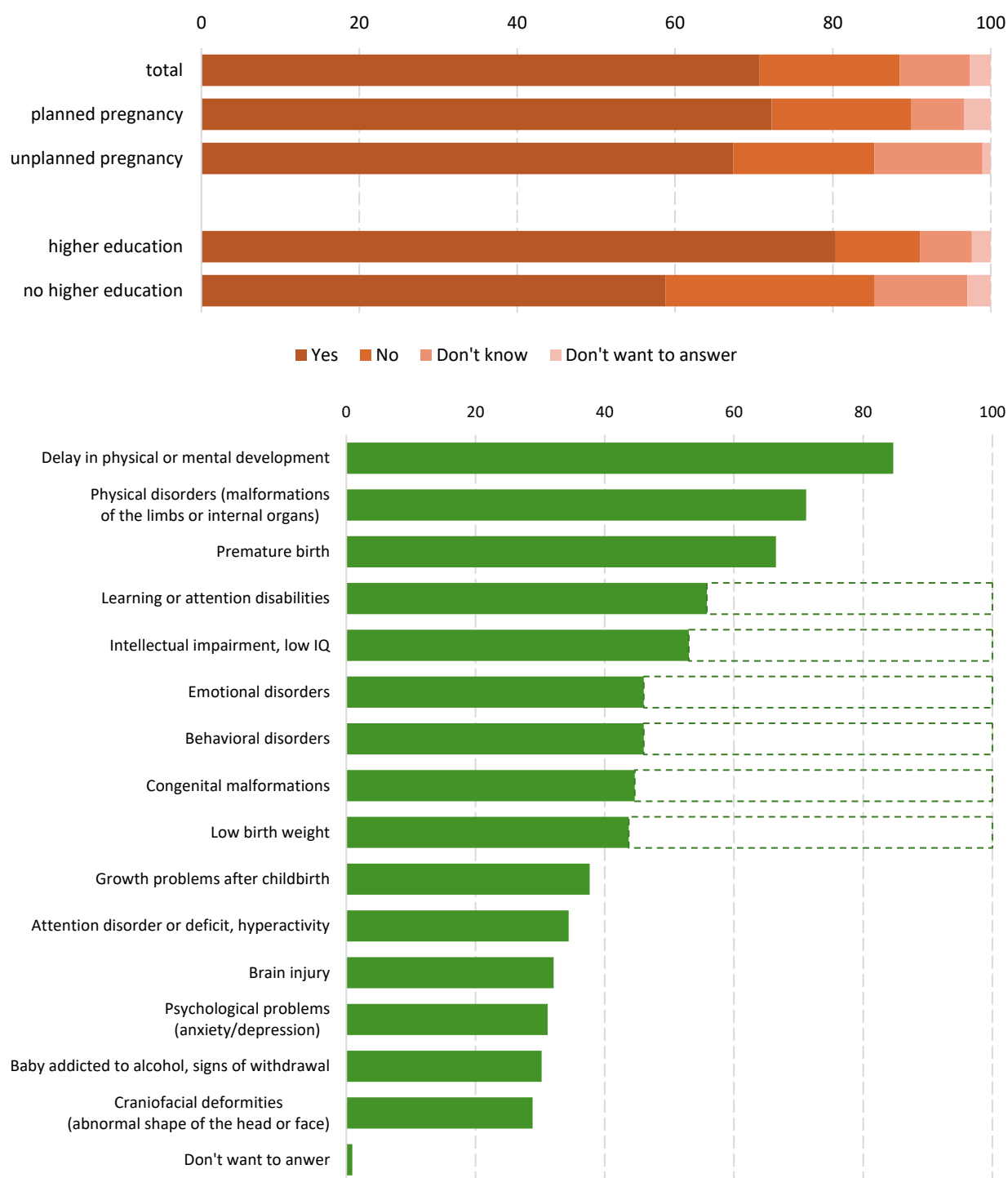


Figure 12. (KAP 09) Have you seen any information about the effects of drinking alcohol during pregnancy on a child? If Yes, from what sources?

When asked about the knowledge of the effects of alcohol consumption on the fetus, 70.7% (n = 215) of the participants answered in the affirmative, with a higher frequency among women with planned pregnancies (72.2%; n = 151) and significantly higher among those with higher education (80.4%; n = 135), reinforcing the already outlined profile of formal education as a factor positively associated with the level of information in the field of reproductive health.

The analysis of the content of the declared knowledge highlights an asymmetric distribution between the effects with visible clinical manifestations and those with less obvious expression. The effects mentioned by more than half of the participants include: delay in physical or mental development, physical disorders and structural malformations, premature birth, learning and attention disabilities, as well as intellectual impairment. These consequences correspond to the manifestations traditionally associated with fetal alcohol syndrome and are generally better represented in the public and media discourse on the risks of alcohol in pregnancy.

In contrast, effects with more subtle clinical expression or late onset were mentioned significantly less frequently. Emotional and behavioral disorders, birth defects, low birth weight, attention deficit hyperactivity disorder, as well as psychological problems were identified by a considerably lower proportion of the participants. This cognitive gap is clinically relevant: it is precisely the less visible effects of prenatal alcohol exposure – neurodevelopmental and behavioral – that are associated with the most significant long-term consequences on the child's quality of life and are also most frequently underdiagnosed in pediatric practice (*Figure 13*).



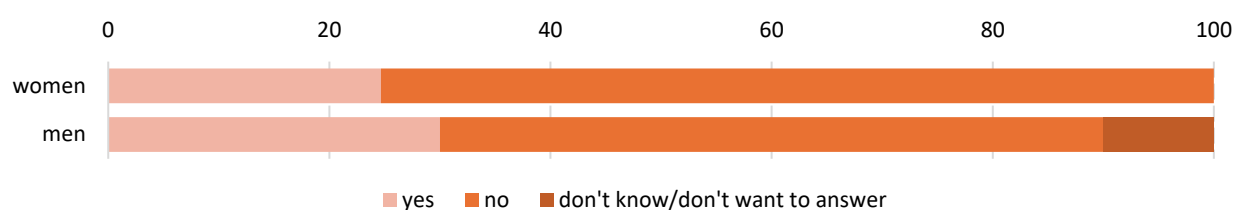
**Figure 13. (KAP 10) Do you know what effects alcohol can have on the fetus?
If Yes, name the possible effects**

Combining these results with data on predominantly digital and clinically unvalidated information sources, it seems that there is a need for structured educational interventions that expand the spectrum of knowledge on the effects of fetal alcohol beyond the classic, visible manifestations to the neuropsychological and behavioral consequences with a major impact on the child's development.

The level of knowledge of FASD among the participants turns out to be very low, constituting one of the most significant information gaps identified in the research. Only 24.7% (n = 75) of the participants reported that they had heard of FASD, a slightly higher proportion among women with planned pregnancies (29.2%; n = 61) and those with higher education (28.6%; n = 48), worryingly low proportions even in subgroups considered better informed.

Of the participants familiar with the syndrome, 61.3% (n = 46) correctly understood that the effects of FAS are permanent and manifest throughout their lives, while 18.7% (n = 14) underestimated their duration, considering that they are limited to weeks or months, and 18.7% (n = 14) explicitly admitted that they did not know the duration of the effects. Therefore, even among those who are familiar with the term, the full understanding of the long-term consequences of FASD is not clear (*Figure 14*).

(KAP11) Have you ever heard of Fetal Alcohol Syndrome (FAS)



(KAP11.1) In your opinion, how long do the effects of fetal alcohol syndrome last?

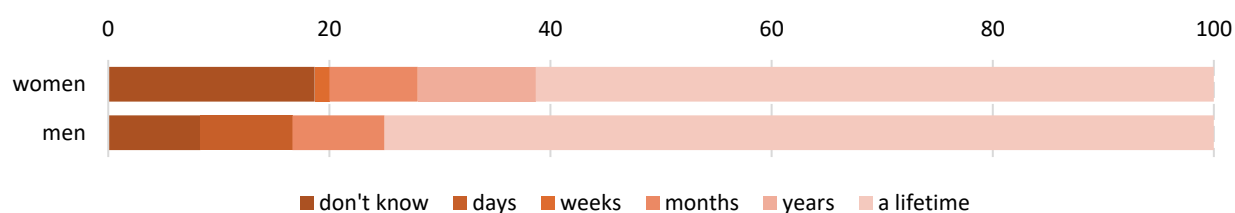


Figure 14. Knowledge of Fetal Alcohol Syndrome (FAS)

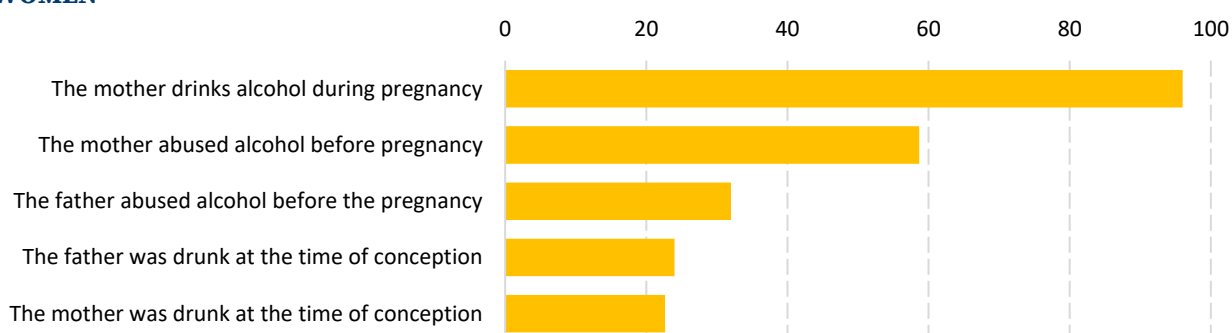
A similar profile can be found among the partners: only 30.0% (n = 12) reported knowledge of FAS, of which 75.0% (n = 9) recognized the permanent nature of the effects of the syndrome – a higher proportion than that recorded among women, but calculated on a small subgroup, which limits the generalizability of this observation.

These data place SAF in the category of specialized knowledge that remains insufficiently disseminated at population level, despite the severity and irreversibility of its consequences. The gap between the general recognition of the harmfulness of alcohol in pregnancy, reported by the majority of participants, and the low level of information about fetal alcohol syndrome suggests that public health messages have managed to

convey risk generically, without anchoring this perception in a specific clinical understanding, capable of motivating concrete preventive behavior. This finding argues for the explicit inclusion of FASD in health education curricula for women of reproductive age and their partners.

Among participants who knew about FASD, 96.0% (n = 72) correctly identified maternal alcohol consumption during pregnancy as the main cause of the syndrome. At the same time, 58.7% (n = 44) also mentioned pre-pregnancy alcohol consumption as a factor – a perception that, although reflecting a partially inaccurate understanding of the teratogenic mechanism, indicates a tendency to extend the period of perceived risk beyond the actual gestational interval. The distribution of those responses is uniform regardless of the planned nature of the pregnancy or the level of education of the participants, suggesting that these perceptions are relatively stable across the sample (Figure 15).

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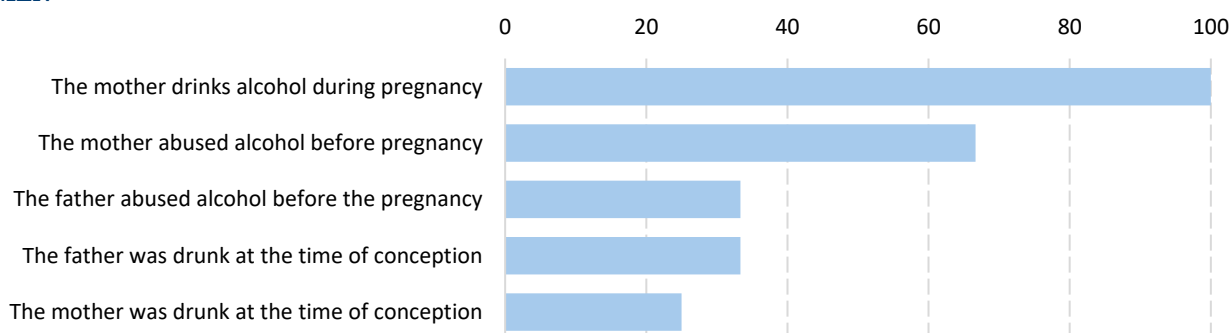


Figure 15. (CAP11.2) In your opinion, a child can have fetal alcohol syndrome if:

The partners' responses, although obtained from a small subgroup, raise questions about the accuracy of their knowledge of the etiology of FAS. Notably, all the surveyed partners indicated the father's intoxication at the time of conception as a possible cause, while only 66.7% (n = 8) recognized the role of maternal alcohol consumption during pregnancy – the clinically validated etiological factor. This reversal of causal attribution suggests that men's responses are anchored in their perception of self-responsibility and emotional reaction to their own behavior, rather than in an understanding based on medical knowledge. The concept that the father's condition at the time of conception could cause FAS is an error with the potential to minimize maternal responsibility and distort preventive messages addressed to couples.

These findings underline the need for gender-differentiated educational interventions that explicitly correct myths regarding the etiology of FAS and clarify the exclusive mechanism of fetal exposure to alcohol through maternal consumption during the gestational period.

KAP – Attitudes

The analysis of the responses to the statements on permissiveness of alcohol consumption in pregnancy confirms the tension identified in the previous sections between the recognition of the overall risk and the persistence of a tolerance to doses perceived as 'moderate' or 'occasional'.

When asked whether drinking alcohol is acceptable if not abusive, most participants (70.4%; n = 214) rejected this idea. The rest of the sample was divided approximately equally between those who agreed (14.1%; n = 43) and those without a formed opinion (15.5%; n = 47). The group of those without an opinion is significantly more numerous among participants without higher education (23.5%; n = 32), compared to those with higher education (11.5%; n = 24), indicating that attitude uncertainty is more pronounced among those who are poorly informed.

Rephrasing the statement in terms of occasional consumption and in small quantities produces changes in perceptions: the proportion of those who agree with the statement that pregnant women can sometimes consume little alcohol increases to 27.6% (n = 84), while disagreement decreases to 58.2% (n = 177). This conditioning of the restrictive attitude according to the wording of the question confirms that permissiveness towards alcohol in pregnancy is sensitive to the reference framework used. Disagreement is more pronounced among participants with planned pregnancies (62.7%; n = 131, vs. 48.4%; n = 46 for unplanned pregnancies) and those with higher education (69.6%; n = 117, vs. 44.1%; n = 60 among those without higher education), differences that reconfirm the role of pregnancy planning and formal education as factors associated with restrictive attitudes toward gestational alcohol consumption.

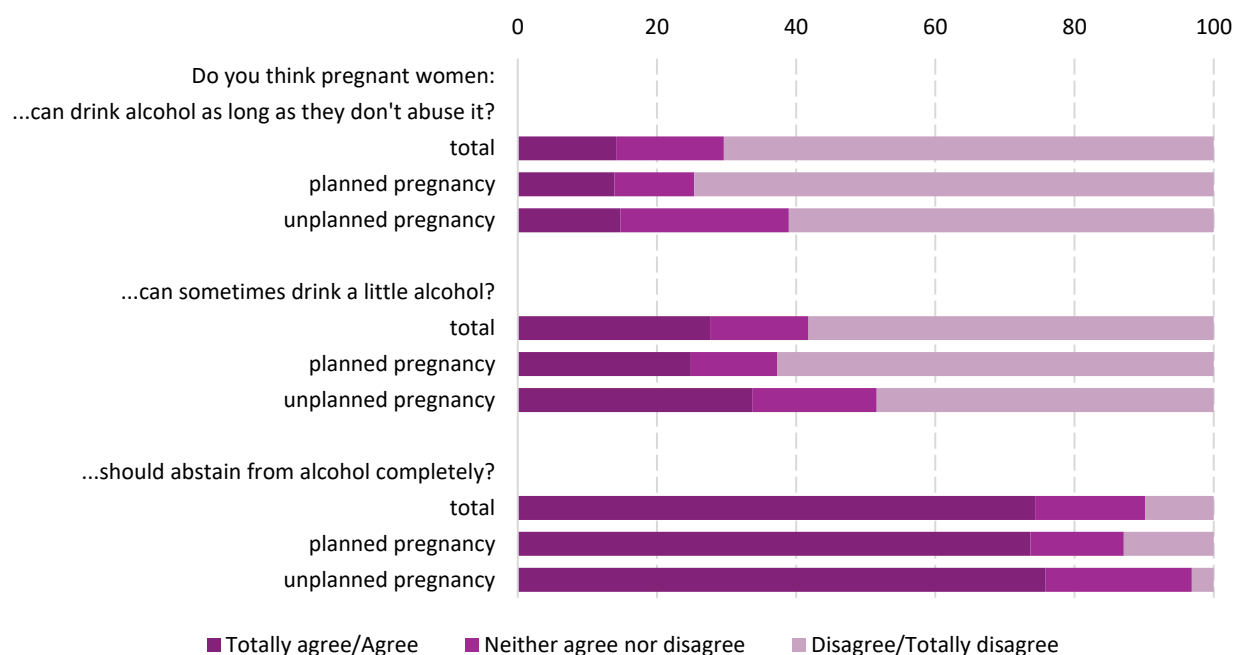
The statement on the need for complete abstinence from alcohol during pregnancy was agreed upon by 74.3% (n = 226) of the participants. A higher proportion of disagreement with complete abstinence was observed among participants without higher education (34.6%; n = 47), compared to those with higher education (22.0%; n = 37). This difference suggests that women with a lower level of education not only recognize the risk of low doses of alcohol less frequently, but also more frequently reject the principle of total abstinence, which places them in an area of behavioral vulnerability from the perspective of perinatal health (*Figure 16*).

Taken as a whole, these data outline an attitude profile, in which the consensus towards the harmfulness of alcohol coexists with resistance to the norm of complete abstinence, resistance modulated by the level of education, the intention to conceive and the specific formulation of the preventive message – an aspect with direct implications for the design of health communication interventions.

Another relevant aspect for the interpretation of the data is the internal inconsistency in attitude identified among a subgroup of participants. Thus, 13.5% (n = 41) of respondents simultaneously agreed with the need for complete abstinence from alcohol in

pregnancy and agreed with the statement that pregnant women can sometimes drink little alcohol – two mutually exclusive positions. This contradiction is not a recording error, but reflects a genuine cognitive dissonance in the perception of risk, in which the norm of abstinence is accepted at the declarative level, without being coherently integrated into a consistent attitudinal system. The phenomenon suggests that verbal adherence to perinatal health principles does not automatically imply a solid conceptual understanding of the incompatibility between abstinence and any level of alcohol consumption.

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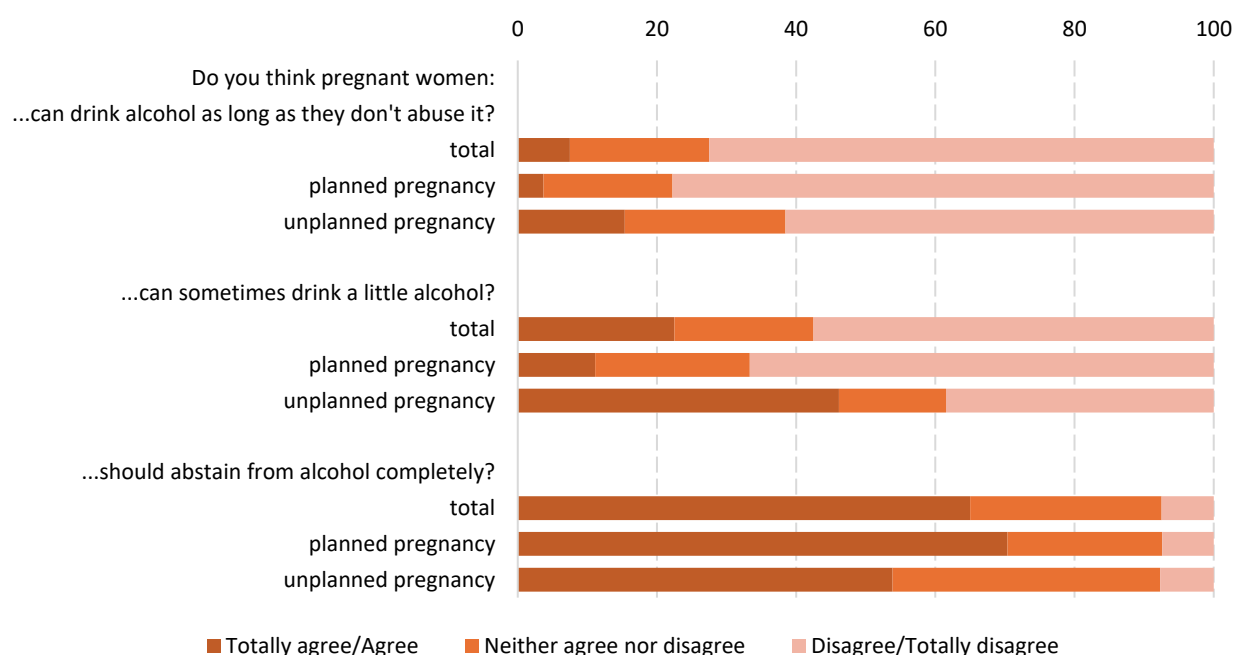


Figure 16. (KAP02, KAP03, KAP04) Attitudes towards alcohol consumption during pregnancy.

Among the partners, a similar attitude profile is outlined, with specific nuances. Although 72.5% (n = 29) reject the idea that pregnant women can drink alcohol in the absence of abuse, the proportion of those who reject occasional drinking in small quantities drops to 57.5% (n = 23), which reflects the same relative interpretation of risk according to perceived amount, identified among women as well. At the same time, only 7.5% (n = 3) of partners reject the principle of complete abstinence, which indicates a high level of acceptance of the restrictive norm among men.

These findings highlight that inconsistency in attitudes is not an isolated phenomenon, but a structural feature of the perception of gestational alcohol risk in the studied sample, present in both women and their partners.

KAP – Practices

Preconception period

The analysis of alcohol consumption behavior in the preconception period, i.e., three months before pregnancy, indicates a general trend of caution, accompanied, however, by a segment of 62.1% of participants with systemic consumption. Thus, 37.8% (n = 155) of the participants reported total abstinence during this period, and 36.8% (n = 112) reported drinking less than one drink per week. However, about a quarter of respondents reported regular drinking: 21.7% consumed between one and three drinks per week, and 3.6% reported four or more drinks per week, a drinking pattern associated with increased reproductive risk, given that conception may occur before pregnancy is known (*Figure 17*).

The difference depending on pregnancy planning is significant: participants with planned pregnancies had a higher rate of preconception abstinence (41.6%; n = 87) compared to those with unplanned pregnancies (29.5%; n = 28), confirming that pregnancy intention involves concrete behavioral changes, including reduced preconception alcohol consumption.

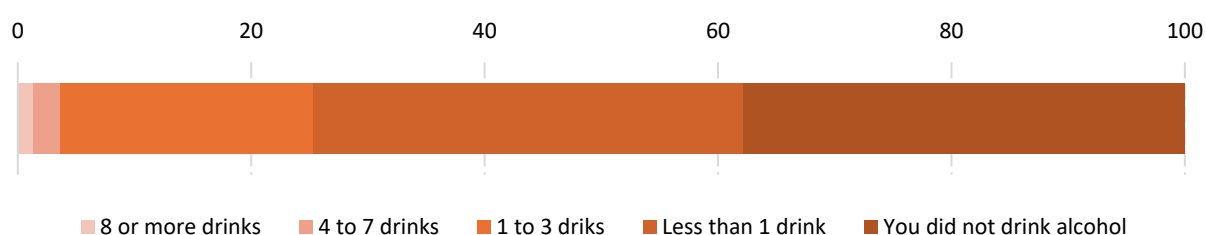


Figure 17. (A10) Three months before becoming pregnant, how many alcoholic beverages did you drink on average per week?

The prevalence of smoking in the preconception period (three months before pregnancy) was reported by 12.2% (n = 37) of participants (*Figure 18*). Women with planned pregnancies had a slightly lower prevalence of smoking (11.5%; n = 24) compared to those with unplanned pregnancies (13.7%; n = 13), a difference that supports the general trend of adopting protective behaviors in the context of intended pregnancy.



Figure 18. (A11) Have you smoked tobacco in the last 3 months before becoming pregnant?

The difference depending on the level of education is considerably more pronounced: only 7.7% (n = 13) of the participants with higher education reported that they smoked in the preconception period, compared to 17.6% (n = 24) of those without higher education, which confirms the role of formal education as a protective factor against risk behaviors in the period before conception.

Pregnancy period

The prevalence of alcohol consumption during pregnancy was reported by 28.6% (n = 87) of the participants, representing almost a third of the total sample, a significant proportion from a perinatal health perspective, given that there is no confirmed safety threshold for fetal alcohol exposure (Figure 19).

The analysis of the distribution of alcohol consumption by the 87 participants depending on the gestational age reveals that in the first three months of pregnancy, 16 (18,4%) abstained completely from drinking alcohol, 52 (59,8%) reported less than one drink per week, and 19 (21,8%) drank between one and three drinks per week. Thus, 16 women, which constitutes 5,2% from the total number of participants, started drinking alcohol from the second trimester on.

This increase in the frequency of consumption during pregnancy compared to the first trimester suggests that the behavioral restrictions initially adopted were not maintained consistently throughout gestation, with direct implications for the cumulative exposure of the fetus to alcohol.

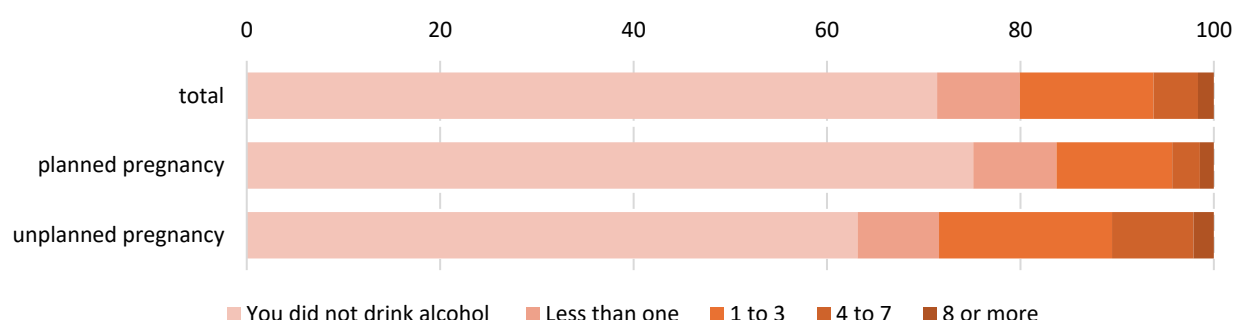


Figure 19. (B05) How many alcoholic beverages, on average, did you drink throughout your pregnancy?

Inconsistencies between opinions and practices

A major behavioral inconsistency is highlighted by analyzing the stated attitudes in relation to the current behavior. Of the total number of participants who agreed with the statement that any alcohol consumption during pregnancy can harm the baby, representing 85.2% (n = 259) of the sample, 19.7% (n = 60) said they had consumed alcohol

during pregnancy. This dissonance between stated belief and actual behavior demonstrates that recognition of risk at the cognitive level does not automatically translate into behavioral abstinence, highlighting a significant gap between attitude and practice (Figure 20).

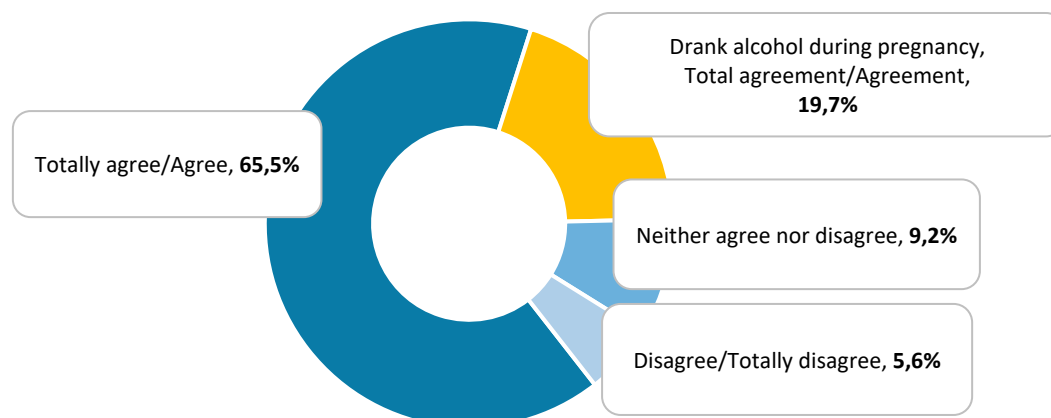


Figure 20. The statement "Any alcohol consumption during pregnancy can harm the baby" and alcohol consumption.

The phenomenon confirms the limits of preventive approaches focused exclusively on passing information: knowledge of the risk is necessary, but insufficient for behavioral change. Effective intervention in this area requires, in addition to the informational component, the approach of motivational factors, permissive social norms and behavioral self-control mechanisms that mediate the relationship between attitude and action.

Alcohol consumption by spouses/partners and its influence on women's alcohol consumption

Data on the behavior of partners during the gestational period reveals a high prevalence of alcohol consumption among them: according to the reports of the participants, 50.3% (n = 153) of the spouses/partners drank alcohol before pregnancy, and 43.1% (n = 140) continued to drink alcohol during pregnancy. These proportions place the partner's behavior in a position of potential influencing the woman's behavior during pregnancy.

However, the participants rated it as unlikely or impossible to change their own behavior under the influence of their partner: 81.9% (n = 249) stated that it is unlikely or impossible to drink alcohol if the partner continued to drink during pregnancy, and 95.4% (n = 290) expressed resistance in the scenario in which the partner explicitly offered them alcohol during this period. These figures suggest that women perceive their own gestational behavior as relatively independent of their partner's direct influence, at least at the declarative level.

However, combining these data with the actual prevalence of alcohol consumption in pregnancy, reported by 28.6% of the participants, a gap between self-perceived behavioral resistance and actual behavior is outlined, which deserves to be investigated in relation to couple dynamics and social norms of consumption in the woman's proximal environment.

Prenatal visits to the medical worker

Analysis of timing of the first antenatal visit indicates that early access to medical care is the norm among the sample studied. Most participants had their first antenatal consultation in the first 12 weeks of pregnancy, a small proportion performed it between 13–22 weeks, and late visits, between 23 and 32 weeks, as well as complete absence of antenatal care were recorded in isolated cases (*Table 2*).

Although the overall rate of early initiation of antenatal care by pregnant women is high, the differences between subgroups are significant and consistent with the trends identified throughout the research. Women with planned pregnancies had a higher rate of visits in the first trimester (95.7%; $n = 200$) compared to those with unplanned pregnancies (85.3%; $n = 81$) – a difference of about 10 percentage points, confirming that reproductive intention favors not only preconception behaviors, but also early access to medical care during pregnancy. A similar gradient is observed according to the level of education: 95.2% ($n = 160$) of the participants with higher education having their first prenatal visit by 12 weeks, compared to 89.0% ($n = 121$) of those without higher education.

These data highlight that although early prenatal visits are widely practiced, behavioral disparities persist depending on pregnancy planning and educational level – two factors that appear to be consistent predictors of preventive behavior across the entire dimension of perinatal care investigated in this study.

Table 2. (B01) When did you have your first prenatal visit to the doctor?

	Total		The last pregnancy was planned				Level of education			
			Yes		No		Higher education		without higher education	
	n	%	n	%	n	%	n	%	n	%
Up to 12 weeks	281	92.5	200	95.7*	81	85.3*	160	95.2*	121	89.0*
13–22 weeks	20	6.6	8	3.8	12	12.5	7	4.2	13	9.6
23–32 weeks	1	0.3	0	0.0	1	1.1	0	0.0	1	0.7
You did not receive medical assistance during pregnancy	1	0.3	1	0.5	0	0.0	1	0.6	0	0.0
Don't know	1	0.3	0	0.0	1	1.1	0	0.0	1	0.7
Total	304	100	209	100	95	100	168	100	136	100

* statistically significant differences at the level of $p < 0.05$

Despite the high rate of early visits for the first prenatal consultation, the content of these visits reveals some shortcomings in the counseling on risk behaviors. Thus, 60.1% ($n = 182$) of the participants stated that they did not receive any information regarding the consumption of alcohol, smoking, or drugs during the first prenatal visit. That proportion indicates that the prenatal screening process does not systematically take advantage of the opportunity to convey essential preventive messages at a time when women are potentially highly receptive (*Figure 21*).

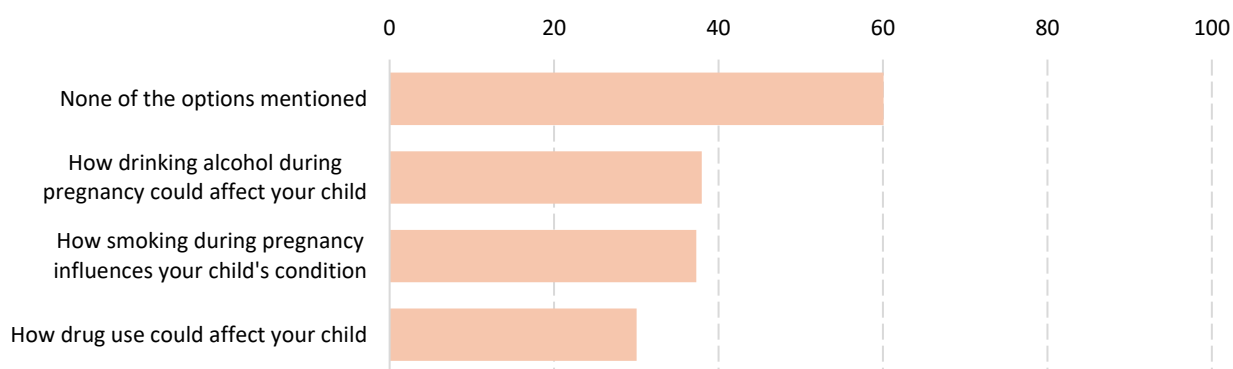


Figure 21. (B03) During your first antenatal care visit, the medical workers SPOKE to you about the topics listed below?

During subsequent antenatal care visits, healthcare workers more frequently addressed topics related to risk behaviors: smoking, alcohol consumption, and use of psychoactive substances were present in most clinical interactions, reflecting a counselling agenda focused mainly on behavioral risk factors with a direct impact on pregnancy progression. In contrast, aspects related to the emotional and psychosocial health of the pregnant woman, such as fear, perinatal depression, or exposure to domestic violence – factors with a documented impact on both maternal health and fetal and neonatal development remained largely outside the agenda of prenatal consultations. Contraceptive planning after childbirth has also been discussed only occasionally, indicating insufficient attention to the continuity of reproductive care beyond the gestational period (Figure 22).

This asymmetric distribution of the content of prenatal counselling, with a focus on behavioral risks and sometimes neglect of the psychosocial dimension, suggests that the dominant model of prenatal care remains centered on biomedical parameters, without systematically integrating the mental health and social protection components essential for a holistic approach to pregnancy.

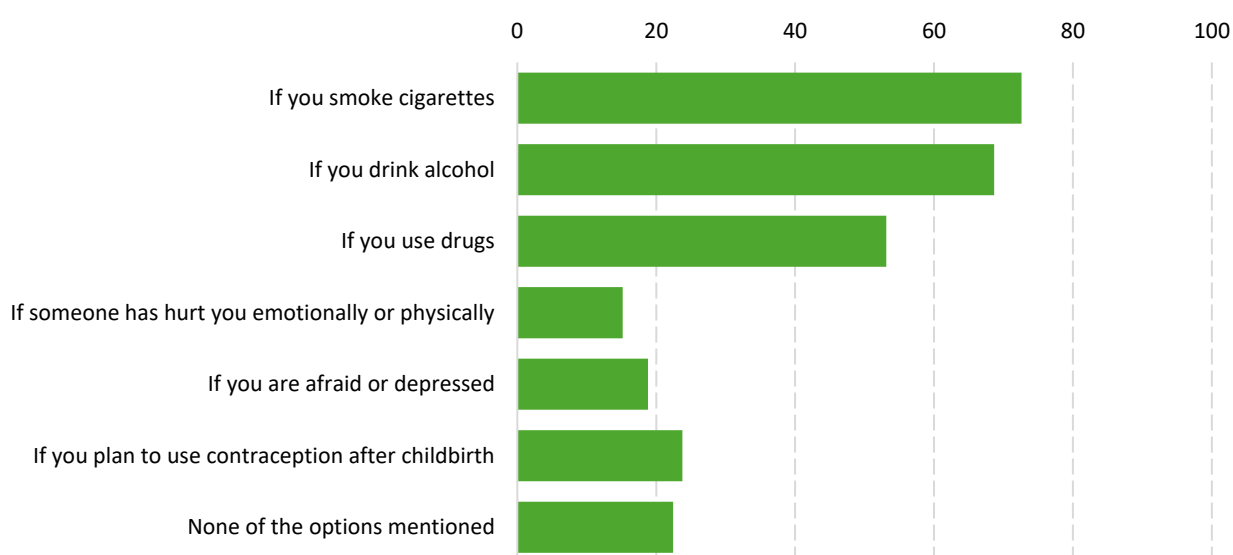


Figure 22. (B02) During prenatal care visits, did medical workers ASK YOU about the topics listed below?

The analysis of the sources of information considered most useful by the participants for information about fetal alcohol syndrome and the effects of alcohol consumption in pregnancy reveals a hierarchy in which digital channels and medical consultation occupy dominant positions. Internet and the doctor's office were the most frequently nominated sources, followed by traditional media (television programs and commercials), a configuration that provides a strategic framework for health communication interventions. Prenatal training classes and printed publications (books, magazines, newspapers) played a complementary role, while printed materials such as leaflets or brochures, support from the informal social network (friends, family), and the professional or academic environment were mentioned with a reduced frequency (*Figure 23*).

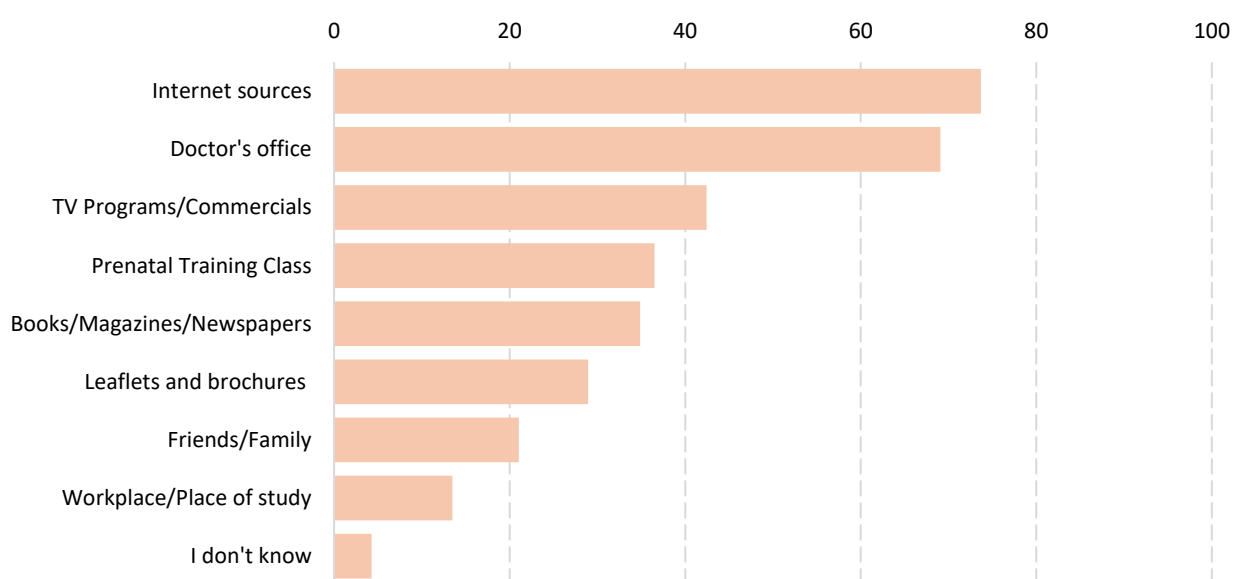


Figure 23. (KAP15) Which sources of information about fetal alcohol syndrome and the effects of alcohol consumption in pregnancy would be most useful for you?

Public warnings about alcohol consumption in pregnancy

The assessment of support for public warning measures on the risks of alcohol consumption in pregnancy indicates a very high level of backing among participants, regardless of the type of intervention proposed. The introduction of warning labels on alcohol containing products is supported by 92.4% ($n = 281$) of the participants, while the display of similar warnings in public consumption spaces (restaurants, bars and clubs) is welcomed by 89.1% ($n = 271$) of the respondents. Media warning campaigns register the highest level of support – 94.4% ($n = 287$), with participants with higher education expressing a significantly more frequent preference for this way of communicating about risks than those with other levels of education.

Among the partners, the support for these measures exceeds the threshold of 95.0% for all types of intervention evaluated, reflecting a consensus as well.

These data are relevant from the perspective of public health policies: the support of both women and partners for diversified warning measures, on the product, in public spaces and through media campaigns, provides a solid basis of social support for the implementation or expansion of such interventions in the Republic of Moldova, in line with European practices in the field.

CONCLUSIONS

WOMEN'S QUESTIONNAIRE

Sociodemographic profile and pregnancy planning

The studied sample is predominantly characterized by women who are married or in a relationship, a context that implies the existence of consistent family support. However, only 68.8% of the participants stated that the last pregnancy was planned, and the presence of an explicit reproductive plan, be it personal or for the couple, was reported by 61.8% of the respondents, reflecting a moderate level of intentional pregnancies in the studied population. The educational level is confirmed as a relevant predictive factor: women with higher education reported more frequently the existence of a reproductive plan and systematically manifested more prudent reproductive behaviors, a trend that is consistently found on all investigated dimensions.

Preconception education and pre-pregnancy medical visit

Although 55.3% of the participants considered that they had preconception training, only 43.1% of them visited a medical practitioner before pregnancy. The fact that 47.4% knew the usefulness of preconception consultation without following up on it highlights a significant behavioral barrier not at the level of information, but of action. The content of preconception counseling also proved to be incomplete: the topics addressed mainly concerned general health and nutritional supplementation, while behavioral risks, smoking, alcohol and drug consumption were treated marginally, signaling a systematic gap in the practice of preconception counseling.

Three months before pregnancy, just 37,8% (n = 155) of women declared that they totally abstained from drinking, and 62,1% of women reported that they did drink alcohol in various quantities.

Partner involvement

Partner involvement in preparing for pregnancy was perceived by fewer than four out of ten participants, representing one of the lowest indicators recorded in the study. This involvement is significantly more common in the context of planned pregnancies and among couples with a higher level of education, suggesting that both reproductive intentionality and formal education favor the assumption of a shared responsibility within the couple for reproductive health.

Access to antenatal care and medical counselling

The rate of 92,4% of first prenatal visits early in the pregnancy (in the first 12 weeks) reflects responsible behavior overall. However, the differences between subgroups are significant: women with planned pregnancies and those with higher levels of education recorded higher rates of early reporting, confirming the protective role of these variables. However, the quality of counseling provided during prenatal visits raises serious questions: 60.1% of the participants said that during the first visit they did not receive any information on the risks of alcohol, smoking, or drug use. Although these topics were addressed more frequently during subsequent prenatal care visits, topics such as psychosocial aspects, perinatal depression, anxiety, and domestic violence remained untouched during the clinical interactions, and postnatal contraceptive planning was

discussed only occasionally, highlighting a predominantly biomedical-behavioral approach, to the detriment of a holistic perspective on maternal health.

Knowledge of the impact of alcohol consumption in pregnancy

The participants demonstrate a satisfactory level of awareness of the general risk associated with alcohol consumption during pregnancy: 85.2% admit that any consumption can harm the child, and 95.1% agree that the risk increases proportionally with the amount consumed. However, knowledge levels become significantly lower when it comes to low and moderate doses: 39.1% of respondents do not consider drinking a small amount of alcohol dangerous, and 40.5% do not recognize the risk associated with preconception consumption. The differentiation of risk according to the type of alcoholic beverage represents another area of conditioned perceptions: wine registered the greatest deficit in perceived harmfulness; 39.5% of the participants do not consider it harmful, compared to only 7.6% in the case of strong spirits, reflecting the persistence of a culturally permissive attitude towards drinking wine during the gestational period. Knowledge of fetal alcohol syndrome remains extremely low: only 24.7% of participants have heard of FASD, and 38.7% of them do not understand the permanent nature of its effects, a cognitive gap with direct implications on the ability to assess long-term risk.

Attitudes towards alcohol consumption during pregnancy

Attitudes towards alcohol consumption during pregnancy are predominantly restrictive, but with significant differences depending on the level of education and pregnancy planning. Although 74.3% of the participants consider complete abstinence necessary, 27.6% accept occasional drinking in small quantities, and 13.5% manifest an inconsistent attitude, simultaneously agreeing with complete abstinence and acceptance of reduced consumption – an indication of a contradictory perception of risk, which has not been coherently integrated at the cognitive level. Support for prevention measures at the population level is high: 92.4% approve the use of warning labels on alcoholic products, 89.1% the display of warnings in public spaces, and 94.4% media campaigns – a solid social consensus, which gives a foundation to public policy interventions in this area.

Alcohol consumption and smoking practices

Alcohol consumption during pregnancy was reported by 28.6% of participants, with a significantly higher prevalence among women with unplanned pregnancies (36.8% vs. 24.9%). Although reported consumption was predominantly low, 21.8% of respondents reported that it was between one and three drinks per week in the first trimester, the gestational interval with the highest teratogenic risk. Preconception smoking was reported by 12.2% of the participants, with a higher prevalence among women without higher education and those with unplanned pregnancies, confirming the behavioral vulnerability profile already identified.

Discrepancy between knowledge and practice

The most significant finding of the study is the gap between risk awareness and actual behavior. The fact that:

- 19.7% of women who admit the harmfulness of any alcohol consumption during pregnancy nevertheless have drunk alcohol during this period, and that

– 25.3% of participants regularly drank alcohol in the preconception period, despite the recognition of the dose-risk relationship, demonstrate that the level of information alone does not determine reproductive behavior. These findings argue for a transition from information-centric preventive models to integrated approaches, simultaneously targeting the cognitive, motivational, and social context of women, with a focus on reproductive planning, individualized counseling, and partner involvement as factors of sustainable behavioral change.

SPOUSES/PARTNERS QUESTIONNAIRE

Knowledge related to the impact of alcohol consumption in pregnancy

Partners demonstrate an overall satisfactory level of awareness of recommended behaviors during the gestational period: reducing or eliminating alcohol consumption, quitting smoking, and avoiding psychoactive substances by women are recognized as essential by most respondents. However, there are significant gaps in nuanced risk awareness. Red wine is perceived as neutral or even beneficial by 22.5% of partners, reflecting the persistence of a culturally permissive attitude towards drinking wine. Although 80.0% admit that any alcohol consumption can harm the fetus, only 60.0% explicitly reject the idea that a small amount would be safe in pregnancy, indicating an underestimation of the risk associated with occasional drinking – a similar situation identified among women.

Knowledge about fetal alcohol syndrome is extremely low among partners: only 30.0% of them said they had heard of FASD, and significant confusion persists among them regarding the mechanism of the syndrome, including the erroneous attribution of causality to the father's intoxication at the time of conception. In terms of the ranking of risk factors, drug use is placed first as the most harmful factor, while alcohol ranks third out of five – a ranking that considerably underestimates the severity of fetal exposure to alcohol compared to current medical recommendations.

Attitudes towards alcohol consumption during pregnancy

Partners' attitudes towards alcohol consumption in pregnancy are predominantly restrictive. Thus, 72.5% reject the idea that pregnant women can drink alcohol in the absence of abuse, and 65.0% support the need for complete abstinence. However, the difference depending on pregnancy planning is notable: partners of women with unplanned pregnancies show a considerably higher tolerance towards occasional consumption – 46.2%, considering it acceptable for the pregnant woman to drink a little alcohol, compared to only 11.1% of partners in couples with planned pregnancies. This difference of 35 percentage points identifies partners in couples with unplanned pregnancies as a priority group for information and counselling interventions.

Support for prevention measures at the population level is high: over 95.0% of the partners approve the introduction of warning labels on alcoholic products, the display of warnings in public spaces and the running of media campaigns – a consensus that even exceeds the level recorded among women and which provides a solid basis for the adoption of firmer public policies.

Practices regarding alcohol consumption in pregnancy

According to the partners' statements, 25.0% of them say that their partner drank alcohol before pregnancy, and 10.0% report their partner's consumption during pregnancy – considerably lower proportions than those declared by women about their own behavior (28.6% consumption during pregnancy). This gap may reflect either underreporting on the part of partners driven by the lack of direct observation of the partner's behavior, or a tendency toward social acceptability in their responses.

The partner's own behavior towards alcohol consumption is relatively independent of that of the partner at the declarative level: 85.0% say that they will not drink alcohol if the partner continues to drink, and 80.0% say that they would not offer alcohol to their partner during pregnancy. However, 37.5% of partners say they would continue to drink alcohol even if their partner encouraged them to quit – a proportion that indicates the limits of mutual influence within the couple and underlines the need for counselling interventions aimed directly at men, not just through their partner.

The main sources of information accessed by the partners are the internet (51.7%) and the doctor's office (35.0%) – a distribution similar to that recorded among women, which confirms the complementary role of digital channels and medical consultation in communicating on reproductive health issues.

BARRIERS AND OPPORTUNITIES IN FASD PREVENTION

(Qualitative study through thematic focus groups)

Purpose of the study

The specific objectives of the study were:

- exploring the perceptions and professional competences of specialists regarding the prevalence and determinants of alcohol consumption in pregnancy;
- identification of current screening and counseling practices in the prevention and management of FASD;
- documenting structural, professional and cultural barriers to preventive interventions;
- identification of training and support needs.

Study methodology

Research Design

The study is qualitative research, using the focus group discussion (FGD) method as the main tool for data collection. Four distinct thematic focus groups have been organized, each bringing together a homogeneous category of participants, to facilitate the free expression of specific professional groups and to allow comparison between categories. The choice of the qualitative method was influenced by the complexity of the phenomenon investigated: the barriers to preventive counseling on alcohol consumption in pregnancy, which involve cultural, social and relational dimensions that cannot be identified by standard quantitative instruments. The focus group discussions allowed highlighting some nuances, contradictions and perspectives that complete the picture provided by the statistical data obtained from the quantitative component of the project.

Participants and Sampling

The selection of the participants was done among representatives of all categories of professionals with a role in the prevention and management of FASD. There were four groups of stakeholders: social workers (n = 10), medical workers (family doctors, obstetrician-gynecologists, nurses and midwives) (n = 10), mothers on childcare leave (n = 12) and psychologists (n = 19). A total of 51 participants were selected.

The recruitment of participants was carried out within the partner institutions associated with the project. The professionals were selected from those who, at the time of the study, were active in the medical, psychological, or social fields, having direct contact with women of reproductive age or pregnant women. The mothers included in the study had young children.

Tools and procedures

A specific interview guide was developed, adapted to the specific profile of each category of participants, and developed based on evidence from literature and international recommendations on the prevention of FASD. The guide covered four main thematic areas: (1) perceptions and drivers of alcohol consumption in pregnancy; (2) identification

of current risk and counselling practices; (3) barriers and support needs in prevention activity; (4) opportunities to strengthen cross-sectoral collaboration.

Each focus group was moderated by a facilitator and an observer, lasting 60–90 minutes. The audio recording of the discussions was made with the explicit consent of the participants to ensure the accuracy of the transcription. Confidentiality was protected by assigning a unique code to each participant (letter or number), used throughout the discussion. Each participant completed a pre-FG questionnaire, developed by the research team, with reference to socio-demographic profile, professional experience, perceived level of preparation, and attitudes towards alcohol consumption during pregnancy.

The structure of each session included: (1) introduction – purpose and principles of confidentiality (10–15 min); (2) guided discussions based on the specific interview guide (60 min); (3) final reflections and recommendations (10–15 min). The questions were open and non-direct, with introductory expressions such as: "To what extent do you consider that...", "What is your perception of...", "From your professional experience...", meant to facilitate authentic expression and reduce the effect of social desirability.

Ethical considerations

Each participant was offered an informative note including: the purpose of the project, the principle of voluntary participation, the way of processing and storing data, the right of withdrawal at any time. Written informed consent was obtained prior to participation, in accordance with the form approved by the Ethics Committee. The data were used exclusively for scientific purposes.

Socio-demographic and professional profile of the participants

A total of 51 people participated in the four focus groups, with a relatively balanced distribution between all the categories. The predominant age group was 31–40 years ($n = 20$; 39.2%), followed by the age group of 21–30 years ($n = 13$; 25.5%), the category over 51 years ($n = 11$; 21.6%), and the group of 41–50 years ($n = 7$; 13.7%). Most of the participants have higher education ($n = 32$; 62.7%) or postgraduate studies ($n = 8$; 15.7%), with a lower representation of specialized secondary education ($n = 8$; 15.7%).

Professional experience covers all career stages: specialists with less than 5 years of experience ($n = 17$; 33.3%), 5–10 years ($n = 10$; 19.6%), 11–20 years ($n = 10$; 19.6%) and more than 20 years ($n = 8$; 15.7%), with 6 participants who did not specify their experience (11.8%). Thus, a diverse exchange of views among professionals was possible. The group of medical workers had the highest average experience in the field, with 5 out of 10 having more than 20 years of activity. The group of psychologists is the largest category ($n = 19$) and the youngest on average, with 9 of the 19 participants having less than 5 years of experience.

Professional experience in counseling on alcohol consumption during pregnancy

Frequency of alcohol consumption recognized by participants

The acknowledgement of alcohol consumption in pregnancy by women in the context of professional interactions is reported with low frequency by all categories of participants (*Table 2*). Of the total number of responses ($n = 39$), 18 (46.2%) say that such

situations are rarely encountered, and 13 (33.3%) never occurred. Only 8 participants (20.5%) report that they sometimes encounter them, signaling systematic underreporting rather than a low actual prevalence.

The analysis by occupational categories reveals that medical workers are the only ones who report a higher frequency of alcohol consumption during pregnancy; 4 out of 10 say they observed it sometimes. Psychologists, although they constitute the most numerous category, most frequently report the absence of acknowledgement (10 of them – rarely, and 7 – never), which can be partly explained by the nature of the therapeutic context, in which sensitive topics are approached with more caution (*Table 3*).

Table 3. Frequency of alcohol consumption during pregnancy recognized by participants (n = 39)

Focus Group participants	Sometimes	Rare	Never	Total
Social workers	2	3	5	10
Medical Workers	4	5	1	10
Psychologists	2	10	7	19
Total, n	8	18	13	39

Opening a discussion about alcohol consumption

The analysis of the initiative to address the subject of alcohol consumption with pregnant women reveals an asymmetric distribution according to the professional role (*Table 4*). Medical workers are the category with the highest level of initiative; 7 out of 10 state that they always approach this subject. Psychologists approach the topic mostly reactively: 7 out of 18 discuss it only if the woman mentions it, 7 out of 18 sometimes address it, 3 – never address it. Social workers have a mixed profile: 5 out of 10 initiate the discussion only if this topic is mentioned. These data confirm that the discussions about alcohol consumption are not systematized at the level of all professions involved in the care of pregnant women. The dependence on individual initiative and the specific context of the interaction limits the coverage of preventive interventions and generates inequalities in women's access to counselling.

Table 4. Alcohol Discussion Initiative (n = 38)

Category	Yes, always	Only if it mentions	The Necessity	Never	Sometimes	Total
Social workers	2	5	1	–	2	10
Medical Workers	7	1	–	–	2	10
Psychologists	1	7	–	3	7	18
Total, n	10	13	1	3	11	38

Perceived level of professional training

The perceived level of readiness of specialists to approach the subject of alcohol consumption in pregnancy is predominantly moderate (53.8%; n = 21) or low (35.9%; n = 14). Only 4 participants (10.3%) consider themselves very prepared, all medical workers or psychologists. Social workers have the lowest level of self-perceived

training: none of the participants in this category consider themselves to be very prepared, 6 consider themselves moderately prepared, and 4 consider themselves unprepared (Table 5).

Table 5. Perceived level of professional training (n = 39)

Category	Very prepared	Moderately prepared	Little prepared	Total
Social workers	–	6	4	10
Psychologists	2	9	8	19
Medical Workers	2	6	2	10
– Senior Nurse	–	–	1	1
– Family doctor	1	3	1	5
– Midwife	1	1	–	2
– Midwife and family nurse	–	1	–	1
– Obstetrician-gynecologist	–	1	–	1
Total, n	4	21	14	39
Percentage, %	10.3	53.8	35.9	100

Use of screening tools

The use of standardized screening tools for alcohol consumption is significantly limited (Table 6). The AUDIT* tool is used by 31.6% (n = 12) of participants, predominantly among healthcare workers (6 out of 10). Alarming, 44.7% (n = 17) do not use any formal tools, 2.6% have never encountered such a situation, and 2.6% are unaware of the available tools. Psychologists are the category with the lowest level of use of standardized screening: 12 out of 19 say they do not use any instruments, and 4 use AUDIT. Social workers have a similar profile (5 out of 9 who responded) not using formal tools. The absence of systematic screening makes risk identification dependent on subjective assessment and spontaneous communication with women, which significantly limits the effectiveness of early preventive interventions.

Table 6. Use of screening tools (n = 38)

Category	AUDIT*	Informal discussion	No tools	Other/unspecified	Total
Social workers	2	1	5	1	9
Medical Workers	6	–	–	4	10
Psychologists	4	1	12	2	19
Total, n	12	2	17	7	38
Percentage, %	31.6	5.2	44.7	18.5	100

* In the Republic of Moldova (2025), according to the standardized clinical protocol, pregnant women take the AUDIT test during their first prenatal visit to the medical professional.

Training experience in the field of FASD

Previous training experience in the prevention of fetal alcohol disorders is almost absent: only 3 participants (7.0%) participated in such training. In contrast, 58.1% (n = 25) never had appropriate training in this field, and 34.9% (n = 15) would like to have such training. That distribution reveals both a major gap in the supply of continuing professional training and a high level of interest in remedying and closing this gap (Table 7).

Table 7. Participation in trainings regarding prevention of FASD (n = 43)

Category	Participated	Did not participate	Would like to participate	Total
Social workers	1	4	5	10
Mothers on childcare leave	–	4	–	4
Medical Workers	1	6	3	10
Psychologists	1	11	7	19
Total, n	3	25	15	43
Percentage, %	7.0	58.1	34.9	100

Challenges and needs

The analysis of the responses to the questions about the main challenges in the prevention of FASD (n = 40) and the need for additional support reveals a remarkable convergence between professional categories, indicating that the barriers are structural and systemic in nature.

Main challenges identified

- **Lack of educational materials** – the most frequently mentioned challenge (present in at least 16 out of 40 responses), singled out as a problem or in combination with other factors. The absence of standardized educational resources, adapted to different target groups and the local context of the Republic of Moldova, significantly limits the ability of specialists to convey coherent and consistent messages.
- **Pregnant women's reluctance to get involved** – mentioned in at least 15 responses. The fear of stigmatization, sanctions, or loss of custody of the child generates denial and avoidance, which makes it difficult to identify the risk and build a trusting therapeutic relationship.
- **Lack of cross-sectoral collaboration** – reported in at least 14 responses. The fragmentation of responsibilities between medical, social, and educational systems, the lack of common protocols, and clear reference paths limit the continuity and coherence of interventions.
- **Lack of time allocated to the counseling process** – mentioned in at least 6 responses, especially by healthcare workers. The 15-minute consultations do not allow for a systematic approach to sensitive topics such as alcohol consumption.

Support needs expressed

- **Additional training workshops** – mentioned in at least 26 responses. Interest in training is high in all categories, reflecting the recognition of the current shortage of specific training.
- **Standardized educational materials** – mentioned in at least 22 responses. Participants ask for resources tailored to different target groups: specialists, pregnant women, families, and the community.
- **Psychological and social support** – mentioned in at least 19 responses. The need for support mechanisms for vulnerable women, beyond the purely informational component, is recognized.
- **Clear national guidelines** – mentioned in at least 10 responses. The absence of a standardized national regulatory framework on screening and counselling in the field of FASD is identified as a major structural gap.
- **Specialized services for at-risk pregnant women** – mentioned by a limited number of respondents but representing a significant need for complex cases.
- **Trainings for adolescents** – mentioned in isolation, but with important preventive potential as a primary prevention measure.

Knowledge and attitudes regarding alcohol consumption in pregnancy

Frequency of approaching the subject with pregnant women

None of the participating professional categories regularly discuss alcohol consumption during pregnancy with pregnant women (*Table 8*). Only 3 people (5.9%) always address this topic, 20 (39.2%) sometimes, 11 (21.6%) often, 12 (23.5%) very rarely, and 5 (9.8%) never. The subject remains dependent on the context and the initiative of each one, without being integrated into the care routine.

Table 8. Frequency of open discussion about alcohol consumption with pregnant women (n = 51)

Category	Permanent	Frequent	Sometimes	Very rare	Never	Total
Social workers	–	4	4	2	–	10
Mothers on childcare leave	–	2	3	3	4	12
Medical Workers	1	3	6	–	–	10
Psychologists	2	2	7	7	1	19
Total, n	3	11	20	12	5	51
Percentage, %	5.9	21.6	39.2	23.5	9.8	100

Acceptance of the message of total abstinence from alcohol during pregnancy

The message regarding the absence of any safe amount of alcohol during pregnancy is widely accepted among participants. Of the total respondents (n = 49), 83.7% completely agree or agree with this statement. Family doctors have the highest consensus (8 out of 9 completely agree), followed by psychologists (17 out of 19 completely agree or agree). Mothers have the greatest diversity of responses, with 4 out of 12 taking a neutral or disagreeing position, possibly influenced by previous personal experiences and contradictory messages (*Table 9*).

Table 9. Agreement with the statement "There is no safe amount of alcohol in pregnancy" (n = 49)

Category	Completely agree	Agree	Neutral	Disagree	Completely disagree	Total
Social workers	6	2	–	–	1	9
Mothers on childcare leave	5	3	2	2	–	12
Family doctors	8	–	–	–	1	9
Psychologists	13	4	1	1	–	19
Total, n	32	9	3	3	2	49
Percentage, %	65.3	18.4	6.1	6.1	4.1	100

Perception of frequency of alcohol consumption in pregnancy

Participants' estimates of the prevalence of alcohol consumption during pregnancy in the Republic of Moldova are worrying: 39.2% (n = 20) believe that pregnant women drink alcohol frequently, and 31.4% (n = 16) believe that this happens sometimes. Psychologists are the category with the most pessimistic perception; 10 out of 19 consider alcohol consumption by pregnant women to be frequent. This perception is consistent with quantitative data from the CAP study (STAF Project), which shows that 28.6% of the women in the sample reported alcohol consumption during pregnancy (*Table 10*).

Table 10. Perception of frequency of alcohol consumption among pregnant women (n = 51)

Category	Common	Sometimes	Rare	Very rare	I don't know	Total
Social workers	4	4	2	–	–	10
Mothers on childcare leave	3	3	1	1	4	12
Family doctors	3	4	1	–	2	10
Psychologists	10	5	–	–	4	19
Total, n	20	16	4	1	10	51
Percentage, %	39.2	31.4	7.8	2.0	19.6	100

Assessing the severity of the effects of occasional alcohol consumption on the fetus

The level of awareness of the seriousness of the effects of occasional alcohol consumption on the fetus is very high: 90.2% (n = 46) of the participants consider them serious, 3.9% (n = 2) moderate, and 5.9% (n = 3) do not know. Social workers are unanimous in this assessment (10 out of 10), and the other professional categories register similar distributions. The contrast between the awareness of the severity of the risk and the low frequency of a systematic approach to the subject in practice is striking (*Table 11*).

Table 11. Perception of the severity of the effects of occasional alcohol consumption on the fetus (n = 51)

Category	Severe	Moderate	I don't know	Total
Social workers	10	–	–	10
Mothers on childcare leave	10	1	1	12
Medical Workers	9	–	1	10
Psychologists	17	1	1	19
Total, n	46	2	3	51
Percentage, %	90.2	3.9	5.9	100

Recommendations for pregnant women made by participants

The messages sent by the participants focus on 5 main directions:

- (1) The first and most common is the warning of absolute danger: no amount of alcohol is safe in pregnancy, regardless of the term of pregnancy or context. Respondents insist on the total exclusion of alcohol consumption – from preconception to breast-feeding – stressing that *"a drop of alcohol destroys a living being"*.
- (2) Secondly, participants describe the direct consequences to the fetus: irreversible damage to the central nervous system, congenital malformations, and some use severe formulations such as *"alcohol consumption kills"* or *"alcohol consumption in pregnancy = a sick child"*.
- (3) The third aspect concerns the responsibility of the mother: the child *"is born in the body of a healthy mother"*, and the pregnant woman has the moral duty to *"protect life from within, not to 'poison' it"*.
- (4) Respondents highlight the need for accurate information by combating the myth that alcohol is allowed in certain trimesters and the urge to seek psychological support instead of resorting to alcohol.
- (5) Some messages adopt a direct and personal tone, addressing the mother with formulations such as *"think about your future and the baby's"* or *"take care of yourself"*.

Results of the qualitative study on thematic focus groups

Focus group with psychologists

Recognition and professional experience

The psychologists reported consistent professional experiences with children who presented developmental delays, attention difficulties, behavioral problems, and emotional regulation difficulties – manifestations associated in the literature with the spectrum of fetal alcohol disorders (FASD). The manifestations described included: difficulty concentrating, impulsivity, problems relating to peers, limited vocabulary, learning difficulties, and intense emotional reactions that were inappropriate to the context. A central aspect of the discussion was the complexity of the diagnostic differentiation between FASD, attention deficit hyperactivity disorder (ADHD), and autism spectrum disorders, highlighted by all participants. Psychologists noted that this differentiation is achieved by combining clinical observation, standardized psychological assessments, anamnesis,

and consultation with other specialists. The difficulty of the process is amplified in cases where information on pregnancy or maternal alcohol consumption is incomplete or undeclared – a frequent situation in the context of the Republic of Moldova.

Collaboration with parents and family

Addressing the topic of alcohol consumption with parents has been described as a recurring challenge, marked by reactions of denial, shame, and avoidance. Psychologists reported specific strategies for maintaining communication: using non-accusatory language, focusing the discussion on the child's needs (not parental behavior), giving time to process information, and emotionally validating feelings of guilt or helplessness. The importance of gradually building the therapeutic relationship of trust as a premise for any effective intervention was emphasized.

Interdisciplinary collaboration

Collaboration with family doctors, social workers, teachers, and other specialists was described as necessary but insufficiently structured – based on personal relationships and individual initiatives rather than institutional protocols. The participants mentioned the existing mechanisms (referrals, exchange of information, inter-institutional communication), while emphasizing the need for formalized multidisciplinary teams, clear reference guides, and case management meetings.

Needs and recommendations

The main needs expressed by psychologists were the following: specific training in identification and management of FASD; methodological guides adapted to psychological practice; educational materials for working with affected children and their families; standardized assessment and monitoring tools. The importance of integrating the FASD dimension in the initial and continuous training of psychologists was emphasized, not as a niche subject, but as a current reality of clinical practice.

In conclusion, focus group discussions with psychologists highlighted the important role of psychological counseling in early identification of developmental difficulties in children and in supporting families in sensitive contexts, including those related to alcohol consumption during pregnancy. Relevant experiences in working with children with emotional, cognitive, and behavioral difficulties were presented, as well as the complexity of working with parents in dealing with these situations. At the same time, in the focus group discussions was mentioned the importance of trust-based communication, interdisciplinary collaboration, and adapting interventions to the individual needs of the child. The discussions contributed to a better understanding of current practices and support needs of psychologists involved in preventing and managing the impact of prenatal alcohol consumption.

Focus group with mothers

Perceptions and attitudes regarding alcohol consumption in pregnancy

Mothers expressed predominantly firm opinions on the harmfulness of alcohol in pregnancy, confirming that the public health messages were received. Statements such as: *"alcohol goes directly to the child"* or *"any amount affects the child, even if it seems small"* were frequent during the discussions. Some participants mentioned the evolution of

perceptions: in the past, messages were more permissive; today, they are perceived as clearer and more restrictive. However, the participants admitted that situations of alcohol consumption during pregnancy exist in the community, motivated by stress, fatigue, lack of social support, or the belief that: *"a small glass does no harm"*. The subject of alcohol consumption in pregnancy has been described as unequally approached in the community: in some contexts, it is openly discussed; in others, it is considered a delicate subject, *"which is known not to be good, but not talked about"*. Reluctance has been associated with traditions, shame, and fear of social judgment.

Experience with medical services

The experiences with the medical staff were described heterogeneously. Some participants reported receiving clear and consistent information – *"the doctor clearly told me that it was not allowed at all"*, and others mentioned that the topic was not explicitly addressed or was treated superficially. The main way of informing was the direct discussion with the medical staff; Leaflets and written materials were rarely mentioned – *"I didn't receive anything printed, only what I heard from the doctor"*.

Social and emotional factors

The participants identified several factors that can influence alcohol consumption during pregnancy: stress, lack of support from partner or family, normalized drinking in the proximal environment, and social pressure in festive contexts – *"at holidays it's hard to refuse"*. The lack of support was described as a major factor of vulnerability: *"when you're alone, it's much harder."* Mothers' groups, counseling, and emotional support were identified as resources with important preventive potential.

Stigma and barriers in communication

The stigma of women who drink alcohol during pregnancy has been identified as a significant barrier in open communication with professionals. *"the community judges quickly"* and *"it is better to be silent than to be pointed at with the finger"* are expressions that summarize this dynamic. The participants emphasized that the empathetic approach of the medical staff: *"if the doctor speaks calmly and without arguing, the woman says more"*.

In conclusion, the focus group conducted with mothers provided a detailed picture of their perceptions, experiences, and needs in relation to alcohol consumption during pregnancy, interaction with medical services, and the social context in which health-related decisions are made. The discussions highlighted that the participants are generally aware of the risks for the child's health associated with alcohol consumption, but the level of information, the way of approaching the subject, and the experience with the medical system differ. Communication about alcohol consumption remains, in many contexts, a sensitive topic, influenced by social norms, stigma and fear of judgment. Participants stressed the importance of empathetic, clear and consistent communication, as well as access to adapted and easy-to-understand information.

Focus group with social workers

The complexity of the social situations of vulnerable pregnant women

Social workers described a picture of multiple vulnerabilities in which alcohol consumption coexists with poverty, housing instability, domestic violence, lack of identity

documents, and social isolation. This perspective is suggestively summarized by one participant: *"it's not just alcohol, it's the whole package – "poverty, conflicts, lack of support, violence"*. Alcohol consumption has been described both as a response to social stress and as an aggravating factor of marginalization: *"alcohol first helps them forget, then destroys them and what they had."* The role of family models and the intergenerational passing of drinking habit was discussed in detail: *"mom drank, grandma drank – she doesn't see anything wrong"*. This intergenerational norm poses a specific challenge for preventive interventions, which must address not only individual behavior, but also the system of values and norms from which it derives.

Identifying and addressing pregnant women at risk

Identifying alcohol consumption has been described as a gradual process, based on behavioral observation and indirect signals – unstable behavior, repeated absences, poor hygiene, inconsistency in communication – rather than direct statements. The community plays an important role in this process: *"the neighbors tell us", "the kindergarten teacher lets us know"*. The fear of sanctions and loss of custody of the child generates active avoidance: *"she disappears, she doesn't answer the phone anymore, you can't find her anymore"*. Building the relationship of trust with the beneficiary was described as an essential premise and as a lasting process: *"when she sees that you visit her not just once, then they start talking"*. The empathetic and non-judgmental approach, consistency, and constant presence were identified as the key elements of a functional therapeutic relationship with vulnerable women.

Types of interventions and limits

The interventions described include home visits, social counseling, referral to medical and psychological services, targeted material support, and collaboration with local authorities. However, the participants underlined the intrinsic limits of social intervention in the absence of the beneficiary's internal motivation: *"you can make plans, explain, but if she doesn't want to, nothing changes."* Direct financial support was viewed with reservations – *"money doesn't solve the problem, sometimes it makes it worse"* – while emotional support and constant monitoring were assessed as essential.

Inter-institutional collaboration and training needs

Collaboration with doctors, police, schools and other institutions was described as necessary, but fragmented and bureaucratic: *"everyone does their own piece", "we walk our papers from one to another"*. The lack of effective legal levers and the professional overload – *"we are few, and the cases are many"* – further limit the capacity to intervene. The support needs expressed are aimed at applied training, clarification of institutional roles, and strengthening multidisciplinary teams: *"we need concrete tools, not just theory"*.

In conclusion, the discussions held within the focus group with social workers highlighted the complexity of the social dimension associated with alcohol consumption in pregnancy, as well as their central role in identifying and supporting pregnant women in vulnerable situations. Participants noted that identifying alcohol consumption in pregnancy is a gradual process, based on observation, a trusting relationship with the beneficiary, and signals from the community, rather than direct statements. The

relationship with the pregnant woman has been described as essential but fragile, influenced by fear of stigmatization, sanctions, or loss of the child, which requires an empathetic and consistent approach. The social interventions presented by the participants included emotional support, counseling, orientation to medical and psychological services, as well as collaboration with other institutions. At the same time, the limits of social intervention were underlined, especially in the absence of beneficiary motivation, family support, or clearly defined inter-institutional mechanisms. Existing collaboration between institutions has been described as necessary but often fragmented and constrained by structural and bureaucratic factors.

The focus group with social workers provided a realistic picture of the role of social workers as key actors in the prevention of alcohol consumption in pregnancy, highlighting both their essential contribution in supporting vulnerable women and the need to strengthen professional capacities, interdisciplinary collaboration, and institutional support mechanisms for the prevention of fetal alcohol disorders.

Focus group with healthcare workers

Perception of the problem and level of population awareness

Medical workers have confirmed that the message about the risks of alcohol consumption in pregnancy is well known at a professional level, but is minimized by some pregnant women. Participants frequently mentioned the persistence of the idea that *"red wine makes blood"* or that *"a small glass doesn't matter"* – ingrained cultural perceptions that undermine the effectiveness of overall preventive messages. Social pressure in festive or family contexts has been described as an important factor influencing the behavior of pregnant women: *"at holidays it is difficult to refuse, especially when everyone insists"*.

Current Clinical Approach Practices

The approach to alcohol consumption is predominantly achieved through direct verbal discussions, integrated into the prenatal anamnesis. The participants reported that the discussion is easier when there is a lasting relationship with the patient – *"with patients they have known for years I can talk openly"* – and more difficult at the first consultation. The reactions of pregnant women are varied: some open and cooperative, others marked by denial or minimization: *"they say they don't drink at all, but later you find out something else from the family"*. The empathetic and non-judgmental approach was emphasized as essential for maintaining the therapeutic relationship: *"if she feels that you are judging her, she no longer comes to consultations"*.

Screening and documentation of cases

Participants acknowledged that standardized screening (AUDIT) is not used systematically. Risk assessment is based on clinical observation and indirect signals – *"we orient ourselves by behavior, as it answers questions"*, *"sometimes the family says more than the patient"*. The documentation of risk cases is limited by the lack of time, the absence of clear protocols, and the fear of stigmatization: *"we don't have a clear protocol, everyone does what they can"*, *"you don't want to put a label that scares them"*.

Resources and training

The need for training in motivational communication and prenatal screening was expressed as a priority: "we have medical knowledge, but we don't always know how to approach the discussion". The absence of standardized educational materials adapted to the local context is felt in all subcategories – "clear leaflets, posters, videos would be very useful". "Consultation time is limited to 10–15 minutes, but they have to do a lot" remains a major structural constraint.

Specific perspectives by professional categories

Family doctors underlined their central role in primary prevention, expressing their need for simple tools that are easy to integrate into their daily work schedule. Obstetrician-gynecologists highlighted the denial of drinking as the main barrier and called for common protocols at the institutional level and functional interdisciplinary teams. The nurses described their role in delivering preventive messages in informal and repeated contexts, stressing the need for standardized messages and training to strengthen their advisory role. Midwives have highlighted their potential for intervention through prenatal courses and direct contact in the postpartum period, if there is specific training and adequate resources. The central message repeatedly formulated by all participants was: "there is no safe amount of alcohol during pregnancy", complemented by the statement that "if we intervene in time and with empathy, we can prevent many serious situations" – underlining the preventive potential of the medical system, conditional on the elimination of the identified structural barriers.

In conclusion, the discussions carried out within the focus group with medical professionals highlighted their central role in the primary prevention of alcohol consumption in pregnancy and underlined that insufficient time for consultations and the absence of clear protocols limit the systematic approach to screening. The use of standardized instruments is reduced and unstructured, often being replaced by subjective evaluation and clinical observation. Family doctors expressed the need for simple tools, easy to integrate into daily practice, standardized educational materials, and training in motivational communication. Collaboration with gynecologists and social workers is recognized as necessary, but insufficiently formalized.

Cross-sectional thematic analysis

The comparative analysis of the data from the four focus groups reveals five cross-cutting themes that cross all categories of participants and define the architecture of barriers and opportunities in the prevention of FASD in the Republic of Moldova.

1. The Gap Between Awareness and Systematic Action

Awareness of the risks of alcohol consumption during pregnancy remains high in all professional categories: 90.2% consider the effects serious; 83.7% accept the absence of any safe amount. Paradoxically, the approach to the subject in practice remains sporadic, dependent on the context and individual initiative. The lack of standardized protocols, educational materials, and a prevention-centered organizational culture explains this gap between knowledge and systematic action.

2. Stigma as a structural barrier

The stigma of women who drink alcohol during pregnancy has been identified as a major barrier by all categories – mothers, psychologists, social workers, and health workers. Fear of social judgment, sanctions, and loss of custody over children leads to systematic underreporting and avoidance of contact with health and social services. The empathetic, non-judgmental approach is unanimously recognized as a premise of any effective intervention.

3. Fragmentation of cross-sectoral collaboration

Collaboration between medical, social, educational, and psychological systems is consistently described as necessary, but insufficiently structured – "*everyone does their piece*". Referral guides are missing, common protocols are non-existent, post-intervention feedback remains a priority, and regular interdisciplinary meetings are an exception. The continuity and coherence of interventions deteriorate under the pressure of professional overload and excessive bureaucracy.

4. Systemic shortage of training and resources

The absence of standardized educational materials, national guidelines, accessible screening tools, and specific professional training in the field of FASD was mentioned convergently by all categories. Only 7.0% of participants benefited from specific training, while interest in training is high (34.9% did not participate, but would like to). Professionals show openness to learning – favorable premises for systemic intervention.

5. The role of social context and cultural norms

Alcohol consumption in pregnancy is not isolated behavior, but is integrated into complex networks of social norms, family traditions, and community pressures. Intergenerational transmission, the normalization of drinking in festive contexts, and the permissive cultural perception towards wine are factors that operate beyond the individual sphere and cannot be addressed exclusively through clinical counseling. Effective interventions must also target the community and normative dimension of behavior.

IMPACT OF TRAINING ACTIVITIES FOR SERVICE PROVIDERS ON REDUCING ALCOHOL CONSUMPTION DURING PREGNANCY

Analysis of the opinions of pregnant women registered for prenatal care before and after the training of specialists (medical staff, social workers and psychologists)

Objectives of the study

The study aimed to meet the following specific objectives:

- Assessing the level of knowledge of the risks of alcohol consumption in pregnancy among pregnant women.
- Evaluating prenatal screening and counseling practices applied by medical staff in the Riscani sector.
- Identifying barriers to information access and the use of screening tools.
- Comparison of all indicators before and after training of medical staff, social workers, and psychologists.
- Making recommendations for improving policies and practices in the field.

Methodology

Study design

The study used a pre-post design, which allows the evaluation of the impact of an intervention by comparing the data collected before and after its implementation. This approach, although less rigorous than a randomized controlled trial, provides valuable evidence on the practical effectiveness of training programs in the context of health services.

The data collection tool was a structured questionnaire, applied individually to pregnant women during prenatal consultations. The questionnaire included 22 main questions, organized on several areas: socio-demographic data, knowledge on the effects of alcohol in pregnancy, drinking-related behaviors, experience of interaction with medical staff, and use of the AUDIT test.

Study participants

The participants of the study were pregnant women aged 18 and over, with registered pregnancies in one of the primary medical care institutions in the Riscani sector, mun. Chisinau, who voluntarily agreed to participate. No exclusion criteria based on gestational age, parity, or other demographic characteristics were established in order to ensure the representativeness of the sample.

The total sample comprised 146 respondents, divided into two comparison groups:

- PRE-training group: 52 pregnant women surveyed before the staff training program (hereinafter – the PRE group).
- POST-training group: 94 pregnant women surveyed after the completion of the training program (hereinafter – the POST group).

Characteristics of the sample

The analysis of demographic characteristics shows that the PRE group and the POST group are similar in terms of age, marital status, and level of education, which lends robustness to the interpretations presented in the report.

Table 12. Demographic characteristics of the sample

Demographic characteristic	PRE-training (n = 52)		POST-training (n = 94)	
	n	%	n	%
Age				
18–24 years	9	17,3%	12	12,8%
25–34 years	30	57,7%	59	62,8%
35–44 years	13	25,0%	23	24,5%
Marital status				
Married	43	82,7%	79	84,0%
As a couple (unmarried)	5	9,6%	13	13,8%
Divorced / Unmarried	4	7,7%	2	2,1%
Level of education				
Higher education	32	61,5%	63	67,0%
Vocational school / high school/college	8	15,4%	20	21,3%
Incomplete secondary education	8	15,4%	8	8,5%
No education/primary education	4	7,7%	3	3,2%
Term of pregnancy				
First Trimester (< 13 weeks)	0	0%	28	29,8%
Trimester II (13–28 weeks)	9	17,3%	37	39,4%
Third Quarter (> 28 weeks)	43	82,7%	29	30,9%

The mean age is identical in the two groups (30.2 years in the PRE group compared to 30.7 years in the POST group), with a similar distribution by age groups. The most represented category is 25–34 years old, which comprises about 60% of respondents in both groups. The predominant marital status is that of married woman (82.7% in the PRE group and 84.0% in the POST group), followed by unmarried couples.

From the perspective of the level of education, higher education predominates in both groups (61.5% PRE compared to 67.0% POST), followed by specialized secondary education. The share of women with primary education or no education is low, but present in both groups, which underlines the importance of communication adapted to different levels of health literacy.

An important difference is related to the term of pregnancy: the PRE group predominantly includes pregnant women in the third trimester (82.7%), while the POST group is more balanced, with a significant share also in the first and second trimesters. This difference reflects changes in screening practice with staff training, which led to surveying women earlier in their pregnancy.

Sources of information for pregnant women on health in pregnancy

Understanding the sources of information that pregnant women turn to is essential for designing effective communication and health education campaigns. The data collected reveal that the OB/GYN and the family doctor remain the main sources of information for pregnant women in the Riscani sector, both in the PRE group and in the POST group.

The Internet ranks third as a source of information, with a higher frequency in the PRE group (55.8%) compared to the POST group (45.7%), possibly as a reflection of a more active involvement of medical staff in the provision of information after training, which reduces the need for independent online search for information. Family and friends are a significant source, mentioned by almost 40% of the respondents in the PRE group and by about 25% in the POST group.

The increase in the role of the family doctor and OB/GYN as sources of information in the POST group (from 76.9% to 78.7%, respectively, and from 80.8% to 87.2%) confirms the positive impact of the training of the medical staff in strengthening their role as a provider of reliable medical information.

Table 13. Sources of information for pregnant women on health in pregnancy

Source of information on health in pregnancy	PRE-training (n = 52)		POST-training (n = 94)	
	n	%	n	%
Family doctor	40	76,9%	74	78,7%
Obstetricians/Gynecologists (OB/GYN)	42	80,8%	82	87,2%
Internet	29	55,8%	43	45,7%
Family / Friends	21	40,4%	23	24,5%
Other sources (books, media)	4	7,7%	3	3,2%

Knowledge of pregnant women about the risks of alcohol consumption in pregnancy

Perception of the safety of alcohol consumption

A fundamental indicator of the level of knowledge is the answer to the question about the safety of alcohol consumption in pregnancy. Mistaken beliefs, such as that an occasional glass of wine poses no risks, are one of the main barriers to total abstinence recommended by the WHO.

The data show that 80.8% of pregnant women in the PRE group considered that no amount of alcohol is safe in pregnancy. Although this is a relatively high proportion, it means that almost 1 in 5 pregnant women (19.2%) held the opinion that moderate drinking is acceptable. After staff training, the proportion of those with correct answers increased to 93.6%, significantly reducing the share of those with incomplete knowledge.

Similarly, the recognition that alcohol can affect the fetus increased from 84.6% to 96.8%. These results suggest that the systematic dialogue initiated by trained staff had a direct and measurable impact on correcting misconceptions.

Knowledge about fetal alcohol syndrome

Specific knowledge about fetal alcohol syndrome is a more sensitive indicator of the level of information, as FAS is a less publicized condition than the general effects of alcohol. In the PRE group, 28.8% of pregnant women had not heard of FAS at all, a proportion that dropped to 17.0% in the POST group – a reduction of almost 12 percentage points.

These data suggest that staff training has expanded access to basic information, and that deepening knowledge will require additional health education efforts.

Pregnant women's behavior regarding alcohol consumption

Alcohol consumption after pregnancy is confirmed

The most relevant behavioral indicator for assessing the impact of the project is alcohol consumption after confirmation of the current pregnancy. From the perspective of FASD prevention, this represents the period in which the intervention of the medical staff can directly influence the behavior of the pregnant woman.

The results are optimistic: if in the PRE group 11.5% of pregnant women (6 respondents) stated that they had drunk alcohol occasionally after finding out that they were pregnant, in the POST-training group no pregnant woman reported alcohol consumption after pregnancy was confirmed. This reduction to zero is the strongest indicator of the impact of medical staff training, demonstrating that adequate and systematic counselling can lead to concrete behavioral changes.

Alcohol consumption before the current pregnancy

Regarding alcohol consumption before the current pregnancy, the data indicate that about 59.6% of pregnant women in the PRE group had reported occasional consumption before pregnancy, compared to 54.3% in the POST group.

Clinical practice – screening and prenatal counseling

Discussion about alcohol consumption at the first visit

International guidelines recommend that, at the first prenatal visit, the medical staff should talk to the pregnant woman about alcohol consumption and provide clear information on the associated risks. The data from the study reveals an important transformation of this practice after training.

Prior to the medical staff training, only 44.2% of pregnant women reported that the medical staff addressed the subject of alcohol consumption at the first prenatal visit, less than half of the cases. More alarmingly, 53.8% said that this discussion did not take place at all. After the training, the proportion of informed pregnant women increased to 84.0%, and that of those not informed decreased dramatically to 11.7%.

This increase of 39.8 percentage points in the direct counselling indicator represents the most significant progress made in the field of clinical practice and directly reflects the change in the behavior of healthcare professionals as a result of participation in the training program.

Another important indicator of the quality of prenatal screening is the direct question addressed to the pregnant woman if they drank alcohol in the last 3 months. This

practice, simple to implement, allows the identification of pregnant women at risk and the orientation of counseling.

The data show a major increase in this practice: from 28.8% in the PRE-training group to 70.2% in the POST training group – an increase of 41.4 percentage points. Simultaneously, the proportion of pregnant women who were not asked decreased from 63.5% to 21.3%. These results confirm that staff training led to the systematic integration of behavioral screening into prenatal consultation.

Use of the AUDIT test in prenatal practice

Completion rate of the AUDIT test

The AUDIT test (Alcohol Use Disorders Identification Test) is an internationally validated screening tool, recommended by the WHO for the systematic identification of problematic alcohol consumption. Its application at the first antenatal visit allows the early identification of pregnant women at risk and provides an objective basis for personalized counseling.

The study data indicate a substantial increase in the completion rate of the AUDIT test in prenatal consultations in the Riscani sector: from 26.9% in the PRE-training group to 67.0% in the POST-training group – an increase of 40.1 percentage points. Simultaneously, the proportion of pregnant women who did not complete the test decreased from 53.8% to 20.2%, and the share of those who were unsure about their AUDIT status decreased from 15.4% to 11.7%.

The training allowed the medical staff to understand the importance and practical usefulness of the test, overcoming initial reluctance related to the sensitivity of the subject or limited time available during the consult.

Quality of the application of the AUDIT test

Formal completion of the AUDIT test does not in itself guarantee effective screening. The quality of the application, the explanation of the meaning of the test, the communication and interpretation of the results are as important as the completion rate.

Post-training data show that of the pregnant women who completed the AUDIT test, 95.2% received explanations about the meaning and purpose of the test (compared to 85.7% before the training), and 88.9% received explanations regarding the interpretation of the results (compared to 78.6%). The questionnaire was considered clear and appropriate by 92.1% of the respondents who completed it POST-training, compared to 85.7% who completed it PRE-training.

These data indicate that the medical staff internalized not only the procedure for applying the test, but also the importance of empathetic communication and explaining the results in a language accessible to the pregnant woman.

CONCLUSIONS

The study provides clear evidence that the training of medical staff, social workers, and psychologists in the Riscani sector has produced positive and measurable changes in the clinical practice of preventing FASD and in the knowledge of pregnant women. The main conclusions are:

Knowledge and attitudes

- The proportion of pregnant women who consider that no amount of alcohol is safe during pregnancy increased from 80.8% to 93.6%, reducing by two-thirds the share of those with incomplete knowledge.
- Recognition of the risk of fetal harm through alcohol consumption increased from 84.6% to 96.8%.
- The proportion of pregnant women who had not heard of fetal alcohol syndrome decreased by 11.8 percentage points (from 28.8% to 17.0%).

Behavior

- Alcohol consumption, after pregnancy was confirmed, decreased from 11.5% to 0% – the most impactful behavioral indicator of the study.
- The reported need for additional information on the effects of alcohol decreased from 23.1% to 8.5%, reflecting that pregnant women feel better informed after staff training.

Clinical practice

- The proportion of pregnant women advised about alcohol at the first antenatal visit increased by 39.8 percentage points (44.2% to 84.0%).
- The question about the frequency of alcohol consumption in the last 3 months increased by 41.4 percentage points (28.8% to 70.2%).
- The use of the AUDIT test increased by 40.1 percentage points (26.9% to 67.0%).

Overall, the data confirms that training of the specialists is an effective strategy to improve the quality of antenatal care and to reduce the risks associated with fetal alcohol exposure. The impact is evident both at the level of clinical practices and at the level of knowledge and behaviors of pregnant women.

FINAL CONSIDERATIONS

Overall Size

1. FASD: A present problem, but institutionally invisible. Although manifestations compatible with fetal alcohol spectrum disorders are frequently encountered in the practice of psychologists, physicians, and social workers, there is no coherent system of identification, diagnosis, referral, and interdisciplinary management. The absence of dedicated methodological and clinical infrastructure generates underdiagnosis, delays in intervention, and dispersion of responsibilities between services.

Prevention and public health dimension

2. The prevention of FASD is approached fragmentarily and unsystematically. Preventive activities depend on the individual initiative of professionals, not on institutionalized mechanisms. There is a lack of uniform counseling standards, screening algorithms, clear intervention pathways, standardized educational materials, and monitoring indicators. The prevention of FASD does not work as an integrated program, but as a sum of dispersed interventions.

3. Prenatal care remains centered on the biomedical dimension. Although access to antenatal services is relatively good, consultations insufficiently address alcohol consumption, mental health, stress, domestic violence, social vulnerability, and family support. The transition to an integrated medical-psycho-social model of maternal care is necessary.

4. Screening of alcohol consumption in pregnancy is not systematized. Validated tools (AUDIT and others) are not used in a standardized manner, leading to late identification, underreporting, and major variations between professionals and institutions. The main obstacles are: limited time, lack of training, fear of stigma, and absence of operational protocols.

5. The prevention of FASD must be extended to the preconception stage. Many risk behaviors precede pregnancy and are linked to unplanned pregnancies, regular alcohol consumption before conception, and reduced addressability to preconception consultations. Family planning services must explicitly integrate preconception health, alcohol reduction, reproductive counseling, and partner involvement.

6. The opportunities for preventing FASD are insufficiently exploited. Even where access to antenatal care exists, the prevention of alcohol consumption is not systematically addressed. The psychosocial context (alcohol consumption, mental health, stress, domestic violence, social support) remains treated superficially and inconsistently.

7. Unplanned pregnancy – a major factor of vulnerability. Women with unplanned pregnancies have a higher prevalence of alcohol consumption and smoking, lower partner involvement, and more permissive attitudes toward alcohol. The prevention of FASD needs to be integrated into a broader reproductive health approach.

Behavioral and cultural dimension

8. Awareness of the risks of alcohol consumption during pregnancy is high, but misperceptions persist. Most women recognize that alcohol harms the fetus, but there is still a belief in the existence of "safe" amounts, especially in the case of occasional drinking, red wine, or preconception drinking. Knowledge about fetal alcohol syndrome and the irreversible nature of the effects remains limited.

9. There is a significant gap between knowledge and behavior. Many women who recognize the harmfulness of alcohol nevertheless declare drinking in the preconception or gestational period. Mere information is not enough. Motivational, social, emotional, and cultural factors decisively influence behavior, which requires a shift from informational models to complex behavioral change approaches.

10. The culture of "acceptable drinking" of alcohol in pregnancy persists. Permissive representations of occasional drinking, small quantities, or drinking in festive contexts are fueled by cultural traditions, the social norms about drinking alcohol, and the passing of these from generation to generation. In the Republic of Moldova, preventive interventions must be adapted to the local cultural specificity.

11. Social norms and community pressure influence reproductive behavior. Refusal of alcohol in social and family contexts is difficult for many women. The individual decision is strongly influenced by spouse/partner support, family, and community traditions. The prevention of FASD cannot be reduced to individual responsibility; it must be addressed at the family and community level.

12. Stigma – major barrier. Fear of moral judgment, social sanctions, labeling, or loss of custody of children causes women to not admit to alcohol drinking. Stigma reduces the sincerity of reporting, affects the therapeutic relationship, and amplifies social isolation. A preventive approach based on empathy, psychological safety, and non-punitive communication is needed.

13. Partners and family are factors that are not sufficiently capitalized. The attitudes of the partners significantly influence alcohol consumption, reproductive decisions, and the woman's ability to adopt protective behaviors. Current interventions do not make sufficient use of this resource. Explicit couple-oriented approaches and shared reproductive responsibility are needed.

14. Social vulnerability amplifies risk and limits the effectiveness of isolated interventions. Alcohol consumption during pregnancy frequently coexists with poverty, domestic violence, housing instability, social isolation, and mental health problems.

Services and human resources dimension

15. Training professionals produces quick and measurable results. The pilot intervention in the Riscani sector has shown that the training of medical workers, social workers and psychologists generates significant changes: increasing the number of women consulted prenatally about alcohol consumption, more frequent use of AUDIT screening, improving pregnant women's knowledge and reducing alcohol consumption

after pregnancy confirmation. The main vulnerability was not the lack of receptivity of the population, but the insufficient integration of the prevention of FASD into current practice. Improving competences can have direct effects on reproductive behaviors.

16. High motivation of professionals, insufficient support. Professionals show interest and openness in FASD issues, but they operate in the absence of operational guides, practical tools, sufficient time, and coordination mechanisms. The main vulnerability is systemic and organizational, not professional attitude. Personal motivation for training is there – the framework and resources are missing.

17. Reporting on alcohol consumption requires specialized skills. Addressing sensitive topics, managing denial, and maintaining the therapeutic alliance are real difficulties for professionals. All professionals indicate the need to develop motivational communication skills, empathic counseling, and specific support interventions.

Cross-sectoral dimension

18. Fragmentation – central vulnerability of inter-institutional collaboration. Cross-sectoral collaboration is insufficiently formalized, lacks continuity, and depends on personal relationships. There are no standardized referral pathways, common protocols, integrated case management, or regular multidisciplinary meetings. Fragmentation affects complex and vulnerable cases the most.

19. Vulnerable women require integrated medical-psycho-social interventions. Prenatal alcohol exposure is commonly associated with poverty, domestic violence, psychological trauma, and social isolation. These situations cannot be addressed exclusively through medical counseling; they require multidisciplinary teams, integrated case management, and continuous psychosocial support.

Early intervention

20. Limited capacity for early identification of affected children. Children with cognitive difficulties, attention problems, behavioral disorders, and emotional regulation difficulties are frequently encountered in practice, but without clear diagnostic pathways, standardized tools, or easy access to multidisciplinary assessment. Often, differentiation between FASD, ADHD, and other neurodevelopmental disorders is hampered by the absence of documentation of prenatal history.

21. Early intervention is limited by the absence of documentation of prenatal exposure. The underreporting of maternal drinking and the lack of systematic documentation of prenatal exposure significantly reduce the possibility of early identification, timely therapeutic intervention, and planning of educational and psychological support.

Public policy dimension

22. There is a solid basis of social acceptability for stronger preventive measures. The general population and professionals strongly support alcohol labeling, public warnings, media campaigns, and population education. This acceptability represents a strategic opportunity for the implementation of more visible regulatory measures.

23. An integrated national strategy for the prevention of FASD is needed. The data obtained justify the development of an integrated policy covering primary and preconception prevention, systematic screening, motivational counseling, multidisciplinary professional training, integrated medical-psycho-social services, early intervention, public campaigns, reduction of stigma, intersectoral collaboration and monitoring mechanisms. The issue of FASD must be explicitly integrated into reproductive health, mental health, child protection, early education and alcohol consumption strategies. The data confirms that the prevention of FASD can become a realistic and effective component of existing services, provided that a coherent strategic and operational framework is developed.

RECOMMENDATIONS FOR THE PREVENTION OF FASD IN CHISINAU AND THE REPUBLIC OF MOLDOVA

1. Strengthening the regulatory and strategic framework

1.1. Development of a National Program/Plan on the prevention of FASD

It is recommended to develop and approve a national strategic document dedicated to the prevention of fetal alcohol disorders, integrated into maternal health and mental health policies, which should include:

- clear primary, secondary and tertiary prevention objectives;
- defined institutional responsibilities;
- monitoring indicators;
- cross-sectoral coordination mechanisms;
- professional training and public communication components.

1.2. Integration of FASD prevention into existing documents

The issue of alcohol consumption in pregnancy and the prevention of FASD must be explicitly integrated into:

- national pregnancy surveillance protocols;
- prenatal care standards;
- reproductive health programs;
- mental health policies;
- strategies for the prevention of harmful alcohol consumption.

1.3. Standardization of the clinical approach

It is recommended to develop:

- standardized clinical protocol on screening, short intervention and referral of pregnant women at risk;
- interdisciplinary intervention algorithms;
- reference routes between medical, psychological and social services.

2. Strengthening primary prevention and reproductive health

2.1. Development of preconception counselling services

The results of the study confirm that prevention should be carried out earlier than in the prenatal period. It is recommended:

- institutionalization of preconception consultation;
- mandatory inclusion of the subject of alcohol, tobacco and drug use;
- actively promoting reproductive planning;
- development of counseling services for couples.

2.2. Promoting the concept of 'planned pregnancy'

Given the clear association between unplanned pregnancy and risky behaviors, the recommendations are:

- development of educational programs on reproductive planning;
- strengthening access to modern contraception;

- inclusion of partners in reproductive counseling;
- promotion of shared reproductive responsibility.

2.3. Interventions addressed to partners/men

Considering the important role of the partner in the behavior of the pregnant woman, the recommendations are:

- development of educational programs for men;
- inclusion of partners in antenatal and preconception consultations;
- development of preventive messages dedicated to fathers;
- promotion of family support and abstinence from alcohol during pregnancy in couples.

3. Improving clinical practices and prenatal intervention

3.1. Introduction of universal and standardized screening

The recommendations are:

- introduction of systematic screening of alcohol consumption in all pregnant women;
- standardized use of validated tools (AUDIT-C/T-ACE/TWEAK);
- repeated screening during pregnancy;
- standardized documentation in the medical record.

3.2. Development of motivational interventions

The recommendations are:

- training medical staff in motivational communication;
- the use of non-judgmental communication techniques;
- support-centered approach and reducing stigma.

3.3. Integration of the psychosocial dimension in antenatal care

It is recommended to take a systematic approach during prenatal visits for:

- perinatal depression and anxiety screening;
- domestic violence assessment;
- evaluation of social and family support;
- assessment of social vulnerabilities.

3.4. Strengthening the role of midwives and nurses

The recommendations are:

- capitalizing on the repeated contact of midwives and nurses with pregnant women;
- developing their educational and advisory role;
- involving them in community and postpartum preventive interventions.

4. Developing professional capacities

4.1. Institutionalization of FASD training

The study data shows the major impact of professional training.

The recommendations are:

- the introduction of FASD modules in the undergraduate and postgraduate curricula;
- development of continuing medical education programs;
- joint interdisciplinary training of doctors, psychologists, social workers and teachers.

4.2. Development of communication skills

Priority is training:

- empathic communication;
- motivational counseling;
- addressing stigma;
- risk communication;
- management of difficult situations and resilience.

4.3. Development of methodological resources

It is recommended to develop practical guides, screening and intervention algorithms, standardized educational materials and visual and digital supports for professionals.

5. Strengthening cross-sectoral collaboration

5.1. Creation of functional multidisciplinary teams

The recommendations are:

- establishing local collaboration mechanisms between health, social assistance, education and mental health domains;
- organizing regular meetings in case management;
- clarification of institutional roles and responsibilities.

5.2. Development of reference paths

The recommendations are:

- develop clear guides for case referral;
- define risk and eligibility criteria;
- ensure the continuity of interventions;
- introduce inter-institutional feedback.

5.3. Development of Community support mechanisms

The recommendations are:

- strengthening support groups for pregnant women and families;
- involving community mediators;
- collaborating with NGOs and community services;
- developing community-based interventions for vulnerable groups.

6. Combating stigma and changing social norms

6.1. Public communication campaigns

It is recommended to develop evidence-based, non-stigmatizing, culturally adapted, repetitive, and multichannel campaigns. Recommended central message: "There is no safe amount of alcohol during pregnancy."

6.2. Combating cultural myths

Campaigns must explicitly target:

- the myth of the "safe glass"
- positive perception of wine
- alcohol consumption during holidays.

6.3. Promoting the empathetic approach

Public and institutional messages must avoid blame, shame, and labeling of women. The focus should be on support, prevention, shared responsibility, and access to help.

7. Development of the monitoring and research system

7.1. Improving data collection

The recommendations are:

- inclusion of alcohol consumption indicators in health information systems;
- monitoring prenatal screening;
- development of FASD surveillance.

7.2. Development of applied research

The following are required:

- prevalence studies
- evaluations of the effectiveness of interventions
- research on cultural and social determinants
- assessment of the socio-economic costs of FASD.

7.3. Periodic evaluation of interventions

The recommendations are:

- monitoring the impact of training programs;
- evaluation of public campaigns;
- periodic audits of clinical practices; assessing the satisfaction of the beneficiaries.

8. Priorities for the municipality of Chisinau

For the municipality of Chisinau, it is recommended to pilot an integrated FASD prevention model that should include:

- standardized prenatal screening in all primary health care institutions;
- territorial multidisciplinary teams;
- continuing education programs;
- municipal communication campaigns;
- counseling services for vulnerable pregnant women;
- recovery services for people with FASD;
- support for families raising children with FASD;
- monitoring and assessment mechanisms;
- assessment of social vulnerabilities.

ANNEXES

Annex 1. Tool for assessing Knowledge, Attitudes and Practices on Alcohol Consumption in Pregnancy

(Women's Questionnaire)

Dear Madam,

We greatly appreciate the fact that you agreed to participate in the survey conducted within the UNICEF project "Opportunities in the prophylaxis of fetal alcohol disorders in the municipality of Chisinau" (STAF) implemented by the Public Association "Progress through Alternative".

The objective of the survey is to identify medical, psychological, and social problems that can influence women's alcohol consumption at the stage of preconception and during pregnancy.

Very few women were selected for the FASD survey, so your participation is particularly important.

Your answers are to be used for analysis purposes only and are confidential.

Thank you for your openness and collaboration!

Important! All questions relate to your last pregnancy.

ID	
Enter the individual identification code provided in the received SMS message	
Section DG. GENERAL DATA	
DG01	What is your year of birth?
DG02	Where do you live?
	☐ sect. Center, Chisinau mun. ☐ sect. Ciocana, Chisinau mun. ☐ sect. Botanica, Chisinau mun. ☐ sect. Buiucani, Chisinau mun. ☐ sect. Riscani, Chisinau mun. ☐ Suburbs, Chisinau mun. ☐ Other localities of the republic
DG03	What is your marital status?
	☐ Married ☐ In couple ☐ Divorced ☐ Widow ☐ Unmarried
DG04	What is your highest level of education?
	☐ No education ☐ Middle School ☐ High School ☐ Vocational School / College ☐ Higher education

Section KAP. KNOWLEDGE AND ATTITUDES	
KAP 01	In your opinion, what can a pregnant woman do to increase the chances of having a healthy baby? <i>Rank the following statements by importance level:</i>
KAP 01.a	See the family doctor or other healthcare worker regularly ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.b	Reduce or quit smoking ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.c	Avoid secondhand smoke ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.d	Reduce or stop drinking alcohol ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.e	Not to use drugs ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.f	Avoid stressful situations ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 02	Do you think pregnant women can drink alcohol as long as they don't abuse it? ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree

KAP 03	Do you think pregnant women can sometimes drink a little alcohol? ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 04	Do you think pregnant women should abstain from alcohol completely? ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 05	Do you think that moderate consumption of the following alcoholic beverages during pregnancy can be beneficial or harmful to the baby?
KAP 05.1	Beer ☐ It can benefit significantly ☐ It can benefit little ☐ Neither harm nor benefit ☐ May harm a little ☐ It can cause significant harm
KAP 05.2	Red wine (including homemade wine) ☐ It can benefit significantly ☐ It can benefit little ☐ Neither harm nor benefit ☐ May harm a little ☐ It can cause significant harm
KAP 05.3	Vodka or other spirits ☐ It can benefit significantly ☐ It can benefit little ☐ Neither harm nor benefit ☐ May harm a little ☐ It can cause significant harm
KAP 05.4	Cocktails containing alcohol ☐ It can benefit significantly ☐ It can benefit little ☐ Neither harm nor benefit ☐ May harm a little ☐ It can cause significant harm
KAP 06	What do you think about drinking alcohol during pregnancy and its effect on the baby? <i>Evaluate the following statements:</i>
KAP 06.1	A small amount of alcohol during pregnancy is safe. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 06.2	The more alcohol a pregnant woman drinks, the greater the risk for the baby of being affected. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree

KAP 06.3	Moderate alcohol consumption during pregnancy is safe for the baby. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 06.4	Any alcohol consumption during pregnancy can harm the baby. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 06.5	Drinking alcohol before pregnancy can harm the baby, even if the woman stops drinking during pregnancy. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 06.6	A small amount of alcohol during pregnancy would never lead to harm to the baby. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 07	Rank from most harmful to least harmful for child development, the following factors: ☐ Smoking ☐ Passive smoking ☐ Moderate alcohol consumption ☐ Occasional drug use ☐ Coffee consumption
KAP 08	In your opinion, in terms of the effect of alcohol on the baby, what amounts of alcohol can be considered safe for a pregnant woman? <i>Rank the following statements by safety level:</i> <i>A drink is 1 glass of wine (170 ml), a bottle of beer (330 ml), or 40 ml of cognac, vodka, or other strong drink</i>
KAP 08.1	One alcoholic beverage daily during pregnancy? ☐ Very safe ☐ Somewhat safe ☐ Not very safe ☐ Not at all safe ☐ I don't know ☐ I don't want to answer
KAP 08.2	An alcoholic beverage occasionally during pregnancy? ☐ Very safe ☐ Somewhat safe ☐ Not very safe ☐ Not at all safe ☐ I don't know ☐ I don't want to answer

KAP 08.3	One or two alcoholic beverages throughout pregnancy? ☐ Very safe ☐ Somewhat safe ☐ Not very sure ☐ Not at all sure ☐ I don't know ☐ I don't want to answer
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KAP 09	Have you seen any information about the effects of drinking alcohol during pregnancy on a child? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
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KAP 09.1	If Yes, from what sources? <i>(tick all applicable options)</i> ☐ Brochure/Books ☐ Media articles in newspapers/magazines ☐ TV Advertising/ Magazine Advertising ☐ Infant Care Groups/Classes ☐ Poster ☐ Medical Worker ☐ Radio/Television ☐ Special school/lessons on topics such as healthy living ☐ Personal/family experience ☐ Alcohol bottles/alcohol sellers ☐ Workplace ☐ Presentation/seminar ☐ Internet ☐ Other, specify ☐ I don't know ☐ I don't want to answer
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KAP 10	Do you know what effects alcohol can have on the fetus? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
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KAP 10.1	If Yes, can you name the possible effects of alcohol consumption on the fetus? <i>(tick all applicable options)</i> ☐ Physical disorders (malformations of the limbs or internal organs) ☐ Baby addicted to alcohol/signs of withdrawal ☐ Learning or attention disabilities ☐ Brain injury ☐ Delay in physical or mental development ☐ Intellectual impairment/low IQ ☐ Craniofacial deformities (abnormal shape of the head or face) ☐ Emotional disorders ☐ Behavioral disorders ☐ Low birth weight ☐ Attention disorder or deficit/hyperactivity ☐ Psychological problems (anxiety/depression) ☐ Congenital malformations ☐ Growth problems after childbirth ☐ Premature birth ☐ Other, specify ☐ I don't know ☐ I don't want to answer
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KAP 11	Have you ever heard of fetal alcohol syndrome (FAS)? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
KAP 11.1	In your opinion, how long do the effects of fetal alcohol syndrome last? ☐ Days ☐ Weeks ☐ Monday ☐ Years ☐ A lifetime ☐ I don't know ☐ I don't want to answer
KAP 11.2	In your opinion, a child can have fetal alcohol syndrome if: <i>(tick all applicable options)</i> ☐ The father abused alcohol before the pregnancy ☐ The mother abused alcohol before pregnancy ☐ The father was drunk at the time of conception ☐ The mother was drunk at the time of conception ☐ The mother drinks alcohol during pregnancy
KAP 12	Did your spouse/partner drink alcohol before your pregnancy? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
KAP 13	Did your spouse/partner drink alcohol during your pregnancy? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
KAP 14	In each of the following situations, how likely it would be to drink alcohol: <i>Rate the following statements</i>
KAP 14.1	If your spouse/partner continued to drink alcohol during your pregnancy? ☐ Very likely ☐ Probably ☐ No difference ☐ Unlikely ☐ Excluded
KAP 14.2	If your spouse/partner encouraged, you to quit or reduce drinking alcohol during pregnancy? ☐ Very likely ☐ Probably ☐ No difference ☐ Unlikely ☐ Excluded
KAP 14.4	If your spouse/partner would offer you alcohol during pregnancy? ☐ Very likely ☐ Probably ☐ No difference ☐ Unlikely ☐ Excluded

KAP 14.4	If the spouse/partner stopped drinking alcohol during pregnancy? ☐ Very likely ☐ Probably ☐ No difference ☐ Unlikely ☐ Excluded
KAP 15	Which sources of information about fetal alcohol syndrome and the effects of alcohol consumption in pregnancy would be most useful for you? <i>(tick all applicable options)</i> ☐ Doctor's office ☐ Prenatal Training Class ☐ Workplace/Place of study ☐ Friends/Family ☐ Books/Magazines/Newspapers ☐ Leaflets and brochures ☐ TV Programs/Commercials ☐ Internet sources ☐ Other, specify ☐ I don't know ☐ I don't want to answer
KAP 16	What attitude would you have regarding the following statements:
KAP 16.1	Support the introduction of warning labels on alcoholic products about the risks of alcohol consumption during pregnancy? ☐ Strongly approve ☐ Approve ☐ Neutral ☐ Disapprove ☐ Strongly disapprove
KAP 16.2	Support the display of warnings in restaurants, bars and clubs about the risks of drinking alcohol during pregnancy? ☐ Strongly approve ☐ Approve ☐ Neutral ☐ Disapprove ☐ Strongly disapprove
KAP 16.3	Support social advertising (media campaigns) that warn of the risks of drinking alcohol during pregnancy? ☐ Strongly approve ☐ Approve ☐ Neutral ☐ Disapprove ☐ Strongly disapprove
Section A1. INTENTION OF PREGNANCY	
A01	Do you have a reproductive plan for your couple/you personally? <i>(meaning, you know how many children you want and at what age you want to have them)</i> ☐ Yes ☐ No
A02	Was your last pregnancy planned? ☐ Yes ☐ No

A03	If the pregnancy was not planned, was the baby wanted? ☐ Yes, it was wanted ☐ Initially it was not wanted, then I wanted it ☐ He was not wanted until birth ☐ Not wanted ☐ I can't say
Section A2. PRECONCEPTION TRAINING	
A04	Do you consider that you have done a preconception training (preparation for pregnancy)? ☐ Yes ☐ No
A05	Before becoming pregnant, did you pay a visit to a medical worker to discuss your plans to become pregnant? ☐ Yes ☐ No, but you knew that it would be good to make such a visit ☐ No, you didn't know it would be good to make such a visit
A06	The specialist you contacted for preconception care discussed with you the following? <i>Please mention only the discussions, not reading or watching videos. (Check all applicable options)</i> ☐ How to be in the best possible health before becoming pregnant ☐ How smoking during pregnancy can affect the health of the future child ☐ How alcohol consumption during pregnancy can affect a child ☐ How drug use during pregnancy can affect a child ☐ The importance of using folic acid and multivitamins ☐ The importance of seeing the family doctor/gynecologist early in pregnancy to initiate perinatal care ☐ None of the options mentioned
A07	During the last month before becoming pregnant, how many times a week have you consumed multivitamins or supplements containing folic acid? <i>(Check only one answer)</i> ☐ You have not consumed ☐ 1 to 3 times a week ☐ 4 to 6 times a week ☐ Daily
A08	What were the reasons why you didn't take folic acid or multivitamins 3 months before getting pregnant? <i>(Check all the appropriate answer options)</i> ☐ You didn't plan to get pregnant ☐ You didn't know you had to use folic acid or multivitamins ☐ Folic acid or multivitamins were too expensive ☐ You had side effects from vitamins (such as nausea or constipation) ☐ You didn't want to consume folic acid or multivitamins ☐ Other reasons, please specify
A09	Do you consider that your spouse/partner prepared for the upcoming pregnancy (to conceive a child)? ☐ Yes ☐ No ☐ You can't expose yourself

A10	Three months before becoming pregnant, how many alcoholic beverages did you drink on average per week? <i>A drink is 1 glass of wine (170 ml), or a bottle of beer (330 ml), or 40 ml of brandy, vodka or another strong drink</i> ☐ 8 or more drinks ☐ 4 to 7 drinks ☐ 1 to 3 drinks ☐ Less than 1 drink ☐ You did not drink ☐ alcohol
A11	Have you smoked tobacco in the last 3 months before becoming pregnant? ☐ Yes ☐ No

Section B. PREGNANCY PERIOD

B01	When did you have your first prenatal visit to the doctor? <i>(Check only one answer)</i> ☐ Up to 12 weeks ☐ 13–22 weeks ☐ 23–32 weeks ☐ 33–40 weeks ☐ You did not receive medical assistance during pregnancy ☐ Don't know
B02	During prenatal care visits, did medical workers ASK YOU about the topics listed below? <i>(Check all applicable answer options)</i> ☐ If you smoke cigarettes ☐ If you drink alcohol ☐ If you use drugs ☐ If someone has hurt you emotionally or physically ☐ If you are afraid or depressed ☐ If you plan to use contraception after childbirth ☐ None of the options mentioned
B03	During your first antenatal care visit, the medical worker SPOKE to you about the topics listed below? <i>(Check all applicable answer options)</i> ☐ How drinking alcohol during pregnancy could affect your child ☐ How drug use could affect your child ☐ How smoking during pregnancy influences your child's condition ☐ None of the options mentioned
B04	Have you drunk alcohol-containing beverages during pregnancy? ☐ Yes ☐ No
B05	How many alcoholic beverages, on average, have you drink in a week in the FIRST 3 months of pregnancy? <i>A drink is 1 glass of wine (170 ml), a bottle of beer (330 ml), or 40 ml of cognac, vodka, or other strong drink</i> ☐ 8 or more ☐ 4 to 7 ☐ 1 to 3 ☐ Less than one ☐ You did not drink alcohol in the first 3 months of pregnancy

B06	How many alcoholic beverages, in the environment, did you drink throughout your pregnancy? <i>A drink is 1 glass of wine (170 ml), a bottle of beer (330 ml), or 40 ml of cognac, vodka, or other strong drink</i> ☐ 8 or more ☐ 4 to 7 ☐ 1 to 3 ☐ Less than one ☐ You did not drink alcohol
B07	Did you smoke during your last pregnancy? ☐ Yes ☐ No

YOUR SPOUSE'S/PARTNER'S OPINION

We would also like to know the opinion of your spouse/partner.

Please encourage him to participate by clicking on the link [...] or by scanning the QR code [...]. If you do not have the opportunity to share the link with your spouse/partner immediately, you can take a picture to access the questionnaire later.

Thank you for participating!

Annex 2. Tool for assessing Knowledge, Attitudes and Practices on Alcohol Consumption During Pregnancy

(Questionnaire for Spouses/Partners)

Dear Sir,

We greatly appreciate the fact that you agreed to participate in the survey conducted within the UNICEF project "Opportunities in the prophylaxis of fetal alcohol disorders in the municipality of Chisinau" (STAF) implemented by the Public Association "Progress through Alternative".

The objective of the survey is to identify medical, psychological and social problems that can influence women's alcohol consumption at the stage of preconception and during pregnancy.

Very few mothers were selected for the FASD survey, so your participation as a partner/spouse of the selected person is particularly important.

Your answers are to be used for analysis purposes only and are confidential.

Thank you for your openness and collaboration!

Important! All questions refer to your partner/wife's last pregnancy.

ID	
Enter the individual identification code provided in the received SMS message	
Section DG. GENERAL DATA	
DG01	What is your year of birth?
DG06	What is your highest level of education? ☐ No education ☐ Middle School ☐ High School ☐ Vocational School / College ☐ Higher education
Section KAP. KNOWLEDGE AND ATTITUDES	
KAP 01	In your opinion, what can a pregnant woman do to increase the chances of having a healthy baby? Rank the following statements by importance level:
KAP 01.a	See the family doctor or other healthcare worker regularly ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.b	Reduce or quit smoking ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer

KAP 01.c	Avoid secondhand smoke ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.d	Reduce or stop drinking alcohol ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.e	Not to use drugs ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 01.f	Avoid stressful situations ☐ Very important ☐ Important ☐ Unimportant ☐ Not at all important ☐ I don't know ☐ I don't want to answer
KAP 02	Do you think pregnant women can drink alcohol as long as they don't abuse it? ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 03	Do you think pregnant women can sometimes drink a little alcohol? ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 04	Do you think pregnant women should abstain from alcohol completely? ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 05	Do you think that drinking the following alcoholic beverages in moderate quantities during pregnancy can be beneficial or harmful to the baby?
KAP 05.1	Beer ☐ It can benefit significantly ☐ It can benefit a little ☐ Neither harm nor benefit ☐ May harm a little ☐ It can cause significant harm

KAP 05.2	Red wine (<i>including homemade wine</i>) ☐ It can benefit significantly ☐ It can benefit a little ☐ Neither harm nor benefit ☐ May harm a little ☐ It can cause significant harm
KAP 05.3	Vodka or other spirits ☐ It can benefit significantly ☐ It can benefit a little ☐ Neither harm nor benefit ☐ May harm a little ☐ It can cause significant harm
KAP 05.4	Cocktails containing alcohol ☐ It can benefit significantly ☐ It can benefit a little ☐ Neither harm nor benefit ☐ May harm a little ☐ It can cause significant harm
KAP 06	What do you think about drinking alcohol during pregnancy and its effect on the baby? Evaluate the following statements:
KAP 06.1	A small amount of alcohol during pregnancy is safe. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 06.2	The more alcohol a pregnant woman drinks, the greater the risk for the baby to be affected. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 06.3	Moderate alcohol consumption during pregnancy is safe for the baby. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 06.4	Any alcohol consumption during pregnancy can harm the baby. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
KAP 06.5	Drinking alcohol before pregnancy can harm the baby, even if the woman stops drinking during pregnancy. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree

KAP 06.6	A small amount of alcohol during pregnancy would never lead to harm to the baby. ☐ Totally agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Totally disagree
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KAP 7	Rank the following factors from most harmful to least harmful to the child's development, the following factors (<i>ranking type</i>) ☐ Smoking ☐ Passive smoking ☐ Moderate alcohol consumption ☐ Occasional drug use ☐ Coffee consumption
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KAP 08	In your opinion, in terms of the effect of alcohol on the baby, what amounts of alcohol can be considered safe for a pregnant woman? <i>Rank the following statements by safety level:</i> <i>A drink is 1 glass of wine (170 ml), a bottle of beer (330 ml), or 40 ml of cognac, vodka, or other strong drink</i>
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KAP 08.1	One alcoholic beverage daily during pregnancy? ☐ Very safe ☐ Somewhat safe ☐ Not very safe ☐ Not at all safe ☐ I don't know ☐ I don't want to answer
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KAP 08.2	An alcoholic beverage occasionally during pregnancy? ☐ Very safe ☐ Somewhat safe ☐ Not very safe ☐ Not at all safe ☐ I don't know ☐ I don't want to answer
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KAP 08.3	One or two alcoholic beverages throughout pregnancy? ☐ Very safe ☐ Somewhat safe ☐ Not very safe ☐ Not at all safe ☐ I don't know ☐ I don't want to answer
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KAP 09	Have you seen any information about the effects of drinking alcohol during pregnancy on a child? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
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KAP 09.1	If Yes, from what sources? <i>(tick all applicable options)</i> ☐ Brochure/Books ☐ Media articles in newspapers/magazines ☐ TV Advertising/ Magazine Advertising ☐ Infant Care Groups/Classes ☐ Poster ☐ Medical Worker ☐ Radio/Television ☐ Special school/lessons on topics such as healthy living ☐ Personal/family experience ☐ Alcohol bottles/sellers of alcohol ☐ Workplace ☐ Presentation/seminar ☐ Internet ☐ Other, specify ☐ I don't know ☐ I don't want to answer
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KAP 10	Do you know what the effects of alcohol can be on the fetus? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
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KAP 10.1	If Yes, can you name the possible effects of alcohol consumption on the fetus? <i>(tick all applicable options)</i> ☐ Physical disorders (malformations of the limbs or internal organs) ☐ Baby addicted to alcohol/signs of withdrawal ☐ Learning or attention disabilities ☐ Brain injury ☐ Delay in physical or mental development ☐ Intellectual impairment/low IQ ☐ Craniofacial deformities (abnormal shape of the head or face) ☐ Emotional disorders ☐ Behavioral disorders ☐ Low birth weight ☐ Attention disorder or deficit/hyperactivity ☐ Psychological problems (anxiety/depression) ☐ Congenital malformations ☐ Growth problems after childbirth ☐ Premature birth ☐ Other, specify ☐ I don't know ☐ I don't want to answer
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KAP 11	Have you ever heard of fetal alcohol syndrome (FAS)? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
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KAP 11.1	In your opinion, how long do the effects of fetal alcohol syndrome last? ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ A lifetime ☐ I don't know ☐ I don't want to answer
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KAP 11.2	In your opinion, a child can have fetal alcohol syndrome if: <i>(tick all applicable options)</i> ☐ The father abused alcohol before the pregnancy ☐ The mother abused alcohol before pregnancy ☐ The mother drinks alcohol during pregnancy ☐ The mother was drunk at the time of conception ☐ The father was drunk at the time of conception
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KAP 12	Did your spouse drink alcohol before pregnancy? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
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KAP 13	Did your spouse/partner drank alcohol during pregnancy? ☐ Yes ☐ No ☐ I don't know ☐ I don't want to answer
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KAP 14	In each of the following situations, how likely would it be for you to drink alcohol:
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KAP 14.1	If the spouse/partner continued to drink alcohol during pregnancy? ☐ Very likely ☐ Probably ☐ No difference ☐ Unlikely ☐ Excluded
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KAP 14.2	If your spouse/partner has encouraged you to quit or reduce drinking alcohol? ☐ Very likely ☐ Probably ☐ No difference ☐ Unlikely ☐ Excluded
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KAP 14.4	If your spouse/partner would offer you alcohol? ☐ Very likely ☐ Probably ☐ No difference ☐ Unlikely ☐ Excluded
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KAP 14.4	If your spouse/partner stopped drinking alcohol? ☐ Very likely ☐ Probably ☐ No difference ☐ Unlikely ☐ Excluded
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KAP 15	For you, what would be the most useful sources of information about fetal alcohol syndrome and the effects of alcohol consumption in pregnancy? <i>(tick all applicable options)</i> ☐ Doctor's office ☐ Prenatal Training Class ☐ Workplace/place of study ☐ Friends/family ☐ Books/magazines/newspapers ☐ Leaflets and brochures ☐ TV Programs/Commercials ☐ Internet sources ☐ Other, specify ☐ I don't know ☐ I don't want to answer
KAP 16	What attitude would you have regarding the following statements:
KAP 16.1	Support the introduction of warning labels on alcoholic products about the risks of alcohol consumption during pregnancy? ☐ Strongly approve ☐ Approve ☐ Neutral ☐ Disapprove ☐ Strongly disapprove
KAP 16.2	Support the display of warnings in restaurants, bars and clubs about the risks of drinking alcohol during pregnancy? ☐ Strongly approve ☐ Approve ☐ Neutral ☐ Disapprove ☐ Strongly disapprove
KAP 16.3	Support social advertising (media campaigns) that warn of the risks of drinking alcohol during pregnancy? ☐ Strongly approve ☐ Approve ☐ Neutral ☐ Disapprove ☐ Strongly disapprove
Section A. INTENTION TO CONCEIVE A CHILD	
A01	Do you have a reproductive plan for your couple/you personally? <i>(meaning, you know how many children you want and at what age you want to have them)</i> ☐ Yes ☐ No
A02	Was the last pregnancy a planned one? ☐ Yes ☐ No
A03	If the pregnancy was not planned, was the baby wanted? ☐ Yes, it was wanted ☐ Initially it was not wanted, then I wanted it ☐ Was not wanted until birth ☐ Not wanted ☐ I can't say

Section A2. PRECONCEPTION TRAINING	
A04	Do you consider that you have done a preconception training (<i>preparation for pregnancy</i>)? ☐ Yes ☐ No
A05	Before your partner/spouse became pregnant, have you paid a visit to a medical worker to discuss your plans to have a child? ☐ Yes ☐ No, but you knew that it would be good to make such a visit ☐ No, you didn't know it would be good to make such a visit
A06	Do you consider that your partner/wife has made preparations for the future pregnancy (<i>to conceive a child</i>)? ☐ Yes ☐ No ☐ You cannot say
A07	Three months before your partner/wife became pregnant, how many alcoholic beverages did you drink on average per week? <i>A drink is 1 glass of wine (170 ml), or a bottle of beer (330 ml), or 40 ml of brandy, vodka or another strong drink</i> ☐ 8 or more drinks ☐ 4 to 7 drinks ☐ 1 to 3 drinks ☐ Less than 1 drink ☐ You have not drink alcohol
A08	Have you smoked tobacco in the last 3 months before your partner/wife became pregnant? ☐ Yes ☐ No