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Fit to conceive? Representations of preconception health in the UK press

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Kirsty Budds 

Leeds Beckett University, UK

Abstract

The period before conception is increasingly claimed to be of critical importance for pregnancy and birth outcomes, prompting calls for public health advice and interventions to be targeted at women before rather than during pregnancy. Drawing on Foucault's concepts of governmentality and technologies of the self, this article explores the implications of preconception health messages for women of reproductive age. Following a critical discursive analysis of 57 UK newspaper articles, three dominant representations of preconception health were identified: preconception health as optimizing fertility, as determining infant health, and as point of intervention. I suggest that these representations reflect neoliberal health agendas, positioning women as in control of and responsible for their fertility, the health of their future children, future generations, and of the wider population, all through careful self-policing of their lifestyles. In this way, “good” preconception health is emphasized as an increasingly important form of health citizenship. Furthermore, the analysis highlights the gendered nature of these expectations, with a disproportionate focus on the potential impact of women's preconception health. Few challenges to these dominant messages were identified, and concerns are raised about the potential impacts on the autonomy and subjectivities of women of reproductive age, regardless of pregnancy intentions.

Keywords

preconception health, fertility, risk, technologies of the self, UK

Corresponding author:

Kirsty Budds, Leeds Beckett University, Leeds LS1 3HE, UK.

Email: k.m.budds@leedsbeckett.ac.uk

Although assertions about the impact of preconception health have a long history (Waggoner, 2017), over the past couple of decades there has been a renewed public health focus on health during the preconception period, which is increasingly claimed to be of critical importance for pregnancy and birth outcomes (Stephenson et al., 2018), prompting claims it is “never too early” to begin health interventions in advance of pregnancy (Mumford et al., 2014, p. 1). In the UK, Public Health England (PHE) (2018) published its most recent guidelines for reproductive health and pregnancy planning, highlighting the importance of preconception health for the health of future children, and it is currently recommended that women wishing to conceive should engage in a number of health-protective practices, such as folic acid supplementation, smoking cessation, and avoidance, or at least marked reduction of, alcohol intake (NICE, 2008). A similar approach has been taken by the Centers for Disease Control and Prevention (CDC) in the US (Johnson et al., 2006), which recently recommended that all women of reproductive age who are not using contraception avoid alcohol altogether (CDC, 2016).

The focus on preconception health reflects a concern to reduce risks and improve health outcomes for women and their children and is partly a response to popularization of the “Barker” or “Fetal Origins” hypothesis (Warin et al., 2012) whereby the early intrauterine environment of the foetus is said to shape long-term health outcomes. Since women are usually unable to detect that they are pregnant in the early weeks, and a significant proportion of pregnancies are unplanned, there is concern that they may be unknowingly putting the foetus at risk by continuing unhealthy practices such as smoking or drinking alcohol. From this perspective, behaviour change at the point women discover the pregnancy may be too late and should occur before pregnancy to rule out any possible risks. Moreover, there is increasing concern that poor preconception health has an impact not only on immediate pregnancy outcomes, but also on a child’s lifelong health and the health of future generations, meaning that poor preconception health is said to represent an intergenerational health risk (PHE, 2018).

The perspective on risk taken in this paper is that it can be conceptualized as a form of governmentality (Foucault, 1991), a means of surveillance, discipline and social regulation of populations. Lupton (2013) suggests that in its contemporary form, governmentality is informed by neoliberal ideology, whereby information about risk is disseminated to populations, and individuals are encouraged to self-regulate their behaviour in order to avoid risks. To use Foucault’s term, this may constitute a “technology of the self” (Foucault, 1988), which according to Foucault, allows individuals:

... to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality. (1988, p. 18)

In this context, individuals are encouraged to review their health practices and adapt them in line with the available expert knowledge and recommendations on preconception health. This reflects a contemporary public health focus on the regulation of private behaviours and personal responsibility for lifestyle and risk management (Bell et al., 2011; Petersen & Lupton, 1996). Within this context, poor health is perceived as “a failure of the self to protect the self” (Greco, 1993, p. 361). Yet, when it comes to preconception health, the health of another is also at stake – the unborn, or not yet conceived, child – potentially marking a failure not only to take care of oneself, but also to take care of a significant other.

As many commentators have noted, within public health discourse, women are positioned as responsible for the health and wellbeing of their children from pre-conception, pregnancy and through to childhood through careful risk management and self-policing of their own health practices (Lee et al., 2010; Lupton, 2012, 2013; Marshall & Woollett, 2000; McNaughton, 2011; Parker & Pausé, 2019; Ruhl, 1999; Warin et al., 2012; Wolf, 2011), regardless of their own, potentially conflicting needs and priorities (Lupton, 2012; Ruhl, 1999). In particular, there has been an emphasis on what are considered “preventable risks” relating to women’s lifestyle “choices”. For example, McNaughton (2011) considers how women are held responsible for their children’s health “from womb to tomb” with reference to childhood obesity and argues maternal obesity is linked to poor health outcomes for offspring from conception onwards, reflecting a move towards research seeking to identify the causes of obesity within the female body and the womb (see also Warin et al., 2012). Other targets have been maternal consumption of alcohol as a risk factor for Foetal Alcohol Spectrum Disorder (Lowe et al., 2010; Salmon, 2011) and maternal smoking (Bell et al., 2009).

Whilst advice on how to manage such risks may be empowering – to a degree enabling women to protect their babies’ health – Ruhl (1999) argues that assigning the responsibility for foetal health with individual women fails to address the complexity of risk or acknowledge that there are many risk factors women have no control over. Moreover, negative consequences have been identified for women during pregnancy as a result of taking on this responsibility, including anxiety (Neiterman & Fox, 2017), guilt and shame (Parker & Pausé, 2019; Wigginton & LaFrance, 2016), as well as judgement from others for not following proscriptions (Roberts & Nuru-Jeter, 2010), resulting in restrictions on the autonomy of pregnant women (Sutton et al., 2011).

Some existing research points to the benefits of preconception care and advice for women. For example, Friedman et al. (2016) found preconception counselling to be valuable for HIV-serodiscordant couples in the US, helping them to understand that natural conception was possible and safe and how to manage the risks of HIV transmission. However, elsewhere, commentators have raised concerns about the increasing medicalization of the preconception period, suggesting that it promotes external policing and medical intervention of women, in addition to self-surveillance (Gentile, 2013; Thompson et al., 2017; Waggoner, 2017). For example, Waggoner (2017) conceptualizes the “pre-pregnancy” period as the

“zero trimester”, arguing that it represents an expansion of the foetal period and positions all women as pre-pregnant and, as such, responsible for regulating their behaviour to reduce risks to future pregnancies. This is particularly concerning since, she contends, there is as yet little robust evidence for the benefits of preconception health interventions (Waggoner, 2017).

This paper extends previous critical scholarship by examining how preconception health messages which may encourage self-surveillance are circulated in the mainstream media. The mass media constitutes one important site for the communication of health risk information and education (Kitzinger, 1999; Lupton, 2014) and plays a significant role in shaping public health issues and framing solutions and responsibilities (Henderson & Hilton, 2018). For example, it has been argued that media representations of health risk information may influence a person’s perception of their degree of risk and prompt behaviour change (Lyons, 2000). In light of a renewed focus on women’s preconception health in public health discourse (PHE, 2018), underpinned by a recent proliferation of biomedical research which aims to highlight the potential for preconception health to improve short and long-term, as well as intergenerational, outcomes (e.g. Stephenson et al., 2018), it is important to examine how this information is communicated by the media. In doing so, the implications for women who are not yet pregnant, but are largely the targets of this advice, will be considered, including for both their subjectivities and practices when it comes to health management during the preconception period. Indeed, we already know that trying to conceive, even among women with no known fertility problems, is experienced as stressful (Jones et al., 2015) and so the increasing responsabilisation (Ruhl, 1999) of women for child outcomes relating to preconception health may serve to increase anxiety at an already stressful and emotional time of women’s lives. Therefore, a consideration of the implications of preconception health messages is timely.

Methods

Data collection

In January 2018, a corpus of newspaper articles was generated by searching the ProQuest UK Newstand database using the following search terms: “*preconception health*”, “*pre-pregnancy health*”, “*health/diet/alcohol/lifestyle/caffeine before conception/pregnancy*”. The following publications and their Sunday equivalents were included in the search: *The Sun*; *Daily Mail*; *Daily Mirror*; *The Daily Telegraph*; *The Times*; *The Guardian*. The search was limited to these publications since, at the time of data collection, they represented the six most popular papers in terms of readership (National Readership Survey, 2017). Altogether, the search terms generated 1206 “hits”. All articles were then screened for relevance and were

included within the corpus when their subject matter was health before conception, or where health before conception was a substantive focus.

Following screening and removal of duplicates, 57 articles published between January 2013 and December 2017 were selected for analysis. This timeframe was chosen in order to interrogate contemporary representations of preconception health in order to understand the current discourses in circulation on this topic. The corpus predominantly consisted of news stories (50), with a smaller number of comment pieces (2) and advice features (5) and featured articles from the following publications: *The Sun* (7); *Daily Mail and Mail on Sunday* (17); *Daily Mirror* (9); *The Daily Telegraph and Sunday Telegraph* (11); *The Times and Sunday Times* (8); *The Guardian and The Observer* (5).

Analytic approach

The data were analysed using critical discursive psychology (CDP) (Budds et al., 2017; Edley, 2001; Wetherell, 1998). This approach advocates a combined focus on discourse, such that it is at once deemed both constitutive (as enabling and constraining possibilities for subjectivities and social action) and constructive – as a tool which may be utilized to achieve particular interactional effects.

The analysis began with a process of inductive data-driven coding (Braun & Clarke, 2006) of each article in full, which was conducted independently by the first author. These codes were then clustered, generating a range of themes. From here, these themes were grouped with other related themes in order to develop overarching themes, which would illuminate something of the culturally available ways of understanding preconception health (Edley, 2001). The themes were reviewed and refined by collating all of the data relevant to each, reading through and checking that the data corresponded well to the themes identified. They were then reviewed a second time to check that they constituted an accurate representation of the data set as a whole. Within the analysis, there was an emphasis on the implications of the themes identified both in terms of social action (the possibilities for social action that are enabled and constrained) and subjectivities (the ways of being that are made available or are closed off) in relation to preconception health.

Findings

Preconception health and “optimal” fertility

Just over one-third of the articles discussed a connection between preconception health and fertility, reporting on a number of health and lifestyle factors that had been linked to either optimizing chances of conception or having a detrimental

impact. These included eating a well-balanced diet; losing weight or maintaining a healthy BMI; reducing stress; smoking cessation; reduction of caffeine intake; doing moderate, rather than strenuous, exercise; and avoiding shift work and heavy lifting. For example:

Losing just a few pounds can help overweight women conceive naturally, according to research. Shedding 9lb 7oz over six months was found to double the chances of becoming pregnant for heavier women with fertility problems. (*Daily Mail*, 5 July 2016)

Women should go “low carb” if they want to conceive, because doing so could increase the chance of success by five times, say fertility experts. (*The Daily Telegraph*, 6 July 2017)

A common narrative within these articles was that women had control over their fertility and that making changes to their health and lifestyles would result in greater chances of a successful pregnancy. In these examples, grand claims are made about the chances of success through quantification – “double the chances”. This discourse has previously been identified as a feature of pregnancy literature, whereby pregnant women are positioned as responsible for preparing their bodies for pregnancy in order to maximise chances of a healthy baby (Marshall & Woollett, 2000). In some ways this could be reflective of an agenda to empower women – giving them the necessary advice to improve their chances of pregnancy. Yet, in others it reflects a neoliberal health agenda, which positions individual citizens as in control of their fertility – or as Waggoner (2017) puts it, individualises “reproductive burden”, when there may be a variety of reasons that may mean that fertility is beyond a woman’s (or man’s) direct control. Moreover, this approach may have negative implications for the subjectivities of women who experience fertility problems, since they may consequently feel as if they are “to blame” for their struggles.

Five articles took the form of “advice features” that listed suggestions regarding what women and men (although to a lesser degree) should do or not do in order to maximise their chances of conceiving.

It sounds simple, but just a few small changes to your lifestyle – from eating better to regular GP [local doctor] visits – could help your chances of becoming pregnant, as fertility expert Prof Geeta Nargund reveals. . . (*The Sun*, 6 June 2017)

These articles often took the form of numbered lists of hints or tips on how to adjust lifestyle in order to improve fertility. The articles encouraged women and their partners to be reflexive, to review their current lifestyle practices and then engage in “technologies of the self”, to make alterations to improve chances of conception. For example, listed as part of the “small changes” required in the article cited above are smoking cessation, maintaining an ideal body weight and

eating a healthy, balanced diet – alterations which are notoriously difficult to achieve and would be unlikely to be classified as “small” in many people’s assessments. However, use of the phrase “small changes” suggests that these alterations are minor – something that individuals should be able to easily rectify through self-discipline.

Based on the available evidence regarding a healthy lifestyle and improved fertility, one article suggested people should address their lifestyle before seeking fertility treatment:

“One in six couples who are trying for a baby turn to IVF – but before they throw themselves into it, I recommend increasing their chances of conceiving naturally by looking at lifestyle and diet,” says Zita, 50, who has over 25 years’ experience as a midwife, nutritional advisor, acupuncturist, author and consultant in fertility. “I honestly believe that there are lots of boxes you should tick before you go down the IVF route and I would never want people to do it as their first choice. I want them to look at everything about their lives before they take the next step.” (*The Daily Mirror*, 25 February 2015)

In this extract, it is suggested that fertility treatment should only be considered after couples have taken a thorough review of their lifestyles, suggesting that fertility is largely self-governable, and that assistance or medical intervention is a last resort – something that the majority of people, once appropriate lifestyle changes have been enacted, will not need. References to “ticking the boxes” and “looking at everything about their lives” implies that there are a considerable number of lifestyle factors that could be affecting fertility that need ruling out before seeking alternative explanations and treatments. Alongside the suggestion that women have control over their fertility, this could leave women questioning when it is permissible to stop reviewing and adjusting lifestyle practices before seeking help and may discourage women from recognising when they have a problem that requires medical intervention. Moreover, women could conceivably continue to make ultimately unsuccessful lifestyle modifications for a substantial period of time, which could cause stress and anxiety at a perceived personal “failure” to conceive.

Whilst the articles generally reported research findings, which would involve women having to place restrictions on their lifestyles, in the case of drinking alcohol, there was some contradictory evidence. The majority of articles cautioned women to stop drinking; however, a few reported on a study which showed that only heavy alcohol consumption was associated with a decline in fertility and that low to moderate consumption had little impact. One article even reported findings which suggested that alcohol consumption – specifically of red wine – could improve the chances of conception, representing some albeit scant resistance to the restrictiveness of the majority of preconception health advice evident in the articles.

There was a gendered dimension to the corpus of articles concerning preconception health. Of the 16 articles that focused on fertility, the vast majority were concerned with women's fertility alone, whilst only two articles solely focused on men's fertility. The remaining articles tended to focus on women's fertility and discussed men's fertility to varying degrees, yet many references were fleeting and tokenistic – for example, through the use of the term “couples”. Where men's preconception health was attended to, the language used indicated that the advice was relevant to individuals other than the men themselves. For example, in an article that attempted to explicitly address the preconception health of both men and women, the women's section was entitled “What *you* can do” – clearly addressed to women, and the men's section entitled “What *he* can do”, such that the material reads as advice on men's fertility, yet aimed at their partners (*The Sun*, 19 November 2017). Furthermore, an advice article explicitly focused on men's fertility issues is handled differently to those aimed largely at women through the use of distant pronouns, for example (emphasis mine):

Addressing problems such as high blood pressure and diabetes can improve *a man's* chances of getting *his partner* pregnant . . . Exercise helps reduce stress, makes *men feel better about themselves* and benefits *their* long-term health. (*The Daily Mirror*, 3 November 2017)

This is in contrast to information articles aimed at women, which address women directly (emphasis mine):

Eating lots of fresh organic food will help *you* absorb key antioxidants and nutrients that are beneficial when trying to conceive. (*The Sun*, 6 June 2017)

Using a distant pronoun suggests that the advice is less directly aimed at men, and that it could be of relevance to others – men's partners, for example. The comparative lack of discussions of men's preconception health advice, in addition to how that advice is communicated, implies that it is largely women who are concerned with fertility issues, even though research is beginning to highlight the importance of fertility and preconception health to men (Hanna & Gough, 2016; Hanna et al., 2018). Moreover, the coverage associated with women's fertility does not reflect the lesser degree to which fertility problems are attributable to women's reproductive systems alone (Wolf, 2011).

Preconception health determines infant health

Within this theme, there is a focus on the impact that poor preconception health may have on both the short- and long-term health of (future) offspring. In the short term, there was concern that poor preconception health could cause harm to the foetus in utero and was linked to risk of birth defects and poor pregnancy outcomes, such as miscarriage, still birth, and premature labour. Again, “lifestyle

choices” such as consumption of alcohol and poor diet were considered largely to blame, positioning women as responsible for poor outcomes.

Similar to issues around fertility, the one exception involved discussions of alcohol. Whilst the majority of articles constructed the consumption of alcohol during the preconception period and early pregnancy as harmful, there was some, albeit limited, resistance to this view:

... it may be wise to avoid alcohol when planning a baby, but the fact is that many pregnancies are not planned. We should reassure women that if they had an episode of binge drinking before they found out they were pregnant, they really should not worry. It is very troubling to see women so concerned about the damage ... they consider ending what would otherwise be a wanted pregnancy. (*Daily Mail*, 11 February 2015)

This quote comes from Ann Furedi, chief executive of the British Pregnancy Advisory Service (BPAS), in which she raises concerns about some unintended consequences of risk communication regarding the consumption of alcohol in pregnancy, namely that some women may consider terminating a pregnancy for fear of the consequences of drinking alcohol before they had discovered they were pregnant. This may be of particular concern since it is suggested that the risks are overstated and are therefore causing women undue anxiety, with potentially serious consequences.

Concerns about longer-term implications of poor preconception health practices on future children included increased risk of developing cancer; obesity; diabetes; having high cholesterol; shorter lifespan; and risk of genetic abnormalities. For example:

WOMEN who eat junk food while trying to get pregnant raise their child's lifetime risk of cancer, research suggests. (*The Sun*, 11 June 2015)

Even before a woman conceives, a mother's choices can have a startling impact with obesity, smoking and vitamin D deficiency caused by a bad diet among the risks, experts say. (*Daily Mail*, 2 February 2015)

The claims in these articles about the risks of poor preconception health are presented as definitive – as “facts” (Potter, 1996). References to “lead a poor lifestyle”, “raise their child's lifetime risk”, and “mother's choices” highlight women's autonomy as a contributing factor, effectively holding women accountable for poor long-term health prospects of their future children. Women have long been positioned as responsible for their children's health throughout pregnancy and childhood (McNaughton, 2011; Ruhl, 1999) and this demonstrates that increasingly women are being positioned as accountable for the health of children they are yet to conceive. A similar discourse was identified by Warin et al. (2012) who analysed the reporting on obesity within Australian newspapers and found

that women were positioned as responsible for obesity and other chronic illnesses in offspring if they failed to prepare their bodies for pregnancy.

Concerns were not raised solely about women's lifestyles during the period immediately before conception, but also much earlier on:

DRINKING, smoking or being overweight could put your baby's health at risk – years before it is even conceived.

Indulging in a wild lifestyle in your teens or 20s could come back to haunt you if you become a parent later, say scientists. (*Daily Mail*, 15 August 2015)

Here, women's behaviours "years before" conception are linked to health risks for the potential child. There are clear moral evaluations of this behaviour – described as "indulging in a wild lifestyle", which conjures up an image of actions such as smoking or drinking alcohol to excess. Interestingly, elsewhere it has been found that constructions of women's alcohol consumption in the UK news media present the idea that women are putting their health, and potentially the health of unborn babies, at risk, whilst also compromising their femininity (Day et al., 2004). The negative consequences of these "indulgences", it is suggested, become apparent much later on, with the phrase "come back to haunt you" indicating that women risk being punished for earlier undisciplined behaviour and inferring that their children will "pay the price" with their health for their earlier misdemeanours. The implications of this argument are problematic, since it could pave the way for the policing of women's health for the sake of the foetus not just during pregnancy, but long beforehand – implying that "parenting starts before conception" (*Daily Mail*, 15 August 2015). This would have consequences for the choices and autonomy of all women of reproductive age, potentially culminating in self-policing of their lifestyles regardless of pregnancy intentions. Indeed, recent guidance from Public Health England (2018) reflects this approach, emphasising the importance of attending to the health of those of reproductive age in general, rather than just those trying to conceive.

References to the impact of men's preconception health on the health of future children were limited, evident in only 8 of the 57 articles. This may reflect the notion that men are rarely positioned as responsible for others' health (Petersen & Lupton, 1996). Indeed, some articles acknowledged this disparity, for example claiming that "Fathers have long had it easy with their preconception health" (*Daily Mail*, 17 May 2016) and that potential impact of men's lifestyle before pregnancy was only just becoming apparent.

Preconception health as intervention

Finally, the preconception period was constructed as an important focus for health intervention strategies. It was argued that interventions to reduce risk and improve pregnancy and child outcomes should be established during the preconception period, not just during pregnancy. Several of the articles highlighted a need to

raise awareness of the importance of preconception health and of the need to encourage women to take action, engaging in technologies of the self to improve their health – by, for example, losing weight, eating a balanced diet and cutting out alcohol before they attempted to conceive.

Study author Professor Andrew Prentice said: “The potential implications are enormous.” Colleague Dr Matt Silver said: “It’s about not just starting to behave yourself once you know you are pregnant.” (*Daily Mail*, 11 June 2015)

This quote is taken from an article that reports research findings observing a link between a mother’s diet before conception and the long-term health risks of offspring. Here, the authors are highlighting the “enormity” of the implications of the research findings – that women will need to adjust their diets prior to pregnancy, or “behave themselves”. This quote again highlights the moral judgments at play here. Being healthy is associated with purity and morality (Petersen & Lupton, 1996), and, by implication, those who eat “unhealthily” are cast as immoral citizens who behave badly and, in this case, risk the health of future children.

Despite the interventions being aimed at women who are not yet pregnant, the articles tended to highlight health benefits to potential children, rather than for women, which may additionally come as a result of behaviour change. In addition, in a number of articles, preconception health interventions were constructed as not only leading to improved health outcomes associated with any immediate or future pregnancies, but also as a novel antidote to serious public health concerns such as cancer and obesity.

Health experts have highlighted a new approach in the fight against obesity: they want to target future mothers and advise them how to avoid giving birth to overweight children. . . . By helping women even before pregnancy, a key step could be taken to tackle Britain’s rising levels of obesity, according to a report published by the Infant and Toddler Forum last week. (*The Observer*, 30 November 2014)

Elsewhere, critical scholarship has exposed the way in which obesity is constructed as a major public health problem within mainstream media to the extent it has become a moral panic, thereby justifying calls for interventions to tackle the “problem” of obesity (Monaghan et al., 2013). In the examples above, a new kind of intervention is proposed, whereby women are encouraged to adopt good preconception health practices as a means of tackling the UK’s rising levels of obesity, providing further evidence that the search for a solution to obesity is increasingly levelled at women’s wombs (McNaughton, 2011; Warin et al., 2012). This reflects the notion that risk management is now considered a social and not just an individual responsibility – a healthy lifestyle is framed as a civic and moral obligation (Wall, 2001). Similar to the rhetoric identified elsewhere (McNaughton, 2011; Salmon, 2011; Wall, 2001), whereby a focus on women’s individual responsibility for health management constitutes a means of reducing

the cost of social programmes, women's management of preconception health is framed as an important social endeavour – a preventative strategy to reduce the burden of obesity on society. Therefore, preconception health is emphasised as a new and increasingly important form of health citizenship.

The targets of preconception interventions varied between the articles. For some, the targets were women who are planning a pregnancy. For others, interventions were to be aimed at all women of reproductive age in anticipation of a *future* pregnancy:

The problem is finding ways to get this advice over to young women. “We need to do this when they are very young – before they have children, so they are well prepared.”
(*The Observer*, 30 November 2014)

As such, there was an emphasis on encouraging even “very young” women to think ahead, to examine and alter their behaviour whether currently planning a pregnancy or not. This is perhaps owing to concerns that, as discussed previously, poor health choices may have implications for offspring conceived several years into the future, yet also during the “critical period” of development (Stephenson et al., 2018) – the early weeks and months following conception, where women may be unable to detect a pregnancy.

Whilst many of the articles discussed the benefits of interventions during the preconception period, and may imply that women should not plan a pregnancy until they have made health changes, a small number of articles discussed the claims made in a report written by NHS chief Jonathan Sher, who seemed to go a step further by explicitly suggesting that women should not become pregnant until they have addressed any “problems” in their lives:

An NHS chief has now been bold enough to say victims of domestic violence and the obese should be told not to have children until they have tackled their problems. (*The Daily Mirror*, 4 July 2016)

Discussion of this matter varied between the four articles that directly reported on it. Two of the articles were largely descriptive of the report, and thereby presented a largely neutral stance. However, the remaining two were critical of the report and were perhaps the only articles within the corpus that expressed criticism of and amounted to resistance to neoliberal preconception health approaches. These articles could both be described as extended comment pieces and came from *The Guardian* and its Sunday equivalent, *The Observer* – known to be left-wing broadsheets. Both articles highlighted the impact that social inequality can have on people's health, thus critiquing the neoliberal approach to health as something that individuals have direct control over.

Only one article problematised the potential for surveillance to extend to women not yet pregnant (*The Guardian*, 30 May 2016). In contrast, another article acknowledged that preconception health approaches encourage surveillance but

considered that on balance this surveillance and interference in family life may be justified “where the most important outcome is a healthy baby” (*The Daily Mirror*, 4 July 2016), thus suggesting that the rights of the foetus may override any right women have to privacy and autonomy.

Discussion

The recent focus on preconception health reflects contemporary concerns about risk management in neoliberal societies and the potential impact that women’s behaviour can have on the health and development of their unborn children even prior to pregnancy. This analysis of UK newspaper articles demonstrates how the media communicate and frame public health messages around preconception health. Firstly, as a means of “optimising fertility”, emphasising the control that women in particular are said to have over their fertility through technologies of the self. Secondly, preconception health was constructed as determining the health of potential children, and finally, as a new and significant opportunity for health intervention strategies.

The analysis highlights that in discussions of preconception public health, women are commonly regarded as “pre-pregnant”. That is, not yet pregnant, but with the potential to be in the future, and this is noteworthy because the implications are that a level of scrutiny and surveillance that has historically been cast upon pregnant women may be applied to them (Waggoner, 2017). Secondly, the corpus highlighted concerns about the *potential child* – that is, a child who is not yet conceived, but whose future is already being determined by the actions of the pre-pregnant woman. Building on Waggoner’s concept of the “future foetus”, the notion of the “potential child” highlights the impact women’s preconception health may have – not only on their unborn foetus in utero, but beyond into childhood, by shaping their future disease risk.

Although there were references to men throughout the corpus, the majority of the articles focused on women’s preconception health and associated lifestyle changes. This gender imbalance is in line with previous studies concerning the presentation of preconception health information (Campo-Engelstein et al., 2016; Thompson et al., 2017). This perpetuates the notion that only women are interested in fertility issues and may imply that fertility issues are disproportionately a result of women’s reproductive health problems, despite increasing recognition of men’s preconception health on pregnancy outcomes (Frey et al., 2008). Additionally, there was less evidence in the corpus of a need to target men for preconception health interventions to improve child outcomes. Altogether, the gendered focus on preconception health reflects Daniels’ (2006) concept of “reproductive masculinity”, including an assumption that men are secondary to women in reproduction, that men’s reproductive systems are less vulnerable to harm than women’s, and that men’s exposure to environmental harm has less of an influence on reproductive outcomes. Based on the analysis presented here, I

suggest that the concept of the “zero trimester” (Waggoner, 2017) does not apply to men to the same degree as women.

The contemporary focus on preconception health and risks to “potential” children reflects the way that through discussions of risk, parenting is increasingly being extended backwards (Lee et al., 2010). Women are encouraged to reflect on the impact their lifestyles and behaviour could have on any children they may have before they even become pregnant, whether they are planning a pregnancy or not (Waggoner, 2017), and future children are positioned as “victims” of mothers’ unhealthy behaviours, in the same way that babies in utero and children have been (Bell et al., 2009; Warin et al., 2012). As other commentators have noted, this defines women in relation to their reproductive potential (Gentile, 2013), encourages the surveillance of their behaviour and imposes limits on their choices and autonomy. Where a pregnancy is desired and women disclose their intentions to become pregnant, this approach paves the way for interventions to shape women’s reproductive decision making by determining when women are “fit” for pregnancy. For example, in an attempt to reduce risks associated with obesity during pregnancy, Brackenridge et al. (2018) designed an intervention where women clinically defined as obese were asked to delay the removal of their intra-uterine contraceptive device in order to engage in an intensive weight loss diet before any attempt to conceive.

The unwavering focus on the interests of potential children reflected in discussions of preconception health is captured in Edelman’s (2004) concept of “reproductive futurity” – the idea that politics is wholeheartedly engaged in shaping the future for the sake and protection of future generations – with children’s futures in mind. As a consequence, he argues, heteronormativity is ardently preserved, and queerness is positioned as resistant of the social order – on the side of those “not fighting for the children” (p. 3).

Worryingly, the corpus hinted at unintended consequences of pre-conception health advice, with evidence to suggest that women may be terminating otherwise wanted pregnancies for fear they had unknowingly exposed their foetus to risk in utero by consuming alcohol. Waggoner (2017) warns that if the link between women’s preconception health behaviours and birth outcomes is taken seriously, it is conceivable that in the event of poor birth outcomes, women could be vulnerable to prosecution on the basis of their preconception health, in a similar way that pregnant women in the US are increasingly facing criminal charges for putting their babies at risk – for example through substance abuse during pregnancy (Hui et al., 2017). These implications warrant serious consideration if preconception health continues to be a focus of public health policy and practice.

The approach to preconception health and risk management identified in the newspaper corpus reflects a neoliberal health agenda (Waggoner, 2017). Women are encouraged to engage in “technologies of the self”, to take responsibility for risk management through self-regulation. This enables a process of “government at a distance” (Rose & Miller, 1992, p. 174) to effect better health outcomes. With reference to the data in this study, these outcomes not only referred to personal

outcomes, such as optimised fertility and healthier future children, but also wider societal benefits, by potentially providing an antidote to serious public health concerns such as cancer and obesity, demonstrating the way in which engaging with expert knowledge on good preconception health has become an increasingly important form of health citizenship. In this way, the aims and desires of individuals – to be healthy and have healthy children – are aligned with governmental aims and objectives (Rose, 1996) to improve health at the population level and reduce the burden of significant public health concerns on the public purse (Petersen & Lupton, 1996). Furthermore, in highlighting individual responsibility for health, the data evidence the new public health approach, whereby discussions about broader structural issues and social inequalities that shape health and lifestyle are largely absent (Bell et al., 2011). For example, there is an established link between low socioeconomic status and poor perinatal and maternal health (de Graaf et al., 2013).

Evidence of resistance to the more mainstream accounts of preconception health identified in the corpus was scant. Preconception health was rarely framed in terms of reproductive justice – which would highlight the responsibility of the state to women’s health. Moreover, critique of the way in which a focus on preconception health may lead to the general surveillance of women of reproductive age, and increasing intervention into women’s reproductive decision-making, was negligible. Thus, whilst Waggoner (2017) highlights a number of diverse and often contradictory framings of the preconception health agenda, this paper extends the literature by demonstrating how only certain messages are circulated within popular discourse, which has implications for commonsense understandings of preconception health – and therefore for the lives of women. For example, highlighting preconception health as a woman’s responsibility may mean that women who fail to comply with official advice experience guilt, shame and judgment whether planning a pregnancy or not – similar to women who are pregnant (Roberts & Nuru-Jeter, 2010). Women may feel responsible and heightened distress in the event of poor outcomes, such as miscarriage (Waggoner, 2017), and women planning a pregnancy may not seek help promptly if they are positioned as being in control of their fertility through lifestyle modifications.

Furthermore, there is increasing evidence to suggest that there may be material consequences for noncompliance with recommendations, by way of interventions which may override women’s reproductive autonomy when they may be perceived as “unfit” for pregnancy. For example, one of the articles within the corpus reported on suggestions that women who are obese should undergo gastric band surgery prior to pregnancy to reduce the risks to their offspring. Elsewhere, Gomez et al. (2014) suggest there is evidence of a racial and class bias with respect to which groups have been the targets of long-acting reversible contraception (LARC) promotion, resulting in the individual preferences and reproductive choices of these women being diminished. Meanwhile, in the UK, one condition of access to the Pause programme, for women at risk of repeated incidents of having children taken into care, is that they agree to use a LARC for the 18-month duration of

the programme (McCracken et al., 2017). This may suggest that, in certain circumstances, the responsibility for reproductive risk management is shifting away from the individual and towards the state.

This study has revealed the dominant messages regarding women's preconception health as they are taken up and circulated by the media. However, it is not possible through this approach to determine the different ways in which these media representations are engaged with and interpreted (Livingstone, 1998). Moreover, whilst this analysis considered the way in which preconception health is represented in newspapers, individuals obtain health information from a wide source of media – including, increasingly, social media and online forums – and so it would be beneficial to conduct a more holistic analysis of media and advice sources. Few studies so far have considered how women themselves engage with information regarding preconception health and risk – this would be a fruitful avenue for further research. Moreover, whilst direct references to the racial or social class backgrounds of women within the corpus was very rare, I would argue that marginalized women are often subtly implicated. For example, many of the articles considered the impact of obesity and poor diets on infant health outcomes, and elsewhere it has been argued that discussions of women who put their children at risk of obesity are obese themselves and lead “unhealthy lifestyles” are underwritten by racist and classist assumptions (McNaughton, 2011). In future research, it would be important to examine further how race and class are implicated in discussions around preconception health, surveillance and intervention.

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ORCID iD

Kirsty Budds  <https://orcid.org/0000-0001-8159-4186>

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Author Biography

Kirsty Budds is currently Senior Lecturer in Psychology at Leeds Beckett University. Her research interests sit broadly in the areas of women’s reproductive health and parenting. With reference to reproductive health, Kirsty is currently undertaking a programme of research which is focused on exploring women’s accounts of the preconception period and their engagement with health recommendations during this time.