

Findings from a roundtable workshop on the communication of pregnancy and risk

In September 2017, BPAS hosted a workshop funded by The Wellcome Trust involving invited stakeholders with an interest in understanding and improving the way that public health messages are communicated to parents. Stakeholders were invited from:

- Big Birthas
- Birthrights
- British Pregnancy Advisory Service
- Cardiff University
- Keele University
- Parenting Science Gang
- Pregnancy Sickness Support
- The London School of Hygiene and Tropical Medicine
- The Royal College of Midwives
- The University of Bristol
- The University of Kent
- The University of Leeds
- The University of Sheffield
- The University of Southampton
- The Wellcome Trust
- University College London

A range of disciplines were represented including science and epidemiology, public health, history, law, clinical services, philosophy, women's rights and advocacy, and the media.

The aims of the workshop were to explore how women of childbearing age are represented in scientific, media, and public health discussions, the impact their behaviour and choices are deemed to have on their pregnancy and the future health of their child, and the consequences this has for women themselves. The objective was to better understand perspectives on these issues, to establish how dialogue between stakeholders could be improved, and to explore whether a centre or knowledge exchange hub dedicated to engaging with these themes would be of value. Participants worked in groups to articulate issues of concern and identify how these issues interacted with the work of stakeholders, including women themselves, health professionals, public health policy makers, and the scientific community. The group were then asked to generate a series of potential actions and recommendations.

Issues of current concern raised by the group

The group raised the following issues relating to risk communication in pregnancy.

1. A culture of blame associated with public health messages directed to pregnant women and new mothers. The group perceived an increasing tendency to attribute adverse outcomes for babies and children to the attributes and behaviour of women during pregnancy. The group viewed this as being part of a wider culture of 'blame' that has become attached to the UK's parenting discourse. The group were concerned that insufficient attention is being paid to the unintended harms caused by a public health discourse that continually emphasises the links between individual pregnant women's attributes and decisions, and outcomes for her baby. Potential unintended harms highlighted by the group included damage to parental mental health and confidence – these harms were perceived to have the potential to lead to adverse outcomes for families and children.
2. Lack of traction for ecologically informed understandings of public health in pregnancy. The group were concerned that a policy trend towards ecological understandings of the determinants of public health problems – which recognises the role of individuals and organisations at multiple levels within a complex system of influences, including community, health services, and wider societal norms – is having little impact at the level of public health message communication. Thus, individual pregnant women are still the primary target for public health interventions to improve outcomes in pregnancy. The group felt there had been a failure to communicate ecological understandings of policy recommendations and public health messages. Furthermore, there is a failure to distinguish between the impact of individual-level decisions and population-level behaviour when communicating risk relating to pregnancy.
3. The erosion of the concept of a 'normal' pregnancy. The group felt that the condition of pregnancy and birth is increasingly subject to risk messaging, with a focus on taking every action possible to prevent relatively rare adverse outcomes. Possible negative effects include increased anxiety leading more women to consider terminating wanted pregnancies because of concerns that they have inadvertently failed to follow advice. Some group members felt that the cumulative impact of increased risk messaging may erode the idea that pregnancies could be normal or pleasurable.
4. Increased focus on the foetus at expense of maternal autonomy. The group were concerned that the principle of bodily autonomy is being undermined by an increased privileging of concern for the health of the foetus. The group recognised this to be a problem that extends all the way from pre-pregnancy planning, through in-pregnancy decision-making, to choices relating to labour and birth.
5. Increased surveillance in pregnancy and pre-pregnancy. The group acknowledged that pregnant women's bodies are increasingly a site of surveillance and intervention, with an extension of the role of health care professionals, for example, into increased use of testing technologies to assess risk exposure. The group were concerned that women of childbearing age are increasingly

being encouraged to maintain their bodies in readiness for having a baby whether they would like to become a mother or not, and to plan their pregnancies. In contrast, the group noted limited focus on the experience of expectant fathers – which some members felt might be causing fathers needs and concerns to be side-lined.

6. Concern about representation of evidence in public health messaging and adoption of a precautionary principle to produce simplified messages. The group were concerned about a failure to convey the extent of the uncertainty of findings from studies and the implications of this uncertainty on managing risk in pregnancy. The group were concerned that a tendency to underplay uncertainty associated with public health messages may be damaging the credibility of the messages themselves, and those who deliver them. The group were concerned that a precautionary ('better safe than sorry') approach to communicating the evidence can underestimate women's capacity to weigh-up and make complex decisions. The group acknowledged a tension between some women's wish to receive simplified messages, and the need for other women to have more nuanced information about the evidence base.
7. Disproportionate impact of a culture of maternal responsibility. The group were concerned that the perceived trends towards increased blame and surveillance are disproportionately impacting women who are in disadvantaged circumstances and may be more likely to be exposed to multiple 'risks' in pregnancy. The group also recognised that the issues identified may be disproportionately negatively impacting groups with particular characteristics or conditions, including,
 - Women with high BMI – The group were particularly concerned about the impact of public health messaging relating to elevated BMI and obesity, and were concerned that this messaging has a potential to be alienating and stigmatising.
 - Women with medical conditions requiring medication – The group were concerned that current challenges relating to communicating risks about medication in pregnancy are not being addressed. The group perceived that current approaches are leading to women feeling uncertain about treatment for serious conditions arising in pregnancy, pre-existing medical conditions, and over-the-counter medications.
 - Increased concern about older mothers – The group perceived an increased focus on risk relating to older women, with older women being subject to high levels of risk messaging relating to their pregnancies from pre-conception through to pregnancy outcomes.

Potential Recommendations for Action

Stakeholders recognised some positives in the current climate for communicating risk in pregnancy. The group recognised that at population level, changes in women's decisions can lead to a reduced prevalence of adverse outcomes for mothers and babies. Furthermore, the group recognised that information and conversations about decisions in pregnancy can provide an invaluable guide to aid women's decision-making. The group also acknowledged that the evidence base for public health in pregnancy is continually extending, and that women themselves and stakeholders involved in mediating public health messages have increasing access to an underpinning evidence base.

The group felt that work to address the concerns raised about the current state of risk communication have the potential to improve both the effectiveness of risk messages and the way in which they are being delivered and received.

The following areas for action were identified by the group as having potential to be taken forward in collaboration with a wider set of stakeholders. The group identified a need to:

1. Develop a network of stakeholders concerned with improving the risk communication environment for those with experiences of pregnancy; including creating an alliance of stakeholders from public health, third sector parent/ women's rights-based organisations, risk communication experts and scientists. To raise awareness through solution focused conference.
2. Develop a set of shared principles that can be used by all stakeholders responsible for devising and communicating public health messages. This might include developing a Respect Filter for public health messages.
3. Advocate for / conduct interdisciplinary research. There is a need for more funding and an interdisciplinary approach to explore risk communication for women in pregnancy. Social science research and PPI approaches should be integrated with biomedical and epidemiological evidence to improve acceptability and effectiveness of public health risk communication. Highlight the issues raised by the workshop in peer reviewed academic journals.
4. Link to a public health approach that de-emphasises the role of individuals in changing health behaviours. Individualised messages targeted to individual women are not always the most effective way of achieving population change in health behaviours or of improving health outcomes at population level. There is a need for critical appraisal of individualised solutions to public health problems.
5. Develop a 'change the conversation' campaign, involving a network of stakeholders and based on an agreed set of principles. This could link to existing agendas, including around 'trust women' and perinatal mental health. Identify key stakeholders in the NHS, in public health, and in government, and engage them with campaigning work on this issue.

6. Empower women to critically appraise risk messages. Develop social media content to highlight the issue and engage public opinion. There is a need to the development of initiatives and communication hubs (existing and new) that seek to improve the understanding of risk related to fertility and pregnancy.
7. Provide information and training for risk mediators including health professionals, to improve the quality of the delivery of public health messages to align with a woman-centred approach.
8. Engage journalists and editors. Monitor media reporting of risk issues relating to women and pregnancy. Identify journalists who are keen to engage with a 'Respect Agenda' for reporting on risk in pregnancy.

Next steps

As an initial step, these concerns and recommendations have been taken forward into the development of a Public Engagement Project, funded by The Wellcome Trust and led by BPAS in partnership Heather Trickey from the School of Social Sciences at Cardiff University. The WRISK project will draw on women's experiences to better understand, and to improve the development and communication of, risk messages relating to pregnancy.

WRISK will take a woman-centred approach, and search for voices that are seldom-heard. Women's voices will be incorporated into the WRISK project through a range of public and patient involvement and engagement (PPI/E) methodologies, and qualitative research methods.

Through WRISK, we believe we can help create more respectful- and ultimately more effective- public health messages relating to pregnancy.

Produced by

This summary was produced by Clare Murphy (bpas), Heather Trickey (Cardiff University), and Rebecca Blaylock (bpas) in November 2018.

Appendix A: Full delegate list

Alice Keely: Lecturer in Midwifery, University of Leeds

Amber Marshall: Founder, BigBirthas.co.uk

Ann Furedi: Chief Executive of British Pregnancy Advisory Service

Caitlin Dean: Chairperson, Pregnancy Sickness Support

Cathy Warwick: Former Chief Executive, The Royal College of Midwives

Dr Gemma Sharp: Lecturer in Molecular Epidemiology, University of Bristol

Ellie Lee: Reader in Social Policy, University of Kent; Director, Centre for Parenting Culture Studies

Fiona Woollard: Associate Professor of Philosophy, University of Southampton

Heather Trickey: Research associate, School of Medicine, Cardiff University and National Childbirth Trust (NCT)

Irene Petersen: Reader in Epidemiology and Statistics, University College London

Kirsty Budds: Lecturer in Psychology; Programme Lead of the MSc Health & Wellbeing, Keele University

Linda Geddes: Journalist and Author of Bumpology

Rebecca Schiller: Chief Executive, Birthrights

Sally Sheldon: Professor of Law, Kent Law School, University of Kent

Sophia Collins: Science Engagement Specialist; Head of Parenting Science Gang

Sue White: Professor of Social Work, University of Sheffield

Virginia Berridge: Professor of History; Director of the Centre for History in Public Health at the London School of Hygiene and Tropical Medicine

Charlene Colegate: The Wellcome Trust (observer)

Lucy Brownsden: The Centre for Facilitatio (facilitator)