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Before the beginning: nutrition and lifestyle in the preconception period and its importance for future health

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Conflict of Interest

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Abstract

A woman who is healthy at the time of conception is more likely to have a successful pregnancy and a healthy child. We reviewed published evidence and present new data from high, low and middle income countries on the timing and importance of preconception health for subsequent maternal and child health. We describe the extent to which pregnancy is planned, and whether planning is linked to preconception health behaviours.

Observational studies show strong links between health before pregnancy and maternal and child health outcomes, with consequences that can extend across generations, but awareness of these links is not widespread. Poor nutrition and obesity are rife among women of reproductive age, and differences between high and lower income countries have become less distinct, with typical diets falling far short of nutritional recommendations in both settings and especially among adolescents.

Numerous studies show that micronutrient supplementation starting in pregnancy can correct important maternal nutrient deficiencies, but effects on child health outcomes are disappointing. Other interventions to improve diet during pregnancy have had little impact on maternal and newborn health outcomes. There have been comparatively few attempts at preconception diet and lifestyle intervention. Improvements in the measurement of pregnancy planning have quantified the degree of pregnancy planning and suggest that this is more common than previously recognised. Planning for pregnancy is associated with a mixed pattern of health behaviours before conception.

We propose novel definitions of the preconception period relating to embryo development and to action at individual or population level. A sharper focus on intervention before conception is needed to improve maternal and child health and reduce the growing burden of non-communicable disease. Alongside continued efforts to reduce smoking, alcohol and obesity in the population, we call for heightened awareness of preconception health, particularly regarding diet and nutrition. Importantly health professionals should be alerted to ways of identifying women who are planning a pregnancy.

Introduction

Health around the time of conception, once a neglected topic, is now a focus of increasing interest, reflected in numerous recent reports from national [1, 2] and international health agencies, [3, 4]. Three linked articles in this issue make the case for preconception health as a key determinant of pregnancy success and next generation health, drawing on evidence across clinical, biological and social/policy fields. In this paper, we follow three lines of enquiry. First we review the evidence linking preconception health, particularly nutritional status, to pregnancy and birth outcomes, including analysis of the few cohort studies in low- and middle- income countries (LMIC) and high-income countries (HIC) to have recruited women *before* pregnancy (web appendix) [5] [6, 7] [8] and survey data on the nutrition of a nationally representative sample of women in a HIC [[9]. Using these data, we assess how well women are prepared, in health terms, for pregnancy. Second, since preconception care is largely neglected, we assess the extent to which intervention *during* pregnancy can mitigate the impact of preconception risk behaviours by reviewing systematic reviews of dietary and lifestyle interventions that started in pregnancy (web appendix). Third, efforts to improve preconception health can be aimed at a population level, irrespective of any pregnancy planning, and / or targeted more specifically at women who are planning for pregnancy. We therefore review what is known about the extent of planning for pregnancy, including new data from a low income country on how to measure pregnancy planning[10]. A host of social, medical and environmental conditions can influence pregnancy outcomes, including genetic disorders, pre-existing physical and mental health conditions, teratogenic agents and domestic abuse to name a few. We recognise their importance, but review of these conditions is outside the scope of this paper. The importance of the fathers' preconception health is addressed in the second paper in this series and targeting of intervention strategies to improve preconception health is considered in a third paper.

Preconception risk factors in perspective

Life course epidemiology provides a useful perspective for examining preconception factors and their effects on maternal, fetal, and child health by considering the timing and duration of exposures and their potential long term or latent impacts [11]. The relationship of exposures to outcomes can be considered in terms of critical periods, sensitive periods, and cumulative effects. For example, the period around conception (two to three months before and after) is a *critical period* for optimising gamete function, and early placental development. In this period, folic acid supplementation, for example, can reduce the risk of neural tube defects by as much as 70% [12, 13]. Other benefits of folic acid supplementation during periconception may include decreased risk of pre-eclampsia, miscarriage, low birth weight, small for gestational age, stillbirth, neonatal death and autism in children [14–16]. The consequences of materno-fetal iron deficiency also fit a critical period model in which repletion after an undetermined time-point fails to rectify structural impairments to developing brain structures. In experimental animal models, dietary restriction of iron from the beginning of gestation can induce a 40–50% decrease in brain iron 10 days after birth [17] and preconception zinc deficiency compromises fetal and placental growth and neural tube closure [18]. Adolescence may represent a particularly *sensitive period* as unhealthy lifestyle behaviours - such as smoking, poor diet and eating disorders - often originate in the

teenage years. These preconception risk factors can set patterns that have a *cumulative effect* on health into adulthood and for future generations, as shown by mounting evidence of the long-term impact of poor maternal nutrition and obesity for the child [19].

Maternal Body Composition, Nutrition and Lifestyle factors

i Body mass index (BMI)—Both maternal underweight and overweight are associated with substantial risks for maternal and child health. An analysis of adult BMI in 200 countries from 1975 to 2014 with over 19 million participants found that the age-standardised global prevalence of underweight in women (BMI <18.5 kg/m²) decreased from 15% to 10%; South Asia had the highest rates with an estimated 24% of women underweight in 2014 [20]. While underweight has decreased, the global prevalence of obesity (BMI ≥30 kg/m²) has risen from 6% to 15% in women [20]; in many HIC and LMIC, up to 50% are overweight or obese when they become pregnant [21, 22]. Obesity is associated with increased risk of most major adverse maternal and perinatal outcomes, from inability to conceive to complications of pregnancy (pre-eclampsia, gestational diabetes) and delivery (macrosomia), congenital anomalies, stillbirth, and low birth weight, unsuccessful breastfeeding and even maternal death [22–25]. The global increase in obesity among men, from 3% to 11% between 1975 and 2014 [20] is not irrelevant; paternal obesity has been linked to impaired fertility by affecting sperm quality and quantity [26] and is associated with increased chronic disease risk in offspring [27]. The cumulative effect of both maternal and paternal obesity on the risk of obesity in future generations has been proposed by numerous studies [28] and causal pathways involving interaction between genetic, epigenetic and environmental factors are emerging (paper 2).

Although the benefits of preconception weight loss remain to be established through clinical trials, observational studies indicate the likely effects of preconception weight loss on pregnancy outcomes. In a population-based study in Canada with 226,958 singleton pregnancies, a preconception weight loss of 10% was associated with clinically meaningful risk reduction in pre-eclampsia, gestational diabetes, preterm delivery, macrosomia, and stillbirth [29]. Women undergoing bariatric surgery at least two years before conception had considerably lower risk or odds of gestational diabetes, hypertensive disorders and large-for-gestational age neonates compared with women of similar BMI who had no bariatric surgery, although this was partially offset by more small-for-gestational-age births [30–32]. Higher levels of preconception physical activity were associated with lower risk of gestational diabetes (OR 0.45, 95% CI 0.28, 0.75 in seven cohorts, 34,929 pregnancies) [33] and pre-eclampsia (RR 0.65, 95% CI 0.47, 0.89, in five studies, 10,317 pregnancies) [34]. Walking at a brisk pace for four hours or more per week before pregnancy was also associated with lower risk of gestational diabetes [35]. The recent success of a lifestyle intervention in reducing weight retention post-partum [36] shows that preparation for health in the next pregnancy can begin straight after the last pregnancy.

ii Preconception diet and nutrition—Diet and nutrition before pregnancy may modify maternal and perinatal outcomes via effects on BMI (as above) or other nutritional factors, including micronutrient deficiencies. WHO estimates that around two billion people are deficient in micronutrients, with women being at particular risk because of menstruation

and the high metabolic demands of pregnancy [37]. Globally, maternal undernutrition and its consequences, including fetal growth restriction, stunting, wasting, vitamin A and/or zinc deficiency, together with sub-optimal breastfeeding, is estimated to account for 3.1 million child deaths annually, or 45% of all child deaths in 2011 [38]. A recent comprehensive review of nutrition among adolescent girls and women of reproductive age in LMIC concluded that, despite the reduction in prevalence of underweight, dietary deficiencies, including iron, vitamin A, iodine, zinc, and calcium remain prevalent [39]. A typical diet in HIC, characterised by high intake of red meat, refined grains, refined sugars, and high fat dairy, is also lacking in several important nutrients including magnesium, iodine, calcium and vitamin D [40, 41].

Our analysis in the UK shows that many women of reproductive age will not be nutritionally prepared for pregnancy, even at lower reference nutrient intake (LRNI) levels; this applies especially to young women and mineral intake (Table 1). Seventy-seven percent of women aged 18-25 years had dietary intakes below RNI daily recommendations for iodine and 96% of women of reproductive age had intakes below iron and folate recommendations for pregnancy (data not shown). Achieving adequate folate levels in pregnancy (red blood cell folate concentration above 906 nmol/L) for prevention of neural tube defects may be hard to achieve through diet alone [42]. Folic acid supplements or fortified foods are effective alternatives. In a cohort of over 1.5 million women in China, folic acid supplementation three months before pregnancy was associated with significantly lower risk of low birthweight (OR 0.74, 95% CI 0.71-0.78), miscarriage (OR 0.53, 0.52-0.54), stillbirth (OR 0.70, 0.64-0.77), and neonatal mortality (OR 0.70, 0.63-0.78) compared to women who did not take folic acid before pregnancy [16]. In several countries (Canada, Chile, Oman, South Africa, USA), a decrease in neural tube defects has been observed following folic acid fortification ([13]. A mild degree of iodine deficiency in pregnancy has been linked to lower intelligence quotients in offspring [40], although the balance of benefit and risk from iodine supplementation before or during pregnancy remains unclear [43].

Cohort studies have suggested that dietary patterns up to three years before pregnancy, characterised by high intake of fruit, vegetables, legumes, nuts and fish and low intake of red and processed meat, are associated with reduced risk of gestational diabetes [44–47], hypertensive disorders of pregnancy [48–50] and preterm birth [51]. Since few people will plan a pregnancy three years in advance, this highlights the need for population-level interventions. In the UK and Australia, more than 9 out of 10 women aged 18-25 years reported consuming fewer than five fruit and vegetable portions daily (Table 1). As the diet of the young child is determined largely by the mother, this has important implications for future child health.

iii Smoking, alcohol and caffeine—Evidence for the impact of maternal smoking on health outcomes, (including pregnancy loss, intrauterine growth restriction and low birth weight) comes largely from studies initiated during, rather than before, pregnancy [52, 53]. While there are no published trials showing that reducing smoking before conception improves these outcomes, indirect evidence of impact at population level comes from introduction of smoke-free legislation in different countries which has been associated with substantial reductions in preterm births (-10.4%, 95% CI -18.8, -2.0; from four cohort

studies with 1,366,862 pregnancies) [54]. Maternal alcohol consumption can result in a range of fetal alcohol spectrum disorders resulting in physical, behavioural and learning difficulties. [55] While discussion of any 'safe level' of alcohol is controversial, there is considerable public awareness that avoidance of both smoking and alcohol during pregnancy is important for health. Caffeine consumption during pregnancy has been associated with a reduction in birth weight of a similar size to that caused by alcohol, and a significant trend for greater reduction in birth weight with higher caffeine intake [56]]. This relationship was consistent across all three trimesters, suggesting that cutting back on caffeine before conception could be beneficial. However, as with all preconception risk factors, the scope for action at individual level is limited by unplanned pregnancy; this in turn highlights the importance of cost-effective public health action (e.g. minimum pricing of alcohol and smoke-free legislation) to reduce risk behaviours in the whole population, with additional benefit for those whose pregnancies are unplanned.

i.v Lifestyle interventions and micronutrient supplementation during pregnancy—Since women are more likely to engage with health services once they are pregnant than beforehand, we considered whether birth outcomes can be improved by intervening in pregnancy to redress poor dietary patterns that were present before conception. In HIC, the obesity epidemic has dominated efforts to improve pregnancy outcomes. Our overview identified 20 systematic reviews of antenatal interventions with a dietary component, six confined to overweight or obese women (Figure 2, detail in web appendix). These reviews, mainly of trials from HIC, provide high quality consistent evidence that diet (with or without exercise) during pregnancy can reduce gestational weight gain, although a recent individual patient data (IPD) meta-analysis of 36 randomised controlled trials with 12,526 women of mixed BMI found an average reduction in gestational weight gain of only 0.7kg (95% CI -0.92 to -0.48) [57]. Some reviews also reported that dietary intervention during pregnancy led to reduction in dietary fat and energy intake, with increased consumption of fibre, protein, fruit and vegetables [58–60]. High quality trials published after these systematic reviews show similar effects on dietary behaviours. The LIMIT trial in Australia showed increased consumption of fruit, vegetables, legumes, fibre, and micronutrients, and a reduction in energy from saturated fat sources among overweight or obese women [61]. The UPBEAT trial in the UK also showed a reduction in consumption of processed foods and snack foods among obese women [62]. Both trials showed dietary behaviour change at 28 and 36 weeks gestation and UPBEAT reported reduced infant adiposity 6 months postpartum [63]. While improved health behaviours and weight gain restriction should not be ignored as there may be longer term benefits, these interventions have had no significant impact on common adverse pregnancy outcomes, including gestational diabetes, pre-eclampsia, large-for-gestational-age or preterm births in women of mixed BMI or in obese women (Figure 2), although the IPD meta-analysis reported a 9% reduction in caesarean section in women of all BMIs (OR 0.91, 95% CI 0.83 to 0.99) [57]. As attempts to improve outcomes in obese women with insulin sensitising drugs have also failed [64, 65] attention is increasingly focused on improving diet and preventing or reversing obesity in the preconception period. Given the substantial time needed to reach a healthy weight, early intervention at a population level is vital to reduce obesity related outcomes in pregnancy.

In LMIC, antenatal dietary interventions have generally focused on the problem of calorific and nutrient deprivation. A single trial in Mumbai found that a daily snack containing leafy green vegetables, fruit and milk before and during pregnancy reduced the prevalence of gestational diabetes (to 7.3% in the intervention group compared with 12.4% in the control group) [[66]]. Numerous studies have examined the impact of antenatal multiple micronutrient supplementation on a range of health outcomes in high-risk populations in LMIC [67, 68] but the findings are disappointing. Systematic reviews of trials of multiple micronutrient supplementation during pregnancy, including over 88,000 women, have consistently shown modest effects on increasing birthweight, but no improvement in childhood survival, growth, body composition, blood pressure, respiratory or cognitive outcomes, compared with control groups receiving iron and folic acid supplementation only[69, 70].

Distinctions between HIC and LMIC have become blurred as many LMIC experience a demographic and obstetric transition [71] coupled with ‘western’ lifestyles that foster obesity, while HIC populations already dominated by obesity commonly have poor nutrition and specific micronutrient deficiencies that go unrecognized until pregnancy. Iron deficiency anaemia is a case in point: it is the most common deficiency globally affecting around 2 billion people and 30-50% of pregnant women [72], including young women in HIC [73]. Although iron supplementation in pregnancy reduces iron deficiency anaemia and improves haemoglobin levels at term, other benefits seem limited to a reduction in low birthweight [74]. Vitamin D deficiency, increasingly common among pregnant women in HIC, can lead to bone mineral deficiency in the developing child, and has been implicated, but with less certainty, in gestational diabetes, pre-eclampsia, low birthweight and preterm birth [75]. A subsequent trial of vitamin D supplementation during pregnancy showed that most women became vitamin D replete, but infant bone mineral content was not increased overall [76]. Further studies, such as the SPRING trial of vitamin D supplementation during pregnancy [77], are awaited.

In summary, interventions to improve diet in pregnancy lead to modest reduction in gestational weight gain, but, with few exceptions [63], have not improved important maternal or newborn health outcomes. Micronutrient supplementation starting in pregnancy can correct important maternal nutrient deficiencies with modest effects on increasing birthweight, but no subsequent improvement in child health outcomes. Likely explanations include starting after early critical periods of fetal programming, and / or inadequate implementation, dose or adherence within this time frame to achieve significant biological influence. In keeping with this hypothesis, one of the few supplementation trials starting before conception found no effect on birth weight unless provided at least 3 months before conception and to women who were not underweight ([78]). To explore adherence to preconception supplementation, we analysed data from the Pune Rural Intervention in Young Adolescents (PRIYA) [8] study. PRIYA is a randomised community-based trial of vitamin B12 supplementation *before* pregnancy in young women and men. Adherence, assessed by pill counts, in this non-pregnant trial population was consistently high at around 80%. While every effort should be made to correct micronutrient deficiencies in a women once pregnant, there is a growing consensus that the greatest gain will be achieved through a

lifecourse approach or continuum of improved nutrition in children, adolescents and young women contemplating pregnancy (paper 3).

Defining the preconception period

The preconception period is often defined as the three months before conception, possibly because this is the average time to conception for fertile couples [79, 80]. However, a time period before conception can only be identified after a woman has become pregnant. Some definitions avoid this problem, for instance “a minimum of one year prior to the initiation of any unprotected sexual intercourse that could possibly result in a pregnancy” [81], but they lack practical application.

We therefore propose three new definitions or perspectives that relate to embryo development or point to action at an individual or population level. From a **biological** perspective, there is a critical period spanning the weeks around conception when gametes mature, fertilisation occurs and the developing embryo forms. These are the events most sensitive to environmental factors such as the availability of macro- and micronutrients or exposure to smoking, alcohol, drugs or other teratogens (Paper 2). For prevention of neural tube defects, a minimum of 4-6 weeks folic acid supplementation is required to reach adequate levels before neurulation begins three weeks after conception[13].

In relation to **individual** action, the preconception period starts whenever a woman or couple decides they want to have a baby, as the time to conception is unknown. Since about a third of fertile couples having regular sex without contraception will conceive within one month, [79, 80] optimising nutrition, including folic acid supplementation, should coincide with the decision to become pregnant. The preconception period may reflect the time required by individuals to achieve desired health outcomes in preparation for pregnancy, such as six or more months to attain a healthy BMI. Maternal motivation to improve health at this stage can be strong. In a recent pilot study, 54% of obese women attending a family planning clinic to have their contraceptive implant or uterine device removed in order to become pregnant were willing to improve their preconception health by deferring removal of contraception for 6 months while they followed an intensive weight loss plan (Stephenson, unpublished data). From a **public health** perspective, the preconception period can relate to a sensitive phase in the life course, such as adolescence, when health behaviours affecting diet, exercise and obesity, along with smoking and drinking, become established before the first pregnancy(paper 3).

These perspectives can be combined into a conceptual framework of the preconception period (figure 1). Benefits that can be achieved fairly rapidly, such as adequate folate levels, are indicated at 3 months before conception or whenever an individual first intends to become pregnant. By contrast, substantial weight loss takes months or years to achieve, while the length of time to establish new dietary patterns is highly variable. Together these findings point to the scale of the challenge in improving preconception health with vast room for improvement, particularly in nutritional status, and the need for intervention strategies at the population level to support action at the individual level. (figure 1).

Pregnancy planning for preconception health

Compelling evidence for early developmental programming (paper 2) and disappointment with micronutrient supplements and dietary interventions in pregnancy are shifting attention to the challenge of intervening before conception. Awareness of the importance of health before pregnancy, some level of pregnancy planning and uptake of interventions before conception are distinct but related requirements for improving preconception health. Qualitative research has identified three groups: women with high levels of pregnancy planning who take up interventions, women who plan but describe themselves as having poor awareness of preconception actions, and women for whom the preconception period has little meaning [82]. Different preconception care approaches are likely to be needed for each group (paper 3).

Our analysis of new data from two preconception cohort studies shows mixed health behaviours reported in relation to pregnancy planning. Women ‘trying for pregnancy’ were less likely to report smoking or drinking alcohol, and reported lower levels of caffeine consumption, but had a higher BMI, and reported lower levels of physical activity, and similar fruit and vegetable intake compared with women who were using contraception or not planning to become pregnant within the next year (table 2). These associations were robust to adjustment for maternal level of educational attainment, age and parity. In the Southampton Womens Study, education had a significant impact on the association between pregnancy status and fruit and vegetable intake before pregnancy. Women educated beyond the age of 16 years with an intended pregnancy were more likely to report eating five portions of fruit and vegetables than those who did not become pregnant and were not planning to (65% vs 57%); whereas no differences between these pregnancy intention groups were seen in women only educated to 16 years of age (46% vs 46%). This suggests that more educated women may improve their diet once a decision has been made for pregnancy, but less educated women do not, demonstrating the effect of disadvantage on women’s ability to change their behaviours.

Although numerous studies suggest that awareness of preconception health and care is low [83, 84], ‘pregnancy planning’ appears relatively common, indicating a missed and unexploited opportunity for intervention. [85, 86] Pregnancy planning has usually been estimated in surveys, either by a single question (e.g. “Did you plan your pregnancy?”) or by more detailed questioning to probe (variously) intentions, reactions to pregnancy, timing of pregnancy and family size desires. The most influential survey, the US National Survey of Family Growth[85] categorises pregnancy as intended, mistimed or unwanted, terms now widely adopted and included in the worldwide Demographic and Health Surveys[87]. A combination of all survey information has estimated that 60% of the 213million pregnancies worldwide in 2012 were intended [86].

In the last 20 years, the growing complexity of family formation patterns worldwide, awareness of the need to accommodate women’s ambivalence, and the contribution of psychometric methodology to measurement development have indicated the need for a more sophisticated measurement of pregnancy planning. The London Measure of Unplanned Pregnancy (LMUP) has been widely used[88], with nine validated language versions across

seven countries, and more in progress [89–95]. Six questions produce a score 0–12, with higher scores indicating a more planned pregnancy. Use of the LMUP has shown that pregnancy planning, at various levels of intensity, is globally common, particularly among pregnancies leading to birth [10, 83, 89–94, 96, 97]. In providing a finer gradation of pregnancy planning, the LMUP is more reliable than previous tools, opening the door to improved prediction of health outcomes associated with pregnancy intention. Despite this, the global standard used in LMIC remains the single Demographic and Health Survey question, asked up to five years after birth: “At the time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have any (more) children at all?” with responses categorised, respectively, as “intended”, “mistimed” and “unwanted” pregnancy.

In a cohort study of pregnant women in Malawi [10], we compared the LMUP reported during pregnancy with the DHS question up to 16 months afterwards. Forty-five percent of women scored 10 or more on the LMUP antenatally, showing that pregnancy planning is a relevant concept in a rural, low-income setting. The estimated prevalence of intended pregnancies was higher using the postnatal DHS question (69%, 95%CI 65% to 73%) than the antenatal LMUP (40%, 95%CI 36% to 44%) in the same group of 623 women followed up at one year (Figure 3). Previous studies have found higher reported intention over time for births [98] but these are the first data to document that this shift occurs within the first year postnatally. This suggests a need for antenatal surveillance of pregnancy intention which would improve accuracy in assessing the scale of unplanned pregnancies and provide an opportunity to act antenatally to mitigate the adverse effects for the mother and child. A measure such as the LMUP would also be sensitive enough to monitor changes in the rate of unplanned pregnancy over time and across population sub-groups. Most initiatives to reduce unplanned pregnancy, such as Family Planning 2020 [99], rely on uptake of contraception as a proxy measure of impact, whereas the LMUP could provide a direct measure of the desired outcome.

The frequency of pregnancy planning identified by the LMUP in both HIC and LMIC suggests considerable scope for intervention before pregnancy; the challenge is to identify women who are planning a pregnancy. Simply asking women of reproductive age “*Do you plan to have any (more) children at any time in your future?*” is being promoted [100], but is likely to lack predictive validity; more nuanced measures that capture ambivalent intentions are required e.g. the ‘Desire to Avoid Pregnancy’ (DAP) Scale, currently in development [101]. Robust measures such as the LMUP and DAP are opening up a largely unexplored area of research into how people plan and prepare for pregnancy, the associated health impacts and how health professionals can identify individuals planning a pregnancy.

Summary

A consistent picture is emerging of the importance of maternal health before conception and the key risk factors for adverse birth outcomes, one that blurs previous distinctions between HIC and LMIC. A lifecourse model of critical periods, sensitive periods and cumulative effects fits well with current data linking preconception exposures to birth outcomes and risk of disease in later life. The adverse consequences of poor nutrition combined with obesity,

rife in women of reproductive age, extend across generations. Dietary interventions starting in pregnancy can reduce weight gain and adiposity in obese women, but with little impact on pregnancy outcomes, while multiple micronutrient supplementation in pregnancy appears ‘too little, too late’ to fundamentally improve child health outcomes.

Novel definitions of the preconception period that relate to embryo development (paper 2) or to opportunities for intervention may be useful. Action to improve conditions around the critical time of conception requires a more systematic approach to identify women planning a pregnancy; efforts to do this are underway. A healthy weight can take longer to achieve than dietary changes and should ideally become established during the sensitive period of adolescence when most women will not be planning pregnancy; this requires a population-level approach. In general, though, a degree of pregnancy planning is common, in both LMIC and HIC, offering considerable scope for intervention before pregnancy. Currently, pregnancy planning is associated with an inconsistent pattern of reported health behaviours; low awareness of the importance of health before pregnancy and possible actions to take may contribute to this. To make a significant impact on preconception health, we need a dual strategy that improves nutritional status across the lifecourse and particularly during reproductive ages, while targeting all women who are thinking of conceiving. How this might be achieved is considered in the third paper of the series.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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References

1. Davies SC, Department of Health. Annual Report of the Chief Medical Officer; 2014, The Health of the 51%: Women. London: 2015. 167
2. Johnson KA, F R, Humphrey JR, et al. Action Plan for the National Initiative on Preconception Health and Health Care (PCHHC) - A Report of the PCHHC Steering Committee. 2012 – 2014:1–49.
3. Hanson MA, et al. The International Federation of Gynecology and Obstetrics (FIGO) recommendations on adolescent, preconception, and maternal nutrition: “Think Nutrition First”. *Int J Gynaecol Obstet.* 2015; 131(Suppl 4):S213–53. [PubMed: 26433230]
4. WHO Policy Brief. Preconception care: Maximizing the gains for maternal and child health. 2013:1–8.
5. Lee C, et al. Cohort Profile: the Australian Longitudinal Study on Women’s Health. *Int J Epidemiol.* 2005; 34(5):987–91. [PubMed: 15894591]

6. Crozier SR, et al. Do women change their health behaviours in pregnancy? Findings from the Southampton Women's Survey. *Paediatr Perinat Epidemiol.* 2009; 23(5):446–53. [PubMed: 19689495]
7. Inskip HM, et al. Cohort profile: The Southampton Women's Survey. *Int J Epidemiol.* 2006; 35(1): 42–8. [PubMed: 16195252]
8. Kumaran K, et al. The Pune Rural Intervention in Young Adolescents (PRIYA) study: design and methods of a randomised controlled trial. *BMC Nutrition.* 2017; 3(1):41.
9. Bates B, L A, Prentice A, et al. National Diet and Nutrition Survey: Results from Years 1, 2, 3 and 4 combined of the Rolling Program (2008/9 – 2011/12). 2014
10. Hall JA, et al. Prevalence and Determinants of Unintended Pregnancy in Mchinji District, Malawi; Using a Conceptual Hierarchy to Inform Analysis. *PLoS One.* 2016; 11(10):e0165621. [PubMed: 27798710]
11. Ben-Shlomo Y, Kuh D. A life course approach to chronic disease epidemiology: conceptual models, empirical challenges and interdisciplinary perspectives. *Int J Epidemiol.* 2002; 31(2):285–93. [PubMed: 11980781]
12. De-Regil LM, et al. Effects and safety of periconceptional oral folate supplementation for preventing birth defects. *Cochrane Database Syst Rev.* 2015; (12):CD007950. [PubMed: 26662928]
13. Mastroiacovo P, Leoncini E. More folic acid, the five questions: why, who, when, how much, and how. *Biofactors.* 2011; 37(4):272–9. [PubMed: 21674648]
14. Hodgetts VA, et al. Effectiveness of folic acid supplementation in pregnancy on reducing the risk of small-for-gestational age neonates: a population study, systematic review and meta-analysis. *BJOG.* 2015; 122(4):478–90. [PubMed: 25424556]
15. Gao Y, et al. New Perspective on Impact of Folic Acid Supplementation during Pregnancy on Neurodevelopment/Autism in the Offspring Children - A Systematic Review. *PLoS One.* 2016; 11(11):e0165626. [PubMed: 27875541]
16. He Y, et al. Folic acid supplementation, birth defects, and adverse pregnancy outcomes in Chinese women: a population-based mega-cohort study. *The Lancet.* 2016; 388:S91.
17. Rao R, et al. Perinatal iron deficiency alters the neurochemical profile of the developing rat hippocampus. *J Nutr.* 2003; 133(10):3215–21. [PubMed: 14519813]
18. Tian X, et al. Preconception zinc deficiency disrupts postimplantation fetal and placental development in mice. *Biol Reprod.* 2014; 90(4):83. [PubMed: 24599289]
19. Hanson M, et al. Interventions to prevent maternal obesity before conception, during pregnancy, and post partum. *Lancet Diabetes Endocrinol.* 2017; 5(1):65–76. [PubMed: 27743974]
20. NCD Risk Factor Collaboration. Worldwide trends in diabetes since 1980: a pooled analysis of 751 population-based studies with 4.4 million participants. *Lancet.* 2016; 387(10027):1513–30. [PubMed: 27061677]
21. Ng M, et al. Global, regional, and national prevalence of overweight and obesity in children and adults during 1980–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet.* 2014; 384(9945):766–81. [PubMed: 24880830]
22. Poston L, et al. Preconceptional and maternal obesity: epidemiology and health consequences. *Lancet Diabetes Endocrinol.* 2016; 4(12):1025–1036. [PubMed: 27743975]
23. Gesink Law DC, Maclehorse RF, Longnecker M. Obesity and time to pregnancy. *Hum Reprod.* 2007; 22(2):414–20. [PubMed: 17095518]
24. Marchi J, et al. Risks associated with obesity in pregnancy, for the mother and baby: a systematic review of reviews. *Obes Rev.* 2015; 16(8):621–38. [PubMed: 26016557]
25. Turcksin R, et al. Maternal obesity and breastfeeding intention, initiation, intensity and duration: a systematic review. *Matern Child Nutr.* 2014; 10(2):166–83. [PubMed: 22905677]
26. Kort HI, et al. Impact of body mass index values on sperm quantity and quality. *J Androl.* 2006; 27(3):450–2. [PubMed: 16339454]
27. Kaati G, Bygren LO, Edvinsson S. Cardiovascular and diabetes mortality determined by nutrition during parents' and grandparents' slow growth period. *Eur J Hum Genet.* 2002; 10(11):682–8. [PubMed: 12404098]

28. Godfrey KM, et al. Influence of maternal obesity on the long-term health of offspring. *Lancet Diabetes Endocrinol.* 2017; 5(1):53–64. [PubMed: 27743978]
29. Schummers L, et al. Risk of adverse pregnancy outcomes by prepregnancy body mass index: a population-based study to inform prepregnancy weight loss counseling. *Obstet Gynecol.* 2015; 125(1):133–43. [PubMed: 25560115]
30. Yi XY, et al. A meta-analysis of maternal and fetal outcomes of pregnancy after bariatric surgery. *Int J Gynaecol Obstet.* 2015; 130(1):3–9. [PubMed: 25863541]
31. Galazis N, et al. Maternal and neonatal outcomes in women undergoing bariatric surgery: a systematic review and meta-analysis. *Eur J Obstet Gynecol Reprod Biol.* 2014; 181:45–53. [PubMed: 25126981]
32. Johansson K, et al. Outcomes of pregnancy after bariatric surgery. *N Engl J Med.* 2015; 372(9): 814–24. [PubMed: 25714159]
33. Tobias DK, et al. Physical activity before and during pregnancy and risk of gestational diabetes mellitus: a meta-analysis. *Diabetes Care.* 2011; 34(1):223–9. [PubMed: 20876206]
34. Aune D, et al. Physical activity and the risk of preeclampsia: a systematic review and meta-analysis. *Epidemiology.* 2014; 25(3):331–43. [PubMed: 24713878]
35. Zhang C, et al. A prospective study of pregravid physical activity and sedentary behaviors in relation to the risk for gestational diabetes mellitus. *Arch Intern Med.* 2006; 166(5):543–8. [PubMed: 16534041]
36. Phelan S, et al. Effect of an Internet-Based Program on Weight Loss for Low-Income Postpartum Women: A Randomized Clinical Trial. *Jama.* 2017; 317(23):2381–2391. [PubMed: 28632867]
37. WHO. Guidelines on Food Fortification with Micronutrients. World Health Organization; 2000.
38. Black RE, et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet.* 2013; 382(9890):427–51. [PubMed: 23746772]
39. Caulfield L, E V, Arlington VA. Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project. Nutrition of Adolescent Girls and Women of Reproductive Age in Low- and Middle-Income Countries: Current Context and Scientific Basis for Moving Forward. 2015
40. Bath SC, et al. Effect of inadequate iodine status in UK pregnant women on cognitive outcomes in their children: results from the Avon Longitudinal Study of Parents and Children (ALSPAC). *Lancet.* 2013; 382(9889):331–7. [PubMed: 23706508]
41. Cordain L, et al. Origins and evolution of the Western diet: health implications for the 21st century. *Am J Clin Nutr.* 2005; 81(2):341–54. [PubMed: 15699220]
42. Cuskelly GJ, McNulty H, Scott JM. Effect of increasing dietary folate on red-cell folate: implications for prevention of neural tube defects. *Lancet.* 1996; 347(9002):657–9. [PubMed: 8596381]
43. Harding KB, et al. Iodine supplementation for women during the preconception, pregnancy and postpartum period. *Cochrane Database Syst Rev.* 2017; 3:Cd011761. [PubMed: 28260263]
44. Bao W, et al. Prepregnancy low-carbohydrate dietary pattern and risk of gestational diabetes mellitus: a prospective cohort study. *Am J Clin Nutr.* 2014; 99(6):1378–84. [PubMed: 24717341]
45. Tobias DK, et al. Prepregnancy adherence to dietary patterns and lower risk of gestational diabetes mellitus. *Am J Clin Nutr.* 2012; 96(2):289–95. [PubMed: 22760563]
46. Zhang C, et al. A prospective study of dietary patterns, meat intake and the risk of gestational diabetes mellitus. *Diabetologia.* 2006; 49(11):2604–13. [PubMed: 16957814]
47. Schoenaker DA, et al. Pre-pregnancy dietary patterns and risk of gestational diabetes mellitus: results from an Australian population-based prospective cohort study. *Diabetologia.* 2015; 58(12): 2726–35. [PubMed: 26358582]
48. Schoenaker DA, Soedamah-Muthu SS, Mishra GD. Quantifying the mediating effect of body mass index on the relation between a Mediterranean diet and development of maternal pregnancy complications: the Australian Longitudinal Study on Women's Health. *Am J Clin Nutr.* 2016; 104(3):638–45. [PubMed: 27465377]
49. Schoenaker DA, et al. Prepregnancy dietary patterns and risk of developing hypertensive disorders of pregnancy: results from the Australian Longitudinal Study on Women's Health. *Am J Clin Nutr.* 2015; 102(1):94–101. [PubMed: 26040639]

50. Gresham E, et al. Diet quality before or during pregnancy and the relationship with pregnancy and birth outcomes: the Australian Longitudinal Study on Women's Health. *Public Health Nutr.* 2016; 19(16):2975–2983. [PubMed: 27238757]
51. Grieger JA, Grzeskowiak LE, Clifton VL. Preconception dietary patterns in human pregnancies are associated with preterm delivery. *J Nutr.* 2014; 144(7):1075–80. [PubMed: 24790026]
52. U.S. Department of Health and Human Services. *The Health Consequences of Smoking-50 Years of Progress: A Report of the Surgeon General.* Centers for Disease Control and Prevention (US). 2014
53. Reeves S, Bernstein I. Effects of maternal tobacco-smoke exposure on fetal growth and neonatal size. *Expert Rev Obstet Gynecol.* 2008; 3(6):719–730. [PubMed: 19881889]
54. Been JV, et al. Effect of smoke-free legislation on perinatal and child health: a systematic review and meta-analysis. *Lancet.* 2014; 383(9928):1549–60. [PubMed: 24680633]
55. British Medical Association. *Alcohol and pregnancy: Preventing and managing fetal alcohol spectrum disorders.* 2007 (updated 2016).
56. Care Study, Maternal caffeine intake during pregnancy and risk of fetal growth restriction: a large prospective observational study. *The BMJ.* 2008; 337:a2332. [PubMed: 18981029]
57. Rogoziska E, MN, Jackson L, et al. Effects of antenatal diet and physical activity on maternal and fetal outcomes: individual patient data meta-analysis and health economic evaluation. *Health Technology Assessment.* 2017 In press.
58. Gardner B, et al. Changing diet and physical activity to reduce gestational weight gain: a meta-analysis. *Obesity Reviews.* 2011; 12(7):e602–e620. [PubMed: 21521451]
59. SchHARR Public Health Collaborating Centre. *Systematic review of dietary and/or physical activity interventions for weight management in pregnancy.* The University of Sheffiled; 2009.
60. Muktabhant B, et al. Diet or exercise, or both, for preventing excessive weight gain in pregnancy. *The Cochrane Database Of Systematic Reviews.* 2015; 6:CD007145.
61. Dodd JM, et al. Antenatal lifestyle advice for women who are overweight or obese: LIMIT randomised trial. *BMJ.* 2014; 348:g1285. [PubMed: 24513442]
62. Flynn AC, et al. Dietary patterns in obese pregnant women; influence of a behavioral intervention of diet and physical activity in the UPBEAT randomized controlled trial. *Int J Behav Nutr Phys Act.* 2016; 13(1):124. [PubMed: 27894316]
63. Patel N, et al. Infant adiposity following a randomised controlled trial of a behavioural intervention in obese pregnancy. *Int J Obes (Lond).* 2017
64. Chiswick C, et al. Effect of metformin on maternal and fetal outcomes in obese pregnant women (EMPOWaR): a randomised, double-blind, placebo-controlled trial. *Lancet Diabetes Endocrinol.* 2015; 3(10):778–86. [PubMed: 26165398]
65. Syngelaki A, et al. Metformin versus Placebo in Obese Pregnant Women without Diabetes Mellitus. *N Engl J Med.* 2016; 374(5):434–43. [PubMed: 26840133]
66. Sahariah SA, et al. A Daily Snack Containing Leafy Green Vegetables, Fruit, and Milk before and during Pregnancy Prevents Gestational Diabetes in a Randomized, Controlled Trial in Mumbai, India. *J Nutr.* 2016; 146(7):1453s–60s. [PubMed: 27281802]
67. Dean SV, et al. Preconception care: nutritional risks and interventions. *Reprod Health.* 2014; 11(Suppl 3):S3.
68. Ramakrishnan U, et al. Effect of women's nutrition before and during early pregnancy on maternal and infant outcomes: a systematic review. *Paediatr Perinat Epidemiol.* 2012; 26(Suppl 1):285–301. [PubMed: 22742616]
69. Haider BA, Bhutta ZA. Multiple-micronutrient supplementation for women during pregnancy. *Cochrane Database Syst Rev.* 2015; (11):CD004905. [PubMed: 26522344]
70. Devakumar D, et al. Maternal antenatal multiple micronutrient supplementation for long-term health benefits in children: a systematic review and meta-analysis. *BMC Med.* 2016; 14:90. [PubMed: 27306908]
71. Graham W, et al. Diversity and divergence: the dynamic burden of poor maternal health. *Lancet.* 2016; 388(10056):2164–2175. [PubMed: 27642022]

72. Stoltzfus R. Defining iron-deficiency anemia in public health terms: a time for reflection. *J Nutr.* 2001; 131(2S-2):565S–567S. [PubMed: 11160589]
73. Baker PN, et al. A prospective study of micronutrient status in adolescent pregnancy. *Am J Clin Nutr.* 2009; 89(4):1114–24. [PubMed: 19244368]
74. Pena-Rosas JP, et al. Daily oral iron supplementation during pregnancy. *Cochrane Database Syst Rev.* 2015; (7):Cd004736. [PubMed: 26198451]
75. De-Regil LM, et al. Vitamin D supplementation for women during pregnancy. *Cochrane Database Syst Rev.* 2016; (1):CD008873. [PubMed: 26765344]
76. Cooper C, et al. Maternal gestational vitamin D supplementation and offspring bone health (MAVIDOS): a multicentre, double-blind, randomised placebo-controlled trial. *Lancet Diabetes Endocrinol.* 2016; 4(5):393–402. [PubMed: 26944421]
77. Baird J, et al. Southampton PRenancy Intervention for the Next Generation (SPRING): protocol for a randomised controlled trial. *Trials.* 2016; 17(1):493. [PubMed: 27729061]
78. Potdar RD, et al. Improving women's diet quality preconceptionally and during gestation: effects on birth weight and prevalence of low birth weight—a randomized controlled efficacy trial in India (Mumbai Maternal Nutrition Project). *The American Journal of Clinical Nutrition.* 2014; 100(5): 1257–1268. [PubMed: 25332324]
79. Potter RG, P M. Predicting the time required to conceive. *Population Studies.* 1964; 18(1):99–116.
80. Gnath C, et al. Time to pregnancy: results of the German prospective study and impact on the management of infertility. *Hum Reprod.* 2003; 18(9):1959–66. [PubMed: 12923157]
81. Dean S, et al. Setting research priorities for preconception care in low- and middle-income countries: aiming to reduce maternal and child mortality and morbidity. *PLoS Med.* 2013; 10(9):e1001508. [PubMed: 24019762]
82. Barrett G, et al. Why do women invest in pre-pregnancy health and care? A qualitative investigation with women attending maternity services. *BMC Pregnancy Childbirth.* 2015; 15:236. [PubMed: 26432278]
83. Stephenson J, et al. How do women prepare for pregnancy? Preconception experiences of women attending antenatal services and views of health professionals. *PLoS One.* 2014; 9(7):e103085. [PubMed: 25058333]
84. Mitchell EW, Levis DM, Prue CE. Preconception health: awareness, planning, and communication among a sample of US men and women. *Matern Child Health J.* 2012; 16(1):31–9. [PubMed: 20734124]
85. Mosher WD, Jones J, Abma JC. Intended and unintended births in the United States: 1982-2010. *Natl Health Stat Report.* 2012; (55):1–28.
86. Sedgh G, Singh S, Hussain R. Intended and unintended pregnancies worldwide in 2012 and recent trends. *Stud Fam Plann.* 2014; 45(3):301–14. [PubMed: 25207494]
87. Program, T.D. Demographic and Health Surveys.
88. Barrett G, Smith SC, Wellings K. Conceptualisation, development, and evaluation of a measure of unplanned pregnancy. *Journal of Epidemiology and Community Health.* 2004; 58(5):426–433. [PubMed: 15082745]
89. Rocca CH, et al. Measuring pregnancy planning: An assessment of the London Measure of Unplanned Pregnancy among urban, south Indian women. *Demogr Res.* 2010; 23:293–334. [PubMed: 21170147]
90. Morof D, et al. Evaluation of the London Measure of Unplanned Pregnancy in a United States population of women. *PLoS One.* 2012; 7(4):e35381. [PubMed: 22536377]
91. Hall J, et al. Understanding pregnancy planning in a low-income country setting: validation of the London measure of unplanned pregnancy in Malawi. *BMC Pregnancy Childbirth.* 2013; 13:200. [PubMed: 24188251]
92. Roshanaei S, et al. Measuring unintended pregnancies in postpartum Iranian women: validation of the London Measure of Unplanned Pregnancy. *East Mediterr Health J.* 2015; 21(8):572–8. [PubMed: 26446528]
93. Borges AL, et al. Evaluation of the psychometric properties of the London Measure of Unplanned Pregnancy in Brazilian Portuguese. *BMC Pregnancy Childbirth.* 2016; 16:244. [PubMed: 27557860]

94. Habib MA, et al. Prevalence and determinants of unintended pregnancies amongst women attending antenatal clinics in Pakistan. *BMC Pregnancy and Childbirth*. 2017; 17(1):156. [PubMed: 28558671]
95. Almaghaslah E, Rochat R, Farhat G. Validation of a pregnancy planning measure for Arabic-speaking women. *PLOS ONE*. 2017; 12(10):e0185433. [PubMed: 29059191]
96. Wellings K, et al. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Lancet*. 2013; 382(9907):1807–16. [PubMed: 24286786]
97. Goossens J, et al. The prevalence of unplanned pregnancy ending in birth, associated factors, and health outcomes. *Hum Reprod*. 2016; 31(12):2821–2833. [PubMed: 27798048]
98. Bankole A, Westoff CF. The consistency and validity of reproductive attitudes: evidence from Morocco. *J Biosoc Sci*. 1998; 30(4):439–55. [PubMed: 9818553]
99. FP2020 Partnership in Action 2012-2013. *Family Planning 2020 Core Indicators*. 2013
100. Centers for Disease Control and Prevention. Reproductive Life Plan Tool for Health Professionals. 2010. Available from: <https://www.cdc.gov/preconception/rlptool.html>
101. Rocca CH, G H, Barar R, et al. Desire to Avoid Pregnancy (DAP) Scale: A new psychometric instrument to measure prospective pregnancy preferences. *North American Forum on Family Plannings*. 2016

Key messages

Health before conception is strongly linked to the outcome of pregnancy; life course research pin-points the preconception period as critical for health across generations.

The preconception period should be redefined according to: a) the biological perspective - days to weeks before embryo development b) the individual perspective - a conscious intention to conceive, typically weeks to months before pregnancy occurs c) the public health perspective - longer periods of months or years to address preconception risk factors such as diet and obesity

Many women of reproductive age, in HIC as well as LMIC, will not be prepared nutritionally for pregnancy.

Micronutrient supplementation starting in pregnancy can correct important maternal nutrient deficiencies and dietary interventions in pregnancy can limit weight gain, but they are 'too little, too late' to fundamentally improve child health and pregnancy outcomes respectively.

The preconception period presents a period of special opportunity for intervention; the rationale is based on life course epidemiology, developmental (embryo) programming around the time of conception, maternal motivation and disappointment with interventions starting in pregnancy.

Better measurement shows that pregnancy planning is more common than previously recognised, in both LMIC and HIC.

Identifying people contemplating pregnancy provides a window of opportunity to improve health before conception, while population-level initiatives to reduce the determinants of preconception risks, such as obesity and smoking, irrespective of pregnancy planning, are essential to improve outcomes.

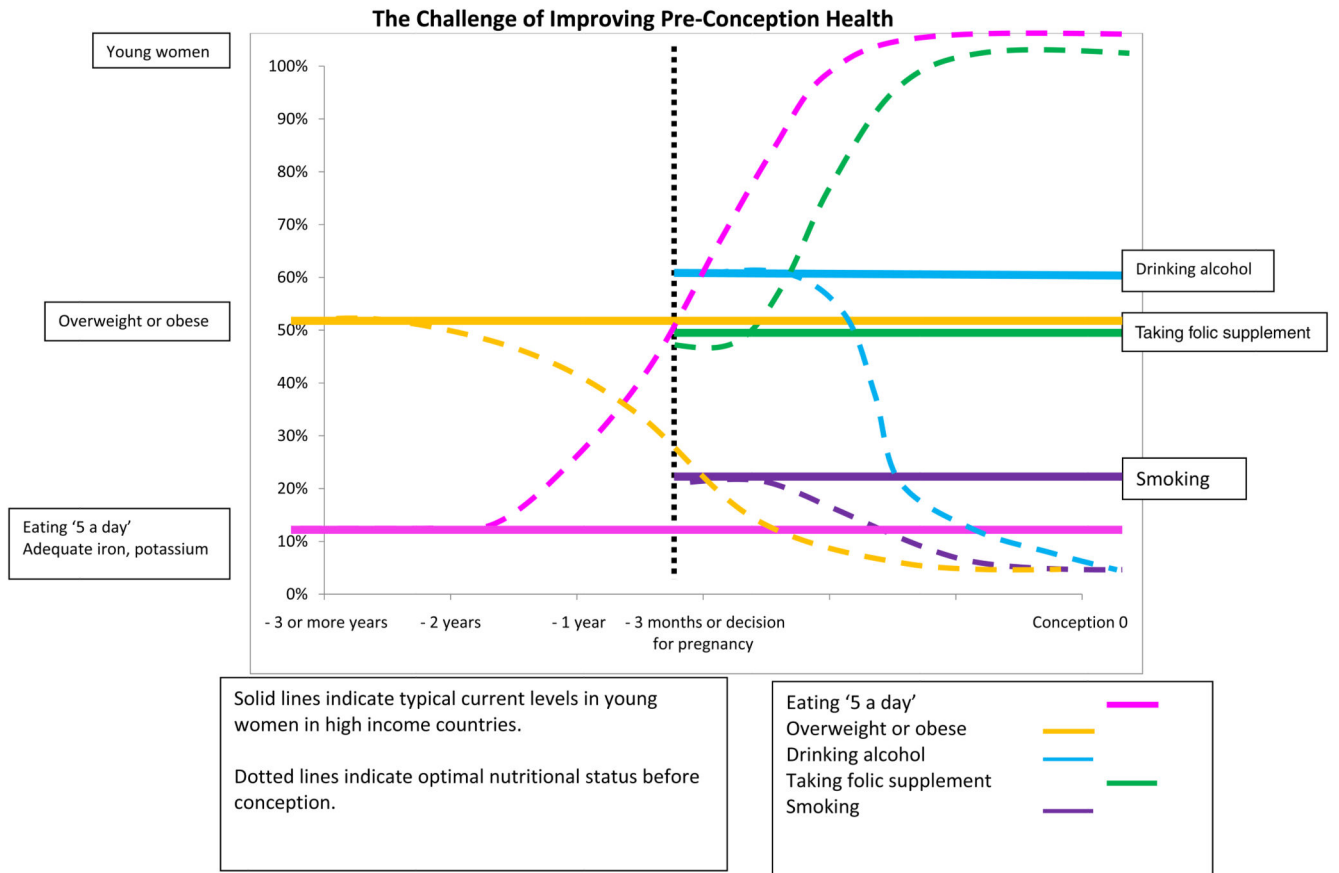
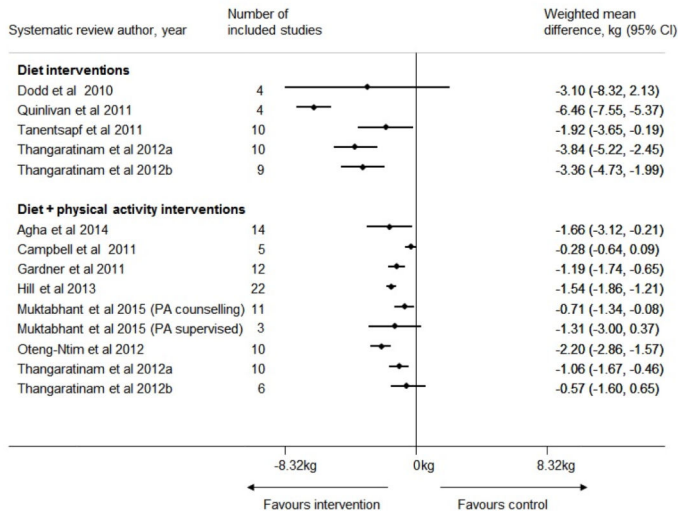
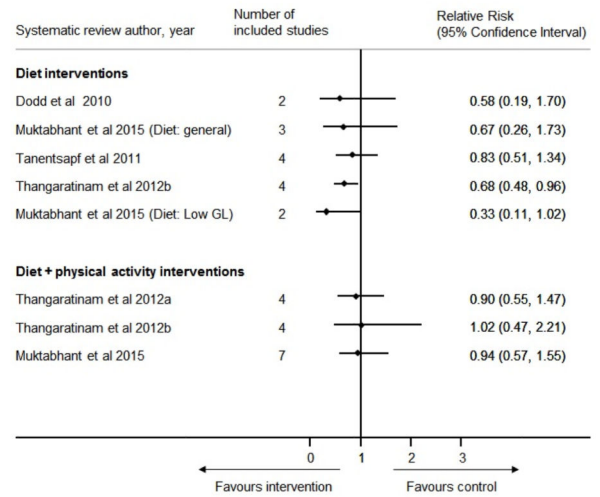


Figure 1.
A conceptual diagram of the challenge of improving preconception health.

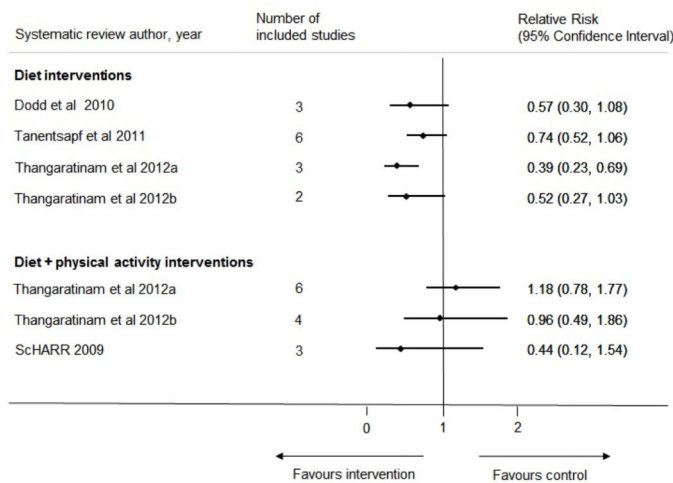
Gestational Weight Gain



Preterm Birth



Gestational Diabetes Mellitus



Preeclampsia

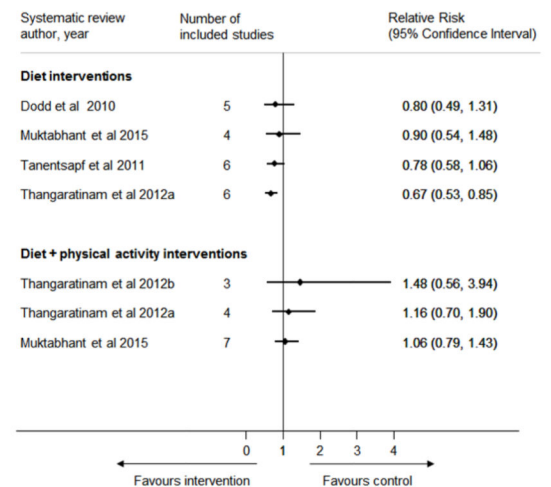


Figure 2. Forest plots of reported meta-analyses in systematic reviews of the effect of dietary behaviour change interventions (with or without physical activity elements) in pregnant women on gestational weight gain, pre-term birth, gestational diabetes and preeclampsia. A summary estimate has not been generated because some intervention studies are included in more than one meta-analysis.

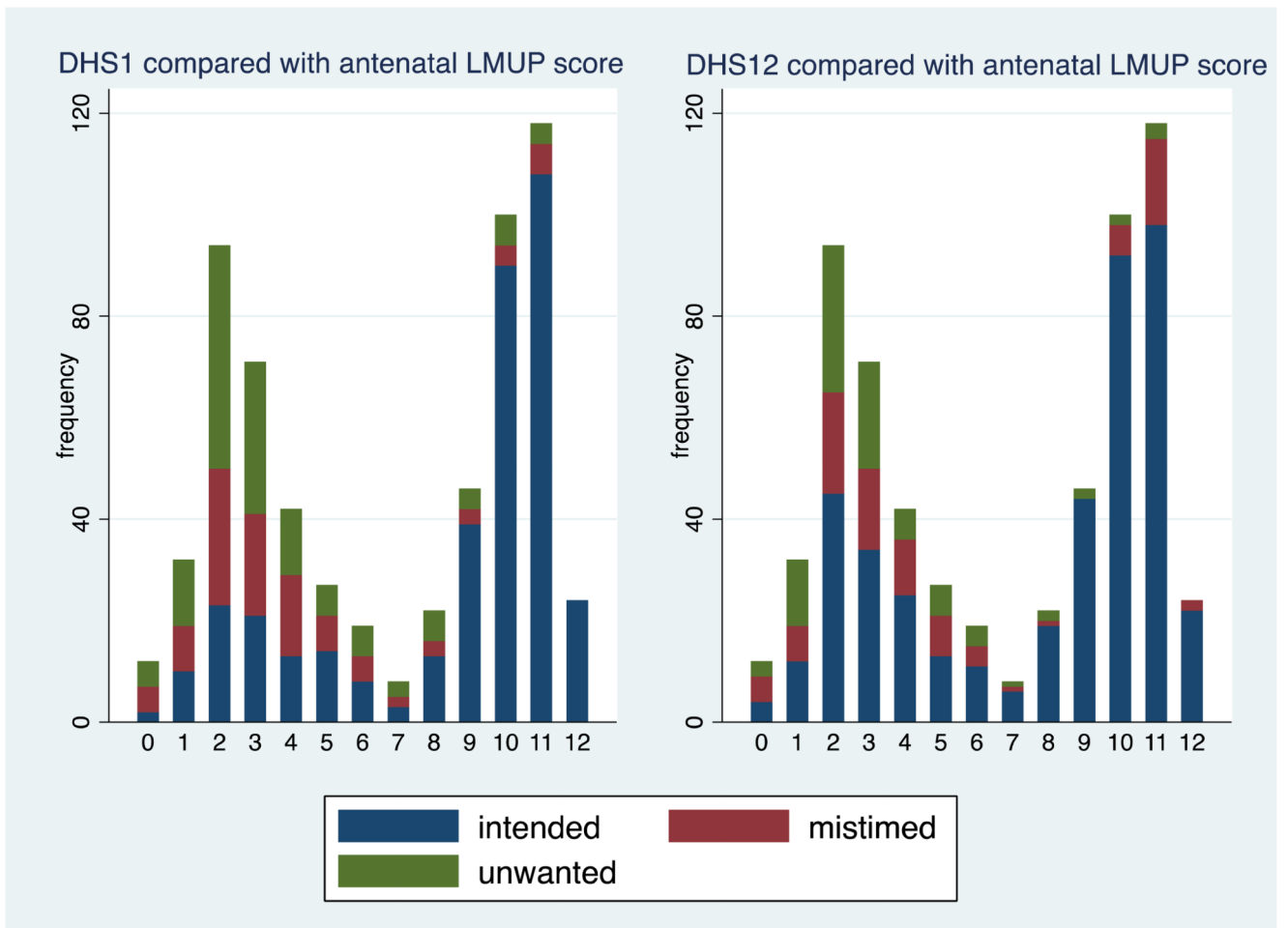


Figure 3. Comparison of women's antenatal LMUP score (0-12) with their response to the DHS question completed at least one (DHS1) and at least 12 (DHS12) months after birth

Table 1
Dietary intake and lifestyle characteristics of women of reproductive age in the ALSWH and UK NDNS

ALSWH ¹	All women (N) ²				Preconception characteristics ³				P-value ⁴			
	Survey1 Age 18-23 (7863)	Survey 7 Age 37-42 (6981)	Age 18-25 (544, 17.4%)	Age 26-30 (1293, 41.5%)	Age at first birth (N,%) Age 31-35 (1024, 32.8%)	Age 36-42 (257, 8.2%)						
BMI, mean (SD)	22.8 (4.1)	26.8 (6.4)	23.4 (4.7)	23.9 (4.4)	24.3 (4.5)	25.2 (5.6)	<0.0001					
Overweight/obese, %	21.3	52.2	27.1	30.8	34.6	39.7	0.02					
F&V (<5 serves/day), %	91.9	91.0	..	91.9	92.5	86.5	0.13					
Physical activity (<30 mins/day), %	38.8	45.0	52.0	38.9	34.4	41.9	<0.0001					
Current smoker, %	28.4	10.5	28.0	18.6	13.4	14.3	<0.0001					
High risk alcohol intake [*] %	5.3	6.9	3.2	3.6	4.9	7.1	0.008					
UK NDNS RP (2008/2012) ⁵												
Non-pregnant women of reproductive age												
	Total (N) (509)			Age at survey (N,%) Age 26-30 (79, 19%)			Age 31-35 (102, 18%)			Age 36-42 (172, 31%)	P-value ⁴	
BMI (SD)	26.0 (6.7)			25.1 (5.4)			25.3 (5.2)			26.7 (6.2)	27.7 (6.3)	0.1
Overweight/obese, %	49 (43, 54)			41 (32, 51)			40 (29, 53)			49 (38, 60)	62 (54, 70)	0.004
F&V (<5 serves/day), %	77 (73, 81)			91 (84, 95)			70 (56, 80)			70 (60, 79)	72 (63, 79)	0.003
Current smoker, %	26 (22, 30)			33 (25, 43)			22 (14, 33)			20 (13, 29)	24 (17, 31)	0.2
High risk alcohol intake ⁶ % (95% CIs)	22 (18, 26)			28 (19, 38)			16 (9, 26)			12 (7, 20)	25 (19, 33)	0.03
Vitamins	LNRI ⁷ Percentage (95% CIs) with diet only intakes below Lower Reference Nutrient Intakes (LRNIs)											
Vitamin A	250 µg/d 7 (5, 9)			12 (8, 19)			5 (5, 14)			2 (1, 4)	5 (3, 10)	0.002
Vitamin B12	1.0 µg/d 2 (1, 3)			4 (2, 8)			0			1 (0, 3)	1 (0, 6)	0.1
Folate	100 µg/d 4 (3, 7)			8 (4, 13)			1 (0, 6)			0 (0, 2)	5 (2, 9)	0.003
Riboflavin	0.8 mg/d 14 (11, 18)			22 (15, 32)			11 (6, 20)			9 (5, 15)	11 (7, 17)	0.03
Minerals												
Calcium	400 mg/d ⁸ 9 (7, 12)			13 (9, 20)			6 (3, 14)			6 (3, 12)	9 (5, 14)	0.2

Iodine	70µg/d	15 (11, 19)	22 (15, 31)	13 (7, 23)	7 (4, 14)	11 (7, 18)	0.02
Iron	8.0mg/d	30 (25, 34)	38 (29, 47)	26 (17, 37)	23 (16, 32)	27 (21, 35)	0.09
Potassium	2000mg/d	29 (25, 34)	41 (32, 51)	26 (17, 38)	19 (12, 28)	25 (19, 33)	0.003
Selenium	40µg/d	51 (47, 56)	57 (47, 66)	37 (26, 49)	52 (42, 62)	54 (46, 61)	0.08
Zinc	4mg/d	4 (3, 7)	6 (3, 11)	3 (1, 9)	4 (2, 9)	4 (2, 9)	0.7

¹The Australian Longitudinal Study on Women's Health (ALSWH) is a population-based study of women born in 1973-78 who have been surveyed every 3-4 years since 1996 (age 18-23 years) [5]

²All women including women who have not given birth

³Preconception characteristics shown in the table were reported at the survey prior to the first pregnancy (up to three years).

⁴For comparison across age groups

BMI = Body mass index, F&V = Fruit and vegetable consumption

⁵UK National diet and Nutrition Survey Rolling Program (NDNS RP) (2008/2012) years 1-4 [9]. Means (SD) and percentages (95%CI) are weighted to provide nationally representative results.

⁶Over 6 units of alcohol in one drinking occasion in the previous 7 days

⁷Micronutrient Lower Reference Nutrient Intake (LRNI) are those recommended for the UK in COMA, 1991 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/547050/government_dietary_recommendations.pdf

⁸LRNI Calcium is different for age 18 =450mg/d

* Three or more standard drinks (10g alcohol) on 5 or more days per week

Table 2

Relative risk of diet and lifestyle behaviours according to pregnancy intention in the ALSWH and SWS cohorts¹

Risk factors	ALSWH Cohort ²			SWS Cohort ³			
	Using contraception or no male sexual partner N=6256 (77%)	Trying for pregnancy N=536 (7%)	Not using contraception N=1285 (15.9%)	Not planning pregnancy and not pregnant N=9932 (80%)	Unintended pregnancy N=301 (2%)	Intended pregnancy N=584 (5%)	Planning a pregnancy but not pregnant N=1623 (13%)
Smoking (yes vs no)	1.00	0.84 (0.76, 0.93)	1.09 (1.01, 1.18)	1.00	1.15 (1.00, 1.33)	0.72 (0.61, 0.83)	0.89 (0.82, 0.96)
Alcohol consumption (yes vs no)	1.00	0.70 (0.56, 0.87)	0.91 (0.77, 1.09)	1.00	1.01 (0.98, 1.05)	1.03 (1.01, 1.06)	0.99 (0.97, 1.00)
Fruit and vegetable consumption (<5 vs 5 serves per day)	1.00	1.01 (0.99, 1.03)	0.97 (0.96, 0.99)	1.00	1.05 (0.94, 1.17)	0.94 (0.85, 1.03)	0.97 (0.92, 1.03)
Physical activity (<30 vs 30 minutes per day)	1.00	1.06 (1.01, 1.11)	1.14 (1.09, 1.18)	1.00	0.98 (0.85, 1.13)	1.10 (1.00, 1.21)	1.13 (1.07, 1.20)
Body mass index (<25 vs <25 kg/m ²)	1.00	1.05 (1.00, 1.10)	1.16 (1.12, 1.21)	1.00			
Caffeine consumption (>300mg caffeine per day)				1.00	1.15 (1.01, 1.31)	0.89 (0.79, 0.99)	0.94 (0.88, 1.01)

¹ All analyses are relative risks and 95% confidence intervals estimated using Poisson regression with robust variance, adjusted for maternal age, level of educational attainment and parity. Statistically significant results ($P < 0.05$) are highlighted in bold.

² The Australian Longitudinal Study on Women's Health (ALSWH) is a population-based study of women born in 1973-78 who have been surveyed every 3-4 years since 1996 (age 18-23 years) [5]. ALSWH women who indicated they or their partner cannot have children were excluded from analysis. N was taken from Survey 3, which was the first survey where women were asked about pregnancy intention.

³ The Southampton Women's Survey (SWS) recruited 12,583 non-pregnant women aged 20-34 years between 1998 and 2002 [6, 7]. When not pregnant, SWS women were asked whether they anticipated trying for a baby within the following year. Data about pregnancy within a year were then used to define four groups of women: not planning pregnancy and not pregnant, unintended pregnancy, intended pregnancy, and planning a pregnancy but not pregnant.