NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Equality and health inequalities assessment (EHIA)

Contents

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NICE guidelines

Equality and health inequalities assessment (EHIA) template

Headaches in over 12s: diagnosis and management

The considerations and potential impact on equality and health inequalities have been considered throughout the guidance development, maintenance and update process according to the principles of the NICE equality policy and those outlined in Developing NICE guidelines: the manual.

This EHIA relates to:

Headaches in over 12s: diagnosis and management

STAGE 1. Surveillance review EHIA

Date of surveillance review EHIA: May 2024

Focus of surveillance review: headaches in over 12s: diagnosis and management (NICE guideline CG150)

The surveillance team conducted an EHIA in 2024. The EHIA is an ongoing document. The following equality and health inequality issues were identified:

1. Topiramate is teratogenic, so cannot be used in pregnancy or for women who may become pregnant. This could make it difficult for women of childbearing age to access prophylactic treatment for migraine. In June 2024, the MHRA published a Drug Safety Update on topiramate, stating that topiramate should not be used for migraine prophylaxis in pregnancy, nor used in women of childbearing potential unless the conditions of the Pregnancy Prevention Programme are fulfilled. NICE medicines advisers have already assessed the impact of this safety warning on the NICE guideline on Headaches in over 12s: diagnosis and management (CG150) and have amended the guideline accordingly. It was noted in a CG150 surveillance report (April 2025) that a topic expert highlighted that the use of topiramate in women of childbearing potential has been associated with developmental disorders and should be discouraged.
2. Potential challenges were noted for trans people receiving gender-affirming hormone therapy, which may interact with an underlying susceptibility to migraine.
3. Migraine disproportionately affects women and is often associated with affective disorders; however, women frequently receive a lower standard of care than might be expected.
4. Headaches are difficult to assess and diagnose in children with neurodisabilities. Children with specific learning difficulties, anxiety, and depression are also at increased risk of primary headaches. It is important to note, however, that the guideline applies only to children aged over 12.

Surveillance documents can be accessed on the CG150 webpage.

Completed by surveillance reviewer: CM, technical analyst

Date: 14 May 2024

Approved by NICE surveillance associate director: KN, associate director

Date:18/05/2024

STAGE 2. Informing the scope

Headaches in over 12s: diagnosis and management

Date of completion: 05/04/2026

Focus of guideline or update: Pharmacological management of migraine with or without aura

2.1 Check existing EIAs or EHIAs at the very beginning of scoping (during early preparation stages). Note any equality and health inequality issues identified.
The items outlined here reflect: 1. The EHIA published with the guideline on Headaches in over 12s: diagnosis and management CG150 in 2015 Topiramate is teratogenic, so cannot be used in pregnancy or for women who may become pregnant. The committee highlighted the teratogenicity of topiramate in the recommendation as they felt that this was an important consideration when offering prophylactic medication, and recommended that women of child bearing age who are offered topiramate should also be offered contraception if needed. 2. The surveillance report conducted in 2016: Surveillance report 2016 – Headaches in over 12s: diagnosis and management (2012) NICE guideline CG150 An equality issue was raised by one topic expert, relating to people with severe and profound intellectual disability or communication disorders, who might not be able to give a clear history of or complain of headache. The NICE guidelines on learning disabilities highlight the challenges of identifying physical health issues in this population and provide relevant recommendations. 3. The findings of the surveillance team review of a previous EHIA conducted in 2024 for their surveillance review underpinning the decision to update CG150 (not currently published) Equality considerations were raised for transgender individuals receiving gender-affirming hormone therapy, as this treatment may interact with underlying susceptibility to migraine. Migraine disproportionately affects women and is often associated with affective disorders; these patients may also receive suboptimal care. In addition, children with neurodisabilities can be particularly challenging to assess and diagnose with headache. Those with specific learning difficulties, anxiety, or depression are also at increased risk of primary

headaches. However, it is important to note that the CG150 guideline applies only to children aged over 12.

4. An amendment of recommendation 1.3.17 about the use of propranolol, topiramate and amitriptyline in Headaches in over 12s: diagnosis and management (NICE guideline CG150)

   During the update of recommendation 1.3.17, some safety and patient-specific risks highlighted potential equality issues. Propranolol should be prescribed with caution, particularly in people with coexisting depression, due to the increased risk of harm in overdose. Topiramate must not be used for migraine prevention during pregnancy, or in women of childbearing age unless strict Pregnancy Prevention Programme conditions are met. When prescribing antidepressants such as amitriptyline, clinicians should follow guidance on safe use and withdrawal. Additionally, the use of topiramate and amitriptyline in children and young people is considered off-label (as of April 2025), and this should be considered when making prescribing decisions.

5. Our own review of the EIA/EHIA conducted for each technology appraisal guideline that this update of CG150 covers:

   a. TA973: Atogepant for preventing migraine

      Migraine is recognised as a disability under the Equality Act 2010, with higher prevalence in women and potential barriers to accessing treatment and specialist care. Atogepant may help improve access, particularly for people who have difficulty self-administering injectable Calcitonin Gene-Related Peptide (CGRP) monoclonal antibody treatments.

   b. TA906 Rimegpant for preventing migraine

      Migraine is more common in women than men and most frequently affects people aged 18 to 45 years. Some current treatments are not suitable during pregnancy due to safety concerns, and while there is no available data on rimegepant use in pregnancy, guidance advises avoiding it as a precaution. Access to specialist headache services in England is limited, with few centres and long waiting lists, potentially leading to unequal access, although this was not linked to protected characteristics. People in more deprived areas may experience greater impact from migraine, including disability and financial hardship, but the committee noted limited evidence for increased risk of disability and that such socioeconomic factors are not included in NICE's cost-effectiveness analyses.

   c. TA871: Eptinezumab for preventing migraine

Migraine is more common in women, particularly those of childbearing age. Eptinezumab, administered intravenously in a hospital setting, may improve access to specialist treatment for individuals who have difficulty self-injecting current CGRP inhibitor therapies.

d. TA764 Fremanezumab for preventing migraine

   Migraine is recognised as a disability under the Equality Act 2010, with higher prevalence in women and potential barriers to accessing treatment and specialist care.

e. TA682: Erenumab for preventing migraine

   Clinical and patient submissions emphasised that migraine may be considered a disability under the Equality Act 2010. They also highlighted that, as migraine is most prevalent among people of working age and affects more women than men, it may contribute to additional workplace disadvantage for women. In addition, concerns were raised about potential inequalities in access to specialist headache services.

f. TA659 Galcanezumab for preventing migraine

   Migraine may be considered a disability under the Equality Act 2010. Since migraine is most prevalent among people of working age and affects more women than men, it may contribute to additional workplace disadvantage for women. In addition, there may be potential inequalities in access to specialist headache services.

g. TA260 Botulinum toxin type A for the prevention of headaches in adults with chronic migraine)

   People with coexisting mental health conditions may face reduced access to appropriate care, while workplace discrimination can further disadvantage those living with migraine, though increased recognition in NICE guidance may help address this. Inequities also exist for people from ethnic minority backgrounds, particularly where language barriers make assessment tools and communication more difficult (for example, questionnaires such as the Migraine Disability Assessment (MIDAS) questionnaire). Migraine, especially chronic migraine, is more prevalent in women.

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2.2 What additional approaches have been used to identify potential equality and health inequalities issues during the check for an update or during development of the draft scope?
To explore the breadth of equality and health inequalities issues affecting the following sources were consulted: 1. Review of NICE Headaches in over 12s: diagnosis and management 2024 surveillance report and equality and health inequalities issues report 2. Relevant technology appraisal documents 3. Associated NICE prioritisation board health inequalities briefing 4. EHIA presented to the committee at a planning meeting (25th June 2026)

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2.3 What potential equality and health inequalities issues have been identified during the check for an update or during development of the draft scope?
The health inequalities experienced by people in the UK population are influenced by protected characteristics, socioeconomic status, geographic location, and inclusion health factors. Intersectionality compounds disadvantage across all groups. **1. Protected characteristics (Equality Act 2010)** Several migraine medicines have implications for protected characteristics, particularly pregnancy and maternity, gender reassignment, age, disability, sex, and race. With respect to pregnancy and maternity, both topiramate and candesartan are contraindicated in pregnancy due to risks of fetal harm, directly affecting women and others of child-bearing age. This raises significant equality considerations, including the need for reliable access to contraception, pregnancy testing and counselling, and may limit treatment options for those planning pregnancy or those who have difficulty accessing contraception, pregnancy testing, and related services. Consideration for transgender individuals receiving oestrogen containing hormone therapy should be, as this treatment may increase susceptibility to migraine. Age-related factors should be considered for amitriptyline, because elderly patients are particularly susceptible to many of the side-effects of tricyclic antidepressants, particularly psychiatric and cardiac side-effects. It was also noted that amitriptyline raises fall risk through several key side effects, including sedation, orthostatic hypotension, and anticholinergic effects which may impact older and frail individuals to a greater extent. Candesartan's potential to cause hypotension presents a risk of syncope and falls, which may disproportionately affect older and frail individuals. Due to licensing requirements for specialist use only, botulinum toxin type A may also disadvantage older

people who find regular hospital attendance more challenging due to mobility, transport or support needs.

Common or very common cognitive side effects of topiramate include memory loss and impaired attention and language skills, including word finding. These domains overlap with areas of difficulty commonly seen in people with learning disabilities or neurodivergent conditions, which may increase vulnerability to, or functional impact of, these adverse effects. Propranolol may worsen fatigue and depression, potentially affecting people with mental health conditions. Injectable therapies, including CGRP monoclonal antibodies, may also present barriers for people with physical or sensory impairments due to the manual dexterity, visual input, and device handling required for self-administration. These factors may reduce independence and make correct or consistent use more difficult without additional support. Linked to this a committee member at a planning and protocol meeting for this update (25th June 2026) highlighted that headache diaries are heavily relied upon to assess treatment effectiveness; however, their use may present a barrier to accessing treatment. The committee member highlighted that in their experience some neurodivergent individuals may experience difficulties in consistently completing headache diaries or accurately rating the severity of pain. Therefore, consideration should be given to ensuring that incomplete diary data, or a sole emphasis on reduction in migraine days, does not act as a barrier to accessing or continuing appropriate care.

Committee members highlighted more generally at a planning and protocol meeting for this update (25th June 2026), that from their experience people who are deaf and the Deaf community may experience issues regarding accessibility to healthcare and issues navigating the healthcare system. For example, there may be potential communication and history-taking difficulties at the point of diagnosis, since migraine assessment relies heavily on verbal symptom reporting. Accessibility of patient-facing materials, including instructions for self-administration of injectable prophylactic treatments, is also something that should be considered. In addition, compliance with the Accessible Information Standard, including the provision of British Sign Language (BSL) interpretation where required, is acknowledged as an important requirement.

Considerations should also be made related to race and ethnicity, where propranolol is contraindicated in asthma (see the EHIA for NICE guideline NG245 on Asthma: diagnosis, monitoring and chronic asthma management), a condition with higher prevalence in some ethnic groups and in urban or deprived populations. Other population groups at risk of poor asthma outcomes include people with cognitive impairment, learning disabilities, people with language and communication difficulties, and people with mental health difficulties. Caution should also be taken by patients of black African or African-Caribbean origin when using all angiotensin II receptor antagonists (for example, candesartan).

No equality issues were identified for marriage and civil partnership, religion or belief, or sexual orientation.

2. Socioeconomic deprivation

Socioeconomic factors influence both access to and experience of migraine treatments. A side effect of propranolol is reduced exercise capacity, which may disproportionately affect people in physically demanding jobs, who are more likely to be from lower socioeconomic groups.

Botulinum toxin type A requires regular twelve-weekly hospital appointments, which may be difficult for people on low incomes, those without flexible employment, or individuals who cannot easily take time off work. CGRP monoclonal antibodies are usually accessed through specialist pathways, meaning patients with greater health literacy or ability to navigate healthcare systems may benefit earlier, potentially widening inequalities linked to deprivation.

Candesartan is low cost and widely available, which may support equity compared with newer therapies; however, the requirement for blood testing and monitoring may be more burdensome for people experiencing socioeconomic deprivation, particularly where barriers such as indirect costs (e.g. transport and lost income), inflexible work patterns, limited health literacy, digital exclusion, and difficulties navigating healthcare systems reduce access to and engagement with primary care and phlebotomy services. Monitoring requirements are recognised to interact with polypharmacy and multimorbidity, which are more common in older and more deprived populations. Concomitant use of non-steroidal anti-inflammatory drugs (NSAIDs), potassium-sparing diuretics, or other antihypertensives may increase the risk of hyperkalaemia, renal impairment, and additive hypotension, thereby increasing both monitoring burden and safety risk. In addition, candesartan would be prescribed off-label for migraine. Off-label use is associated with additional consent and information requirements, which may disproportionately impact individuals with communication difficulties, language barriers, or lower health literacy.

3. Geographical area variation

Geographical variation is likely to impact access to all migraine treatments to a certain extent, but particularly for those medications requiring specialist services. CGRP monoclonal antibodies and botulinum toxin type A rely on access to neurology services, which may be less readily available in rural, coastal, or underserved regions, contributing to regional variation in treatment availability. Eptinezumab, which requires intravenous infusion, may further disadvantage people living far from infusion centres due to travel time and transport costs.

Botulinum toxin type A provision may vary considerably by region, leading to a postcode lottery in access.

Propranolol and candesartan are generally accessible through primary care, which may reduce geographical disparities, although local prescribing practices and clinician certainty of prescribing and optimising these medicines in people with migraine still influence availability.

4. Inclusion health and vulnerable groups

People from inclusion health groups may face additional barriers to accessing migraine treatments. Injectable therapies, including CGRP monoclonal antibodies and botulinum toxin type A, may be less suitable for people with unstable living circumstances or those in contact with the criminal justice system, where regular attendance and continuity of care are difficult to maintain.

Topiramate and candesartan require ongoing monitoring, which may be challenging for vulnerable migrants, people experiencing homelessness, or others with limited engagement with primary care services. Compared with injectable CGRP inhibitors, oral options such as atogepant may improve accessibility for some inclusion health groups by reducing reliance on specialist appointments and injections, although restricted access pathways may still limit uptake. Variability in diagnosis and referral may further disadvantage groups such as Gypsy, Roma and Traveller communities or young people leaving care, who already experience structural barriers to healthcare access.

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2.4 How can the identified equality and health inequalities issues be further explored and considered at this stage of the development process?
The approach to updating this guideline, using a review question and committee development, specialist topic advisers and clinical consultants, and a formal stakeholder consultation, will support ongoing consideration of equality and equitable access to services across the UK population. This process will enable the guideline development group to remain alert to potential inequalities in diagnosis, treatment access and service delivery, with particular attention to underserved and minoritised groups.

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2.5 Do you have representation from stakeholder groups that can help to explore equality and health inequalities issues during the consultation process including groups who are known to be affected by these issues? If not, what plans are in place to address gaps in the stakeholder list?

We will review the stakeholder list for this topic with a focus on equality and health inequalities assessment; the current list includes organisations representing:

1. **NHS organisations and healthcare providers**
   Alder Hey Children's NHS Foundation Trust, Barts Health NHS Trust, Belfast Health and Social Care Trust, Bradford District Care Trust, Central & North West London NHS Foundation Trust, City Health Care Partnership CIC, Croydon Health Services NHS Trust, Cumbria Partnership NHS Foundation Trust, East Midlands Ambulance Service NHS, Great Ormond Street Hospital, Guy's and St Thomas' NHS Foundation Trust, Hillingdon Hospital NHS Trust, Hull and East Yorkshire Hospitals NHS Trust, National Hospital for Neurology & Neurosurgery, Norfolk and Norwich University Hospitals NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, Northern Health and Social Care Trust, Oxford University Hospitals NHS Foundation Trust, Plymouth Hospitals NHS Trust, Salford Royal, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, South East Coast Ambulance Service, South Eastern Health and Social Care Trust, South London & Maudsley NHSFT, South West Yorkshire Partnership NHS Foundation Trust, Southern Health & Social Care Trust, St George's University Hospitals NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, The Walton Centre NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, University Hospital Of South Manchester NHS Foundation Trust, University Hospitals Birmingham NHS Foundation Trust, Western Health and Social Care Trust.

2. **Professional bodies, Royal Colleges, and clinical associations**
   Academy of Medical Royal Colleges, Association of Ambulance Chief Executives, Association of Anaesthetists of Great Britain and Ireland, Association of British Neurologists, Association of Chartered Physiotherapists interested in Vestibular Rehabilitation, British Dental Industry Association, British Infection Association, British Medical Acupuncture Society, British Medical Association, British Nuclear Cardiology Society, British Pain Society, British Psychological Society, British Society of Neuroradiologists, British Thoracic Society, College of Optometrists, College of Paramedics, Faculty of Pharmaceutical Medicine, Federation of Ophthalmic and Dispensing Opticians, Joint Royal Colleges Ambulance Liaison Committee, Primary Care and Community Neurology Society, Primary Care Pharmacists Association, Royal College of Anaesthetists, Royal College of Chiropractors, Royal College of General Practitioners, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Royal College of Ophthalmologists, Royal College of Paediatrics and Child Health, Royal College of Pathologists, Royal College of Physicians, Royal College of Psychiatrists, Royal College of Radiologists, Royal College of Speech and Language Therapists, Royal College of Surgeons of

Edinburgh, Royal College of Surgeons of England, Royal College of Pharmacy, Royal Society of Medicine, Scottish Clinical Virology Consultants Group, Society of British Neurological Surgeons.

3. **Government and public sector bodies**
   Care Quality Commission, Department of Health - Northern Ireland, Department of Health and Social Care, Healthcare Improvement Scotland, Healthcare Quality Improvement Partnership, Medicines and Healthcare products Regulatory Agency (MHRA), Ministry of Defence, NHS England, NHS England - Digital Clinical Informatics, NHS England - Genomics Unit, NHS Health at Work, NHS Leeds clinical commissioning group (CCG), Public Health Wales, Scottish Intercollegiate Guidelines Network, UK Health Security Agency, Welsh Government.

4. **Universities, research, and academic organisations**
   BMJ Technology Assessment Group, Children's Brain Tumour Research Centre, King's College London, National Center for Biotechnology Information, National Council for Osteopathic Research, National Institute for Health & Care Research, University of Warwick Medical School.

5. **Pharmaceutical, biotech, and medical technology companies**
   AbbVie, BHR Pharmaceuticals Ltd, DexCom International Ltd, Lanes Health, Medtronic, Novartis, Pfizer, Pharmametrics GmbH, Roche Diagnostics Limited, Sandoz Ltd, St Jude Medical UK Ltd., Tenscare Ltd.

6. **Charities, patient groups, and advocacy organisations**
   Cerebra, CIS'ters, Elcena Jeffers Foundation, Halton Fibromyalgia Support Group, Headache Clinics UK, Healthwatch Salford, Hypermobility Syndromes Association, Idiopathic Intracranial Hypertension UK, International Brain Tumour Alliance, International Neuromodulation Society, Meningitis Research Foundation, Migraine Trust, Muslim Doctors and Dentists Association, National Deaf CAMHS, National Deaf Children's Society, Pain Concern, Policy Connect.

7. **Primary care, local services, and smaller providers**
   Birley Health Centre, Castle Street Medical Centre, Cregagh Nursing Home, Ferndale Care Home, Integrity Care Services Ltd., Pharmicus - Gateshead CBC, Warrington Health Plus, Weybridge & Walton Physiotherapy.

8. **Complementary, alternative, and specialist practitioner organisations**
   Anglo European College of Chiropractic, Esoteric Practitioners Association UK/EU, General Hypnotherapy Register, NLSSM The School of Sports Massage, Welsh Institute of Chiropractic.

9. Other organisations Association of NHS Occupational Physicians, British Medical Journal, British National Formulary (BNF), British Paediatric Mental Health Group, Caplond Services, Ethical Medicines Industry Group, H & R Healthcare Limited, Hindu Council UK, Leeds South and East Clinical Commissioning Group, MIPCA, Paracetamol Information Centre, XCD Consulting Services T/A BrainTrainUK.

2.6 How will the views and experiences of those affected by equality and health inequalities issues be meaningfully included in the guideline development process going forward?
The guideline committee will reflect the diversity of people providing care for those affected by headache disorders and those who are experiencing headache disorders across the UK. Recruitment processes will be adapted as needed to support this, including working with the people and communities team and the topic adviser to ensure adverts reach a wide range of groups and are accessible in format. Lay members will be recruited to the committee to ensure diverse perspectives are represented. Equality, diversity and inclusion will be a standing consideration throughout committee discussions. Views from a range of stakeholders will be considered during stakeholder consultation.

2.7 If applicable, what questions will you ask at the draft scope stakeholder consultation about the guideline/update and potential impact on equality and health inequalities?
1. Are there additional equality or health inequalities issues we should consider?

2.8 Has it been proposed to exclude any population groups from the scope? If yes, how do these exclusions relate to any equality and health inequalities issues identified?
Young people under 12 years will not be included in this guideline update because puberty plays an important role in how headaches develop and present. Headache patterns in young people aged 12 years and over may differ from those in younger children because of the hormonal and developmental changes associated with puberty, and includes girls after menarche.

Completed by topic team: Shalmali Deshpande and James Jagroo

Date: 06/07/2026

Approved by committee chair: Ana Filipa Semedo

Date: 06/07/2026

Approved by NICE CFG topic hub senior topic adviser: Sharon Swain

Date: 06/07/2026