NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality and health inequalities assessment (EHIA) template

Maternal and child nutrition

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:

Maternal and child nutrition

Appendix: equality and health inequalities assessment (EHIA)

NICE guideline NG247 on maternal and child nutrition

STAGE 1. Surveillance review

No surveillance review was conducted for this guideline.

STAGE 2. Informing the scope

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

2.0 Checking for updates and scope: before scope consultation (to be completed by the Developer and submitted with the draft scope for consultation)

2.1 Is the proposed primary focus of the guideline a population with a specific communication or engagement need, related to disability, age, or other equality consideration? If so, what is it and what action might be taken by NICE or the developer to meet this need? (For example, adjustments to committee processes, additional forms of consultation.)
We will consider how to engage with pregnant women who are harder to reach – for example teenage mothers or those who are not engaged in the NHS system due to cultural background, asylum seekers, or the inability to speak English, for example.

2.2 Have any potential equality issues been identified during the check for an update or during development of the draft scope, and, if so, what are they?
1. Lower socio-economic groups, those living in deprived areas, those experiencing food insecurity and economically vulnerable groups, such as young teenage mothers, refugees and asylum seekers. 2. Age related assumptions, in particular about young teenage mothers and older mothers

3. Women and parents with disabilities, including learning disabilities and other physical and mental health conditions 4. Women going through assisted conception 5. LGBTQ+ women and parents 6. Fathers and others with parental responsibility and partners of mothers 7. Children with developmental problems 8. Geographical variation e.g. places without adequate provision of primary care (outside cities). 9. Different outcomes for some black and minority ethnic groups (e.g. BMI measures) 10. Take account of religious and cultural considerations within the recommendations.

2.3 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee?
1. We will consider the evidence about different outcome measures for some black and minority ethnic groups (e.g. BMI measures) 2. We will look for evidence about interventions that particularly support women, parents, fathers, children and families from lower socio-economic groups, those experiencing food insecurity and economically vulnerable groups. 3. We will make sure the recommendations tackle age related service assumptions, especially around young teenage mothers and older mothers. 4. The recommendations should reflect the diverse circumstances in which women experience pregnancy and weight management issues including religious and cultural considerations, existing physical and mental health conditions, LGBTQ+ women and parents, experience of assisted conception, geographical location and access to primary services. 5. The role or fathers and partners should be considered in the reviews about early years child nutrition and the continuation of breast feeding.

Completed by Developer _Lisa Boardman___(Guideline Lead) _____

Date_____28th September 2021_____

Approved by NICE quality assurance lead _____Nichole Taske, Guideline Lead

Date_____29th September 2021____

STAGE 3. Finalising the scope

See Equalities impact assessment on guideline website.

3.0 Checking for updates and scope: after consultation (to be completed by the Developer and submitted with the revised scope)

3.1 Have any potential equality issues been identified during consultation, and, if so, what are they?
1. A number of stakeholders raised the issue of vitamin supplementation and dietary advice for people with particular long term conditions. We were also asked to review on what basis we were excluding women with diabetes, epilepsy and HIV. The scoping group discussed these issues and noted that the guideline could not cover specific recommendations for women and children who have been advised to follow a particular diet for control of a medical condition e.g. diabetes. However all these groups will now be included in evidence reviews around advice, information and support and there will be some scope to make specific recommendations for some groups where evidence is available and where the committee feels this is important, but again these will not focus on particular medical interventions e.g. folic acid or vitamin dosage. Where available the guideline will link to specific recommendations in NICE or government advice relevant for these groups. 2. Several stakeholders referenced evidence showing a correlation between socio-economic circumstances and malnutrition, including underweight and overweight. We have already included this in the equality considerations. 3. Several stakeholders wanted us to consider age, ethnicity and socioeconomic status particularly in relation to diet in pregnancy and breastfeeding advice. We had already noted these groups. We will consider within the specific reviews. 4. The impact of employment status on employment rights for breastfeeding mothers was mentioned and this can be picked up within the protocol of the relevant review about workplace interventions to support breastfeeding – but as it is not strictly an equalities consideration and is specific only to one review it has not been added to the scope. 5. Pre-pregnancy BMI was mentioned, and in the context of obesity or problems with underweight as a long term health condition, this may be something that can be considered in the evidence reviews.

3.2 Have any changes to the scope been made as a result of consultation to highlight potential equality issues?
In relation to point 1 above, the scope section on "Areas that will not be covered by this update" was amended to include: *"Specialist dietary interventions for women and children following a specific diet for a medical condition."* In relation to point 2 and 4 above we have been clearer about the coverage of both underweight and overweight" *"We will give specific consideration to women who are underweight, overweight or obese during pregnancy"*

3.3 Have any of the changes made led to a change in the primary focus of the guideline which would require consideration of a specific communication or engagement need, related to disability, age, or other equality consideration? If so, what is it and what action might be taken by NICE or the developer to meet this need? (For example, adjustments to committee processes, additional forms of consultation)
No

Updated by Developer _____ Lisa Boardman_(Guideline Lead)_____

Date_17th November 2021_____

Approved by NICE quality assurance lead _____Nichole Taske _____

Date_____24th December 2021_____

STAGE 4. Development of guideline or topic area for update

(to be completed by the developer before consultation on the draft guideline or update)

Maternal and child nutrition

Date of completion: 8/4/2024

Focus of guideline or update: maternal and child nutrition

4.1	From the evidence syntheses and the committee's considerations thereof, what were the main equality and health inequalities issues identified? Were any **further** potential issues identified (in addition to those identified during the scoping process) or any gaps in the evidence for any particular group?

1) *Protected characteristics outlined in the Equality Act 2010*

Age

Children up to 5 years are a focus of the guideline.

Experiences of young pregnant women/people or parents came up in the qualitative evidence on the uptake of government advice on folic acid and vitamin supplementations (see The committee's discussion and interpretation of the evidence in evidence review P) and on healthy eating in pregnancy (see The committee's discussion and interpretation of the evidence in evidence review Q).

Some evidence review protocols included age as a stratification criteria but no evidence was identified that would have allowed stratification by age (evidence reviews C, I, N, O) so the available evidence did not provide any information on equality issues based on age.

Some evidence review protocols included age as a subgroup analysis criteria, in case heterogeneity was observed in the outcomes across studies (evidence reviews A, D, J) but such data was not available or this was not required (because no heterogeneity was observed).

Disability

Some evidence review protocols included disability as a subgroup analysis criteria, in case heterogeneity was observed in the outcomes across studies (evidence reviews A, B, C, D, E, G, H, N, O) but such data was not available or this was not required (because no heterogeneity was observed). While disability did not come up in the evidence the committee acknowledged the need to consider people's level of understanding when having discussions, including considering people with learning disabilities.

Gender reassignment
Some evidence review protocols included 'LGBTQ+' as a subgroup analysis criteria, in case heterogeneity was observed in the outcomes across studies (evidence reviews C, D, E, G, H) but such data was not available or this was not required (because no heterogeneity was observed).
In theory, there is a possibility that the interventions in a small number of evidence reviews (such as folic acid or vitamin D dose) could have a different effect for, for example, trans men who have undergone hormonal gender affirming treatment compared to cis women without such treatments. However, we do not know whether this is the case. Generally, the evidence review searches were not designed to look for evidence specifically on trans men or non-binary people who are pregnant, who have given birth or who are breastfeeding and therefore there is a small chance relevant evidence among these groups could have been missed, if such evidence exists. Regardless, the guideline uses inclusive language in the recommendations. This is discussed in the relevant evidence reviews (see Other factors the committee took into account in evidence reviews A, B, C, D, E, F, G, H, I, J, K, M, P, Q).

Pregnancy and maternity
Focus of the guideline.

Race
Some evidence review protocols included ethnicity as a stratification criteria but no evidence was identified that would have allowed stratification by ethnicity (evidence reviews D, E, F) so the available evidence did not provide any information on equality issues based on ethnicity.
Some evidence review protocols included ethnicity as a subgroup analysis criteria, in case heterogeneity was observed in the outcomes across studies (evidence reviews A, B, C, G, H, I, N, O) but such data was not available or this was not required (because no heterogeneity was observed).
The increased risk of vitamin D deficiency in people with darker skin was discussed by the committee and health economic evidence was identified on this (see evidence review E).
Some studies were conducted among ethnic minority women although the issue of race in itself was not the focus. For example, there was qualitative evidence among Pakistani women on the facilitators and barriers of uptake of government advice on healthy eating in pregnancy (see The committee's discussion and interpretation of the evidence in evidence review Q).

Religion or belief
Some evidence review protocols included 'religion and cultural considerations' as a subgroup analysis criteria, in case heterogeneity was observed in the outcomes across studies (evidence e reviews A, B, D, F, I, N, O) but such data was not available or this was not required (because no heterogeneity was observed).

Religion or belief was discussed within the wider context of considering the person's or family's individual needs and circumstances and being culturally sensitive.

Sex
The population of interest is largely women, although some may not identify as women. Furthermore, some of the reviews included parents and carers, i.e. male and female parents or carers.

Sexual orientation
Some evidence review protocols included 'LGBTQ+' as a subgroup analysis criteria, in case heterogeneity was observed in the outcomes across studies (evidence reviews C, D, E, G, H) but such data was not available or this was not required (because no heterogeneity was observed).

2) *Socioeconomic deprivation (for example, variation by area deprivation such as Index of Multiple Deprivation, National Statistics Socio-economic Classification, employment status, income)*
Socioeconomic deprivation and disadvantage was a key consideration across almost every topic.
Some evidence review protocols included socioeconomic deprivation or status as a stratification criteria but very little evidence was identified that would have allowed stratification by socioeconomic deprivation or status (evidence reviews C, E, I, M, N, O).
Some evidence review protocols included socioeconomic deprivation as a subgroup analysis criteria, in case heterogeneity was observed in the outcomes across studies (evidence reviews A, B, F, G, H, J) but such data was not available or this was not required (because no heterogeneity was observed), except in evidence review J.
The effects of financial challenges, food insecurity and poverty on some families came up in the qualitative evidence reviews on uptake of government advice on folic acid and vitamin supplementations (see The committee's discussion and interpretation of the evidence in evidence review P), on introducing solids and healthy eating in children (see The committee's discussion and interpretation of the evidence in evidence review R) and on healthy eating in pregnancy (see The committee's discussion and interpretation of the evidence in evidence review Q and evidence review I). The committee were also interested in understanding the impact of food insecurity and poverty on safe and appropriate formula feeding practices but there was limited qualitative evidence on this (see The committee's discussion and interpretation of the evidence in evidence review L).
Level of socioeconomic deprivation and parental education were considered as stratification criteria in some of the evidence review protocols, however, evidence was limited.

3) *Geographical area variation (for example, geographical differences in epidemiology or service provision- urban/rural, coastal, north/south)*
Some evidence review protocols included geographical area variation as a subgroup analysis criteria, in case heterogeneity was observed in the outcomes across studies (evidence reviews C, D, E, F, I, N, O) but such data was not available or this was not required (because no heterogeneity was observed).
The variation in availability of some services across different areas was highlighted for some topics: breastfeeding support groups (see The committee's discussion and interpretation of the evidence in evidence review J), appointment or session at around 4-5 months after birth to discuss introduction of solids (see The committee's discussion and interpretation of the evidence in evidence review N) and cooking classes to gain skills and confidence in including healthy foods to diet (see The committee's discussion and interpretation of the evidence in evidence review Q and R).

4) *Inclusion health and vulnerable groups (for example, vulnerable migrants, people experiencing homelessness, people in contact with the criminal justice system, sex workers, Gypsy, Roma and Traveller communities, young people leaving care and victims of trafficking)*
The evidence reviews were not designed to look for evidence on these groups specifically. One evidence review included a study conducted among UK-based refugee mothers (evidence review L).
The committee discussed asylum seekers and families experiencing homelessness and living in temporary accommodation, particularly in relation to difficulties in taking up government advice on healthy eating in pregnancy in the absence of appropriate cooking facilities (see The committee's discussion and interpretation of the evidence in evidence review Q) and in children (see The committee's discussion and interpretation of the evidence in evidence review R). It was also highlighted that asylum seekers are not eligible for some benefits, such as the Healthy Start scheme (see The committee's discussion and interpretation of the evidence in evidence review I).

Other

When discussing facilitators and barriers to help continuation of breastfeeding when returning to work or study, the committee noted that there may be inequalities in relation to flexible working opportunities (which can facilitate continuation of breastfeeding) as many employers may not offer such opportunities or they are practically not feasible. Further inequalities may arise from differences in maternity pay packages which could lead to people returning to work early if the maternity pay is not sufficient, which can in turn jeopardise continuation of breastfeeding (see The committee's discussion and interpretation of the evidence in evidence review M).

4.2 How have the committee's considerations of equality and health inequalities issues identified in 2.2, 3.2 and 4.1 been reflected in the guideline or update and any draft recommendations?
The committee recognised that due to poverty, food insecurity and cost of living crisis, many people and families struggle to afford healthy foods, formula milk or vitamin supplements. Reference to Healthy Start scheme or other schemes or initiatives to improve access to healthy foods, drinks or supplements, or income schemes were reflected in the following recommendations: 1.1.3, 1.1.10, 1.1.12, 1.2.3, 1.3.14, 1.5.3, 1.5.7, 1.5.11, 1.5.12. The committee made a recommendation about vitamin D supplementation, highlighting that people who have darker skin, for example, people of African, African-Caribbean or south Asian ethnicity, are particularly at risk of vitamin D deficiency (recommendation 1.1.11). Furthermore, the committee recommended that commissioners and service providers offer free vitamin D supplements for those at increased risk of vitamin D deficiency (including the above groups) in recommendation 1.1.13. The committee agreed that it was important to highlight that information about importance of folic acid supplementation before and during pregnancy is available in young people's services (recommendation 1.1.1). Similarly, the committee agreed that the importance of vitamin supplementation during pregnancy and breastfeeding and for children should be discussed at opportunities such as visits to young people's services (recommendation 1.1.9). In recommendation 1.2.2 about the discussion around health eating in pregnancy, the committee agreed to highlight that discussion should include healthy food choices that are acceptable and available to the individual. Acceptability referring to ethnic or cultural preferences and availability referring to socioeconomic factors. In recommendation 1.2.3 about discussion around healthy eating in pregnancy, the committee agreed that additional support for young pregnant people and those from low income or disadvantaged backgrounds should be considered. In the same recommendation (1.2.3), the committee agreed that healthcare professionals should take into account affordability and people's resources when giving advice about a healthy diet and cooking. In recommendation 1.5.10 about healthy eating in children, the committee agreed that healthcare professionals should give particular consideration to children from low income or disadvantaged backgrounds. In recommendations 1.5.7 and 1.5.12, about discussion on introduction of solids and on healthy eating in children 1 to 5 years, respectively, the committee agreed that discussion

should include any concerns parents or carers might have about the cost of healthy food and where to get support.

Recommendation 1.2.7 about discussion on weight change in pregnancy includes a point about providing information about local and online sources of information and support, including self-management tools and materials, and the committee decided to highlight "particularly those that are free or low-cost" in the recommendation because they were aware that not everyone would be able to afford apps or other tools that cost.

More generally, the committee thought that healthcare professionals should give consideration for people's individual circumstances, needs or level of understanding when having discussions about different topics. This can relate to for example socioeconomic factors, age, disability, immigration or housing situation. This is reflected in the following recommendations: 1.1.3, 1.1.10, 1.2.3, 1.2.7, 1.3.4, 1.5.6, 1.5.10.

In recommendations 1.2.4 and 1.5.11, the committee recommends offering or referring people to cooking classes where people can gain skills and confidence in including healthy foods in their diet. Although not mentioned in the recommendations, this might be particularly relevant for young people or people with learning difficulties.

The guideline refers to the Equality Act 2010 in recommendations 1.3.2 and 1.3.9 in relation to the legal right to breastfeed in any public space.

4.3 Could any draft recommendations potentially increase inequalities?
No.

4.4 How has the committee's considerations of equality and health inequalities issues identified in 2.2, 3.2 and 4.1 been reflected in the development of any research recommendations?
Research recommendation on facilitators and barriers for safe and appropriate formula feeding in the context of poverty and food insecurity specifically focuses on socioeconomic deprivation. All research recommendations include ethnicity and socioeconomic factors as important equalities considerations. Research recommendation on high dose folic acid includes specific subgroups according to socioeconomic status and deprivation (using IMD), age and ethnicity.

Research recommendation on digital technologies to increase the uptake of folic acid supplementation includes specific subgroups according to age, socioeconomic status and deprivation (using IMD), geographical variation and ethnicity. Research recommendation on appropriate vitamin D dose during pregnancy for people with a BMI medically classified as overweight or obese includes specific subgroups according to ethnicity and socioeconomic status and deprivation (using IMD). Research recommendation on the dietary interventions to improve glycaemic control, maternal and baby outcomes for people with gestational diabetes includes specific subgroups according to ethnicity and socioeconomic status and deprivation (using IMD).

4.5 Based on the equality and health inequalities issues identified in 2.2, 3.2 and 4.1, do you have representation from relevant stakeholder groups for the guideline or update consultation process, including groups who are known to be affected by these issues? If not, what plans are in place to ensure relevant stakeholders are represented and included?
This guideline project has a very wide-ranging stakeholder list, however, we are asking the committee members to specifically check if any organisations are missing from the list and these organisations will be invited to register as stakeholders.

4.6 What questions will you ask at the stakeholder consultation about the impact of the guideline or update on equality and health inequalities?
Yes, the stakeholders will be asked if the committee should be aware of any other equalities and health inequalities issues that may impact the guideline.

Completed by developer _____Maija Kallioinen (Topic Lead) _____

Date_____08/04/24_____

Approved by committee chair ____Sarah Jefferies (Guideline Chair)

Date _____08/04/24_____

Approved by NICE quality assurance lead ___Sara Buckner (Senior Topic Adviser)_____

Date____08/04/2024_____

STAGE 5. Revisions and final guideline or update

(to be completed by the developer before guidance executive considers the final guideline or update)

Maternal and child nutrition

Date of completion: 24/10/2024

Focus of guideline or update: Maternal and child nutrition, including:

- folic acid supplementation before and during pregnancy
- vitamin supplementations during pregnancy, breastfeeding and in children
- breastfeeding and formula feeding beyond 8 weeks after birth
- introducing solid foods to babies aged 6 months to 1 year
- healthy eating in children aged 1 up to 5 years.

5.1 How inclusive was the consultation process on the draft guideline in terms of response from groups (identified in box 2.2, 3.2 and 4.1) who may experience inequalities related to the topic?
A total of 306 stakeholders are on the stakeholder list for this guideline, of which 35 responded to the consultation. These stakeholders represent national healthcare organisations, charities, groups representing those with lived experience, government departments, healthcare service providers, professional organisations, medical royal colleges, academic institutions and commercial sector. In addition, 4 individuals responded to the consultation. Quality of responses were generally very good and additional equality and health inequalities issues were raised which led to revisions in the final guideline.

5.2 Have any **further** equality and health inequalities issues beyond those identified at scoping and during development been raised during the consultation on the draft guideline or update, and, if so, how has the committee considered and addressed them?
Overall, various equalities issues were raised by the stakeholders during the consultation and the committee addressed these by revising some of the recommendations to more explicitly address these issues, where appropriate. Below we address these individually. *Protected characteristics outlined in the Equality Act 2010* *Age*

A stakeholder suggested to amend the research recommendation about digital intervention to increase update of folic acid saying “When referring to ‘to increase uptake’, we recommend adding ‘and reduce inequalities in uptake’.” The committee thought this would change the aim of the recommended research but reassured the stakeholder that subgroup analysis according to age, socio economic status and deprivation, comorbidities, geographical variation and ethnicity were recommended in the research recommendation.

Disability
A stakeholder commented that health professionals need to be sensitive to any eating difficulties or restricted eating that autistic people might have. The committee agreed to amend the recommendation around discussing healthy eating in pregnancy so that difficulties in eating are taken into account. (see recommendation 1.2.3)

A stakeholder commented that a child's disabilities (including hidden disabilities) should be taken into account when discussing approaches to feeding. The committee agreed to amend the recommendation around discussing healthy eating in children so that the child’s needs are taken into account. (see recommendation 1.5.9)

A stakeholder commented about the importance of being aware of reasonable adjustments from sensory issues that might arise from certain formulations of vitamins (tablet or liquid form preferred, taste etc). The guideline already addressed this by including ‘different formulations’ as a discussion point related to vitamin supplements during pregnancy, when breastfeeding and for children. (see recommendation 1.1.11)

A stakeholder commented about being aware of diagnostic overshadowing. “This occurs when the symptoms of physical ill health are mistakenly either attributed to a mental health or behavioural problem or considered inherent to the person’s learning disability or autism diagnosis. People with a learning disability or autism have the same illnesses as everyone else, but the way they respond to or communicate their symptoms may be different and not obvious.” This was not considered to be specific to this guideline and no changes to the guideline have been made based on this comment.

Gender reassignment
A stakeholder suggested that the guideline use inclusive language with respect to breastfeeding and chest feeding. NICE recognises that some people use the term ‘chest feeding’, however, in the guideline only the term breastfeeding is used because this is in line with the current NICE style. NICE is constantly researching and redeveloping its style guide to take into account developments in language from various sources, including stakeholder feedback. This comment has been forwarded to the team reviewing and updating the NICE style guide.

The same stakeholder also suggested to mention of induced lactation in the guideline which could be relevant to for example ‘AMAB parents’ (assigned male at birth). Induced

lactation has not been covered in this guideline and likely would require an evidence review to appropriately address issues around this so no changes were made based on this comment.

Pregnancy and maternity
A stakeholder commented that the recommendations about supporting breastfeeding when returning to work or study do not "go far enough to acknowledge the challenges of working/studying and breastfeeding" and that they would "like to see more acknowledgement that practically it can be very difficult to breastfeed at work/while studying even if the Equality Act says you have the right to do so and despite employers being in theory supportive". The committee agreed to amend the recommendation to be more explicit that the person's perceived challenges and potential solutions are discussed. (see recommendation 1.3.13)

Race
A stakeholder suggested that the context section would highlight that folic acid update is lowest among women from Black ethnic background. In response to this, we amended the text and added a reference to the study you where this is based on. According to the findings, the uptake of folic acid was lowest among Black women but it was also lower in other ethnic minority groups compared to white women so we have not singled out Black women and instead refer to people from minority ethnic backgrounds. (see Context section)

A stakeholder commented on the wording used in a recommendation in the draft guideline about advising people to take vitamin D supplements throughout the year if they are at increased risk of vitamin D deficiency because they "have darker skin, for example, people of African, African-Caribbean or south Asian ethnicity, because their bodies may not make enough vitamin D from sunlight". The stakeholder said the language used was "highly problematic" and "Nothing is fundamentally wrong with these bodies. Suggest change to reflect the UK setting/climate and consider more sensitive language." This is a valid point and the wording in the recommendation has been changed based on this comment. (see recommendation 1.1.12)

A stakeholder suggested to amend the research recommendation about digital intervention to increase update of folic acid saying "When referring to 'to increase uptake', we recommend adding 'and reduce inequalities in uptake'." The committee thought this would change the aim of the recommended research but reassured the stakeholder that subgroup analysis according to age, socio economic status and deprivation, comorbidities, geographical variation and ethnicity were recommended in the research recommendation.

In addition, race is not directly addressed, but ethnicity may relate to the following:
A stakeholder commented that they would like to see the guideline give practical tools and resources for professionals related to, for example, culturally-sensitive information and

support around healthy eating and breastfeeding where this is recommended (see recommendations 1.2.3, 1.3.8, 1.5.6, 1.5.11), such as “ideas for non-westernised foods that are suitable”. This was considered to be specific to local populations’ needs and should be determined locally so no changes were made to the guideline based on this comment.

Religion or belief
Not directly addressed but may relate to the following:
A stakeholder commented that they would like to see the guideline give practical tools and resources for professionals related to, for example, culturally-sensitive information and support around healthy eating and breastfeeding where this is recommended (see recommendations 1.2.3, 1.3.8, 1.5.6, 1.5.11), such as “ideas for non-westernised foods that are suitable”. This was considered to be specific to local populations’ needs and should be determined locally so no changes were made to the guideline based on this comment.

Sex
A stakeholder commented that the guideline has almost completely removed the term ‘woman’ and suggested to use additive language e.g. ‘woman and people…’. The guideline has been edited according to the current NICE style guide principles and uses neutral language where this is reasonable and additive language (women and people…) where needed. They also commented that the guideline scope states that “This guideline will use the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant or have given birth. Similarly, when the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby or child.” but this is not reflected in the guideline. The guideline scope was published in 2021 and some of the editorial and style principles have since changed.

Another stakeholder commented that the guideline should use gender-sensitive language, such as ‘anyone who is pregnant’ and state this applies regardless of their gender identity. The guideline uses gender-sensitive language throughout, we have not explained this further in the guideline.

Sexual orientation
None.

Socioeconomic deprivation (for example, variation by area deprivation such as Index of Multiple Deprivation, National Statistics Socio-economic Classification, employment status, income)
A stakeholder commented that the Healthy Start scheme “does not currently go far enough in addressing equitable access to vital vitamin supplementation for at risk groups and many of the at-risk groups during pregnancy are not eligible for the Healthy Start

voucher scheme or choose not to access it". A recommendation about providing free vitamin D for at risk groups was already in the guideline. (see recommendation 1.1.14)

A stakeholder commented that "This guideline points to healthy start as an answer for many of the issues around healthy eating and vitamins etc." and that the Healthy Start scheme "is simply not enough to resolve food insecurity for families with young children". The committee fully agree that the Healthy Start scheme is not enough to resolve food insecurity for families and young children and have tried to address these challenges in various parts of the guideline, while acknowledging that it is not within NICE's remit to change national policies. For example, the recommendations advice signposting to various government or local schemes for support (including the Health Start scheme) (see recommendations 1.1.3, 1.1.11, 1.2.3, 1.3.5, 1.3.18, 1.5.3, 1.5.6, 1.5.10, 1.5.11); recommendation on healthy eating in pregnancy include discussion about "healthy food and drink options that are acceptable and available for the person", recognising that cost of some foods may make them unavailable to people. (see recommendation 1.2.2) In the same section, the recommendation say that when discussing healthy eating in pregnancy, "take into account the person's needs and circumstances" and "consider additional support for young pregnant people and those from low income or disadvantaged backgrounds", and "take into account affordability and people's resources when giving advice about a healthy diet and cooking". (see recommendation 1.2.3) The recommendations on introducing solids include "take into account the family's circumstances and living conditions" (see recommendation 1.5.6) and discussion points include "the cost of healthy food and where to get support" (see recommendation 1.5.6). In the healthy eating in children section, the recommendations include "take into account the family's circumstances, and sensitively tailor the discussion and advice around healthy eating and drinking to the child's and family's needs, circumstances, preferences and understanding. Give particular consideration to children from low income or disadvantaged backgrounds, for example, by providing additional support for their families" (see recommendation 1.5.9) and recommended discussion points include "Concerns about the cost of healthy food and where to get support". (see recommendation 1.5.11)

A stakeholder commented that Healthy Start vitamins are low-cost and should be recommended for those who may not be eligible to get them for free. The committee amended the recommendations accordingly. (see recommendations 1.1.3 and 1.1.11)

A stakeholder commented that there are good reasons to monitor weight regularly throughout pregnancy, and particularly highlighted that "It may be especially important to identify where women are losing weight or failing to gain weight as this may indicate problems that can be addressed such as financial or social issues, mental health issues and appropriate referrals can be made." The committee's conclusion was that the evidence does support routine monitoring of weight during pregnancy, unless there is a clinical indication for this. No changes were made based on this comment.

A stakeholder commented that they were pleased to see a research recommendation on formula feeding in the context of poverty and food insecurity but that suggested the committee go further as "food insecurity is also a driver of maternal obesity, poor diet, and inadequate GWG…as well as gestational diabetes, poor mental health, dental problems". Poverty and food insecurity are addressed in various sections of the guideline (see stage 4 of the EHIA). Research recommendations should be based on topics that were directly reviewed for this guideline so no changes were made to the guideline based on this comment.

A stakeholder commented that the "Whilst mention has been made to the cost-of-living crisis in relation to formula feeding, the guidance does not address the unique needs of breastfeeding mothers, nor the impact of food insecurity on breastfeeding." The committee recognised the impact that poverty, cost-of living crisis and food insecurity can have on breastfeeding, although this was not something that came up in the qualitative evidence review about facilitators and barriers for continuing breastfeeding. They were also aware that breastfeeding rates are lowest in the most disadvantaged populations groups. The committee added a recommendation about being aware that parents from a low income or disadvantaged background may need more support to continue breastfeeding, and healthcare professionals should also signpost to government and local schemes that can offer advice and help to access healthy food and drinks and income support schemes. (see recommendation 1.3.5)

A stakeholder commented on a draft recommendation that talked about how "supplementing with formula milk compromises breast milk supply". They said "the relationship is likely bidirectional and influenced by a number of factors. In addition, many of the observational studies are cross sectional and confounded by factors such as maternal socioeconomic status, marital status, household income and education." The committee did not review evidence on this topic for this guideline update but used their expertise when drafting the recommendation. However, based on various other stakeholder comments on the section on breastfeeding and formula feeding, the recommendation wording was amended so that the focus of discussion with parents is providing encouragement to sustain breastfeeding and advising about how they can maintain their breast milk supply. (see recommendations 1.3.3 and 1.3.17)

A stakeholder suggested to amend the research recommendation about digital technologies to increase update of folic acid saying "When referring to 'to increase uptake', we recommend adding 'and reduce inequalities in uptake'." The committee thought this would change the aim of the recommended research but reassured the stakeholder that subgroup analysis according to age, socio economic status and deprivation, comorbidities, geographical variation and ethnicity were recommended in the research recommendation.

Another stakeholder also commented on the research recommendation about digital technologies to increase update of folic acid, they recommended changing it to 'Approaches to increase uptake..'. They said that "Focusing only on digital technologies may increase inequalities for those who experience digital exclusion and/or have low literacy levels.". The committee specifically wanted to focus the research on digital technologies because in the evidence reviewed for this guideline, no evidence was available on digital technologies whereas there was evidence available for other approaches. The committee agreed that further research in this area was particularly important as it is becoming more common in healthcare services, and this would help inform future updates of this guideline. The impact of social differences (e.g. age, socio economic status, geography etc.) on digital technologies would be explored with subgroup analysis in the research, this has been captured in the research recommendation.

Geographical area variation (for example, geographical differences in epidemiology or service provision- urban/rural, coastal, north/south)
A stakeholder commented that cookery classes or groups (given as examples in the guideline of interventions that can improve people's skills and confidence in healthy eating) are not currently available. Based on the committee's knowledge, these types of services are available in some areas but recognised that there may be geographical variation in the availability of these. This was already acknowledged in the Stage 4 of the EHIA and in the committee's discussion sections but this has now been even more explicit and added to the 'How the recommendations may affect practice' sections.

A stakeholder suggested to amend the research recommendation about digital intervention to increase update of folic acid saying "When referring to 'to increase uptake', we recommend adding 'and reduce inequalities in uptake'." The committee thought this would change the aim of the recommended research but reassured the stakeholder that subgroup analysis according to age, socio economic status and deprivation, comorbidities, geographical variation and ethnicity were recommended in the research recommendation.

Inclusion health and vulnerable groups (for example, vulnerable migrants, people experiencing homelessness, people in contact with the criminal justice system, sex workers, Gypsy, Roma and Traveller communities, young people leaving care and victims of trafficking)
None.

Other
A stakeholder suggested to include a reference to making reasonable adjustments as this is a legal requirement as stated in the Equality Act 2010. No changes were made to the guideline based on this comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. However, the guideline cross-refers to NICE's foundational guidelines on patient experience and shared-decision making, which

reference the Equality Act and highlight the importance of individualised care and shared-decision making.

5.3 If any recommendations have changed after consultation, how could these changes impact on equality and health inequalities issues?
A recommendation (1.3.5) was added about being aware that parents from a low income or disadvantaged background may need more support to continue breastfeeding, and healthcare professionals should also signpost to government and local schemes that can offer advice and help to access healthy food and drinks and income support schemes. This should improve support for breastfeeding parents from low income or disadvantaged background.

5.4 Following the consultation on the draft guideline and response to questions 4.1 and 5.2, have there been any further committee considerations of equality and health inequalities issues across the four dimensions that have been reflected in the final guideline?
Nothing in addition to points discussed in 4.1 and 5.2.

5.5 Please provide a summary of the key equality and health inequalities issues that should be highlighted in the guidance executive report before sign-off of the final guideline or update
Overall, there were various equality and health inequalities issues that were raised by stakeholders during the consultation and the committee were able to address some of these by revising some of the recommendations to more explicitly address these issues. Socioeconomic deprivation has been the key equalities issue for this guideline and this has been addressed across the guideline (see sections 4.1 and 5.2 under socioeconomic deprivation), including a recommendation for research around safe and appropriate formula feeding practices within the context of poverty and food insecurity.

Completed by developer __Maija Kallioinen (Topic Lead)_____

Date_____24/10/2024_____

Approved by committee chair Dr Sarah Jefferies_____
Date __1.11.2024_____

Approved by NICE quality assurance lead ___ Sara Buckner (Senior Topic Adviser)_____

Date__29/11/2024_____

STAGE 6. After guidance executive amendments

Maternal and child nutrition

Date of completion: 9/12/2024

Focus of guideline or update: maternal and child nutrition

6.1 Outline any amendments related to equality and health inequalities issues suggested by guidance executive and what the outcome was.
No amendments required.

Completed by developer __ Maija Kallioinen (Topic Lead)

Date____9/12/2024_____

Approved by NICE quality assurance lead ___ Sara Buckner (Senior Topic Adviser)_____

Date_____9/12/2024_____