

1.0.7 DOC EIA (2019)

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Antenatal care

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

3.0 Guideline development: before consultation (to be completed by the Developer before consultation on the draft guideline)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

The subgroups identified during the scoping process which might require equalities consideration are listed below. Apart from people with cognitive or neurological disability, the equalities issues identified for all other subgroups were at the time considered to be covered by the NICE guideline on pregnancy and complex social factors (CG110). Cross references to the CG110 guideline has been made in various sections of the guideline (recommendations 1.18, 1.2.6, 1.3.4, 1.3.7, 1.3.16).

Furthermore, during the development of the guideline, the committee made recommendations that addresses equalities issues which may be relevant to these groups. Throughout the guideline, consideration for the woman's individual needs and circumstances are made so that the care and information provided can be tailored. No mention of particular subgroups or conditions have necessarily been made in the recommendations but they aim to address different individual needs and circumstances which, if not considered, might lead to disadvantage for these individuals.

Disability (cognitive or neurological)

Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal care which consider the women's needs and circumstances. The referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

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A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. In some situations, this might be particularly relevant for disabled women. (Evidence review I and J)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. It also advises to give written information in a suitable format depending on the need, for example Easy Read. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This might be particularly relevant for disabled women who might have difficulty accessing mainstream antenatal classes and who might experience stigma or discrimination. (Evidence review E)

Sensory or physical disabilities

Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal care which consider the women's needs and circumstances. The referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. In some situations, this might be particularly relevant for disabled women. (Evidence review I and J)

A recommendation (1.1.9) was made about ensuring that reliable interpreting services were available for those who needed them. This includes sign language interpreters. (Evidence review J)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. It also advises to give written information in a suitable format depending on the need, for example braille or Easy Read. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This

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might be particularly relevant for disabled women who might have difficulty accessing mainstream antenatal classes and who might experience stigma or discrimination. (Evidence review E)

Women from some socioeconomic groups

As stated above, cross references to the NICE guideline on pregnancy and complex social factors (CG110) were made in various sections of the guideline (recommendations 1.18, 1.2.6, 1.3.4, 1.3.7, 1.3.16).

Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal care which consider the women's needs and circumstances. The recommendation specifically mentions making referral available via different routes, including self-referral, GP, other healthcare professionals or for example community centres. The recommendations also highlight that the referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. In some situations, this might be relevant for women from disadvantaged backgrounds. (Evidence review I and J)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. (Evidence review E)

Teenage mothers

As stated above, cross references to the NICE guideline on pregnancy and complex social factors (CG110) were made in various sections of the guideline (recommendations 1.18, 1.2.6, 1.3.4, 1.3.7, 1.3.16). The CG110 guideline includes a section on young pregnant women under 20 years.

Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal

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care which consider the women's needs and circumstances. The recommendation specifically mentions making referral available via different routes, including self-referral, GP, other healthcare professionals including school nurses or for example community centres. The recommendations also highlight that referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. This might be particularly relevant to teenagers and a cross-reference to the NICE guideline on pregnancy and complex social factors was made which includes a section on young women. (Evidence review J and I)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. This might be particularly relevant for teenagers. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This might be particularly relevant for teenagers who might benefit from antenatal classes among their age peers and a cross reference was made to the section on young pregnant women under 20 years in the NICE guideline pregnancy and complex social factors. (Evidence review E)

Gender reassignment

The guideline recognises that not all people who are pregnant identify as women. The guideline uses the term 'woman/women' throughout but the following text has been added in the beginning of the guideline: "For simplicity of language, this guideline will use the term 'woman' or 'mother' throughout, and this should be taken to include people who do not identify as women but who are having a baby." Throughout the guideline, the importance of tailoring care and approaches to the woman's individual needs and circumstances has been emphasised and this may be the case for pregnant trans people.

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. In some situations, this might be relevant for pregnant trans

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people. (Evidence review I and J)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendations highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. This might be particularly relevant for pregnant trans people. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This might be particularly relevant for pregnant trans people who might face stigma or discrimination. (Evidence review E)

Religion

Nothing specific to religion has been recommended, however, religion may relate to some of the equalities issues that were addressed and further discussed under the other categories, for example migrants and refugees, and ethnic minorities.

Migrants and refugees

As stated above, cross references to the NICE guideline on pregnancy and complex social factors (CG110) were made in various sections of the guideline (recommendations 1.18, 1.2.6, 1.3.4, 1.3.7, 1.3.16). The CG110 guideline includes a section on women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English.

Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal care which consider the women's needs and circumstances. The recommendation specifically mentions making referral available via different routes, including self-referral, GP, other healthcare professionals including school nurses or for example community centres or refugee hostels. The recommendations also highlight that the referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. A cross-reference to the NICE guideline on pregnancy and complex social factors was made which includes a section on recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English.

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(Evidence review I and J)

A recommendation (1.1.9) was made about ensuring that reliable interpreting services were available for those who needed them. (Evidence review J)

A recommendation (1.2.3) was made about considering clinical assessment by a doctor to detect cardiac conditions if there is a concern based on the woman's personal or family history. The committee agreed that this might be particularly pertinent to women who were brought up in countries with high incidence of rheumatic fever, such as many countries in sub-Saharan Africa and South Asia. These women might have an undiagnosed rheumatic heart disease. This notion also links with the findings of the MBRRACE-UK report 2019 which highlights that cardiac causes were the main cause of maternal mortality and Black and Asian women had a significantly higher risk of dying in pregnancy, childbirth or postnatally. (Evidence review G)

A recommendation (1.2.7) was made about discussing and assessing risk of female genital mutilation (FGM) at the booking appointment. A cross reference was made to the Department of Health and Social Care's practical guideline for health care professionals, which gives advice on countries where FGM is practiced and how to have the discussion about it. The committee recognised the need to identify women who have undergone FGM or whose unborn baby girl might be at risk of FGM so that appropriate safeguarding can take place. In the context of this guideline, this could be the pregnant woman, or the unborn baby when there is a family history or tradition of FGM. There is a mandatory duty to report suspected or known FGM in under 18s. (Evidence review G)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendations highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive and translated into other languages if needed. (Evidence review B)

A recommendation (1.3.15) was made to consider antenatal classes for multiparous women (and their partners) if they could benefit from attending, for example if they have never attended antenatal classes before. This might be relevant for some recent migrants or refugees who have not had antenatal classes in their previous country of residence. A further recommendation about antenatal classes (1.3.16) says to ensure that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This might be particularly relevant for areas

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with many migrants or refugees. (Evidence review E)

British born women of colour

In the stakeholder consultation for the guideline scope, “British born women of colour” were identified as a potential group requiring particular consideration due to equalities issues. The committee agreed that equalities issues relating to Black and minority ethnic women need consideration, however, the committee did not think their citizenship (being British or not) was relevant.

The committee took ethnicity into consideration in a number of evidence review protocols (for example by planning stratified analysis if there was such evidence): evidence A on information provision, evidence review B on approaches to information provision, evidence review C on involving partners, evidence review E on antenatal classes, and evidence review J on referral and delivery of antenatal care. In most cases, evidence pertinent to particular ethnic groups were not available but where they were, the committee considered whether the evidence warranted a particular recommendation to be made.

The committee were aware of the disproportionate risk of maternal mortality among Black, Asian and mixed ethnicity women, as reported by the MBRRACE-UK report 2019. No recommendations were made that were specific to ethnicity because the evidence reviews did not identify interventions that would particularly be beneficial for women from minority ethnic backgrounds, however, various recommendations where individual consideration or flexibility is advised might be relevant for Black and minority ethnic women because of their increased risk of adverse outcomes. For example, a recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman’s medical, social and emotional needs. (Evidence review I and J)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman’s individual needs and preferences, be individual and sensitive. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. (Evidence review E)

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3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?

The committee recognises the varying family and home situations that pregnant women may have, including single mothers and same-sex couples. Throughout the guideline, we refer to 'partner' which we have defined as "A partner could be the baby's father, the woman's partner, family member or friend, or anyone who the woman wishes to involve in her antenatal care." Where we refer to 'parents' we have clarified this to also include people who will be the baby's main caregivers, and single parents. Partner involvement has been considered throughout the guideline and in particular in recommendations 1.1.11 to 1.1.13 (evidence review C), however, the committee recognises that any involvement of the partner should be done according to the woman's wishes. When discussing the involvement of partners in antenatal care, the committee recognised that some women may be in an abusive or coercive relationship and involving partners without the woman's consent might be harmful.

No other equality issues were identified which have not already been addressed in box 3.1. However, the committee made recommendations (1.3.17 and 1.3.18) about discussing potential benefits of peer support and giving information about how to access local or national peer support services. The committee did not specify any particular subpopulations in the recommendations but noted in the rationale and impact section that evidence on peer support was identified among some subpopulations, such as migrant women, women from a lower social-economic backgrounds, women with intellectual disabilities, or younger women and noted that peer support is likely to be particularly beneficial when the peer support comes from women (or partners) in similar circumstances to themselves. (Evidence review D)

3.3 Have the Committee's considerations of equality issues been described in the guideline for consultation, and, if so, where?

The committee's considerations have been included in the recommendations, rationale and impact sections or the committee discussion sections of the evidence reviews as outlined in the sections above.

3.4 Do the preliminary recommendations make it more difficult in practice for a

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specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

No, the committee thinks the preliminary recommendations are intended to make it easier for specific groups to access services.

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No, the committee does not think the preliminary recommendations will have an adverse impact on people with disabilities because of something that is a consequence of the disability.

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in box 3.4, or otherwise fulfil NICE's obligation to advance equality?

No, the committee does not think there are any further recommendations or explanations that could remove or alleviate barriers to, or difficulties with, access to services but we look forward to hearing from stakeholders at consultation.

Completed by Developer Maija Kallioinen

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Approved by NICE quality assurance lead Christine Carson

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