NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Equality and health inequalities assessment (EHIA)

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: 29/07/24

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 (Guideline Lead) _____

Date_____08/04/24_____

Approved by committee chair ____Sarah Jefferies (Guideline Chair)

Date _____08/04/24_____

Approved by NICE quality assurance lead __Victoria Axe_____

Date_____29/07/24_____