1.3.21 Consider antenatal classes for multiparous women (and their partners) if they could benefit from attending (for example, if they have had a long gap between pregnancies, or have never attended antenatal classes before).

1.3.22 Ensure that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. Also see the section on young pregnant women aged under 20 in the NICE guideline on pregnancy and complex social factors.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on antenatal classes.

Full details of the evidence and the committee's discussion are in evidence review E: antenatal classes and evidence review B: approaches to information provision.

Peer support

1.3.23 Discuss the potential benefits of peer support with pregnant women (and their partners), and explain how it may:

- provide practical support
- help to build confidence
- reduce feelings of isolation.

1.3.24 Offer pregnant women (and their partners) information about how to access local and national peer support services.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on peer support.

Full details of the evidence and the committee's discussion are in evidence review D: peer support.

Sleep position

1.3.25 Advise women to avoid going to sleep on their back after 28 weeks of pregnancy and to consider using pillows, for example, to maintain their position while sleeping.

1.3.26 Explain to the woman that there may be a link between going to sleep on her back and stillbirth in late pregnancy (after 28 weeks).

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on sleep position.

Full details of the evidence and the committee's discussion are in evidence review W: maternal sleep position during pregnancy.

1.4 Interventions for common problems during pregnancy

Nausea and vomiting

1.4.1 Reassure women that mild to moderate nausea and vomiting are common in pregnancy, and are likely to resolve before 16 to 20 weeks.

1.4.2 Recognise that by the time women seek advice from healthcare professionals about nausea and vomiting in pregnancy, they may have already tried a number of different interventions.

1.4.3 For pregnant women with mild-to-moderate nausea and vomiting who prefer a non-pharmacological option, suggest that they try ginger.

1.4.4 When considering pharmacological treatments for nausea and vomiting in pregnancy, discuss the advantages and disadvantages of different antiemetics with the woman. Take into account her preferences and her experience with treatments in previous pregnancies. See table 1 on the advantages and disadvantages of different pharmacological treatments for nausea and vomiting in pregnancy to support shared decision making.

1.4.5 For pregnant women with nausea and vomiting who choose a pharmacological treatment, offer an antiemetic (see table 1 on the advantages and disadvantages of different pharmacological treatments for nausea and vomiting in pregnancy).

1.4.6 For pregnant women with moderate-to-severe nausea and vomiting:

- consider intravenous fluids, ideally on an outpatient basis
- consider acupressure as an adjunct treatment.

1.4.7 Consider inpatient care if vomiting is severe and not responding to primary care or outpatient management. This will include women with hyperemesis gravidarum. For more information on managing hyperemesis gravidarum, see the Royal College of Obstetricians and Gynaecologists' guideline on the management of nausea and vomiting of pregnancy and hyperemesis gravidarum. Also see the section on venous thromboembolism.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on nausea and vomiting.

Full details of the evidence and the committee's discussion are in evidence review R: management of nausea and vomiting in pregnancy.

Heartburn

1.4.8 Give information about lifestyle and dietary changes to pregnant women with heartburn in line with the section on common elements of care in the NICE guideline on gastro-oesophageal reflux disease and dyspepsia in adults.

1.4.9 Consider a trial of an antacid or alginate for pregnant women with heartburn.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on heartburn.

Full details of the evidence and the committee's discussion are in evidence review S: management of heartburn in pregnancy.

Symptomatic vaginal discharge

1.4.10 Advise pregnant women who have vaginal discharge that this is common during pregnancy, but if it is accompanied by symptoms such as itching, soreness, an unpleasant smell or pain on passing urine, there may be an infection that needs to be investigated and treated.

1.4.11 Consider carrying out a vaginal swab for pregnant women with symptomatic vaginal discharge if there is doubt about the cause.

1.4.12 If a sexually transmitted infection is suspected, consider arranging appropriate investigations.

1.4.13 Offer vaginal imidazole (such as clotrimazole or econazole) to treat vaginal candidiasis in pregnant women.

1.4.14 Consider oral or vaginal antibiotics to treat bacterial vaginosis in pregnant women in line with the NICE guideline on antimicrobial stewardship.

For a short explanation of why the committee made the recommendations and how they might practice, see the rationale and impact section on symptomatic vaginal discharge.

Full details of the evidence and the committee's discussion are in evidence review T: management of symptomatic vaginal discharge in pregnancy.

Pelvic girdle pain

1.4.15 For women with pregnancy-related pelvic girdle pain, consider referral to physiotherapy services for:

- exercise advice **and/or**
- a non-rigid lumbopelvic belt.

For a short explanation of why the committee made the recommendation and how it might affect practice, see the rationale and impact section on pelvic girdle pain.

Full details of the evidence and the committee's discussion are in evidence review U: management of pelvic girdle pain in pregnancy.

Unexplained vaginal bleeding after 13 weeks

1.4.16 Offer anti-D immunoglobulin to women who present with vaginal bleeding after 13 weeks of pregnancy if they are:

- rhesus D-negative **and**
- at risk of isoimmunisation.

1.4.17 Refer pregnant women with unexplained vaginal bleeding after 13 weeks to secondary care for a review.

1.4.18 For pregnant women with unexplained vaginal bleeding after 13 weeks, assess whether to admit them to hospital, taking into account:

- the risk of placental abruption
- the risk of preterm delivery
- the extent of vaginal bleeding
- the woman's ability to attend secondary care in an emergency.

1.4.19 For pregnant women who present with unexplained vaginal bleeding,