information about various practical issues related to pregnancy and antenatal care so that the woman knows what to expect and how to get support. The evidence showed that partners also value practical information throughout the pregnancy. For example, in relation to safe use of medicines in pregnancy, the committee were aware of the UK Teratology Information Service's information resources on best use of medicines in pregnancy (bumps).

The evidence suggested that women want information on how behavioural factors, such as smoking, alcohol, diet and physical activity may affect them and their baby's health. The evidence also highlighted how emotional these topics could be for women and that women may feel judged or patronised. The committee agreed that it is important to have these discussions in a sensitive manner that supports individual women. Guidance on all these issues is covered by other NICE guidelines or government documents.

The committee recognised that pregnant women and their partners often look for information and support from various sources, such as websites, and not all of them are necessarily evidence-based, so signposting to trusted resources may be helpful.

There was some evidence that women and their partners valued information and discussion around the transition to parenthood, and the changes that pregnancy and becoming a parent will bring to their life and relationship. The committee were aware of various available resources that could be helpful for parents, particularly new parents.

The evidence showed that women want information on their options for giving birth. The committee agreed that these discussions should start, at the latest, around the start of the third trimester, depending on the woman's preferences and circumstances. The committee agreed, in line with the Montgomery ruling, that discussing the implications, benefits and risks is fundamental to making shared and informed decisions. Guidance on making decisions about place of birth, mode of birth and prolonged pregnancy are also covered by other NICE guidelines.

Considering the amount of new information given at the beginning of antenatal care, discussions around practical aspects related to labour, childbirth and postnatal care are often more appropriate later on in pregnancy. There was some evidence that healthcare professionals thought that providing information on emotional attachment and bonding could improve women's confidence and increase their preparedness for birth. Further recommendations about promoting emotional attachment and bonding, as well as planning and managing infant feeding, are covered by the NICE guideline on postnatal care.

How the recommendations might affect practice

The recommendations will improve consistency of care and reinforce best practice.

Return to recommendations

Antenatal classes

Recommendations 1.3.19 to 1.3.21

Why the committee made the recommendations

Evidence among nulliparous women showed that women who went to antenatal classes were more likely to have their cervix dilated by 3 cm or more on admission to labour. A dilated cervix on admission may reduce the need for interventions. This may indicate that women who attended antenatal classes have better coping strategies and the confidence to deal with pain at home in the early stages of labour. There was no evidence about the most effective content for antenatal classes, so the committee made the recommendations based on their experience.

The committee recognised that there may be multiparous women who could also particularly benefit from antenatal classes, so providing them for these women should be considered.

The committee recognised that some groups of women may be less likely to attend antenatal classes (for example, some women from low income or disadvantaged backgrounds or minority ethnic groups, or those for whom English is not their first language). The committee agreed that in order to increase engagement with antenatal classes, service providers should ensure that classes are accessible, welcoming and adapted to meet the needs of local communities.

How the recommendations might affect practice

The recommendations reflect current practice. However, adapting classes to the needs of the local communities might involve some reorganising of practices.

Return to recommendations

Peer support

Recommendations 1.3.22 and 1.3.23

Why the committee made the recommendations

The evidence showed that peer support could offer helpful and valuable care and guidance during the antenatal period. There was evidence among women from particular subpopulations, such as migrant women, women of lower socioeconomic status, women with intellectual disabilities, or younger women, and the committee agreed that peer support groups among women in similar circumstances might be particularly helpful.

The committee discussed that peer support, including group peer support, volunteer peer support, doula support and online support, is usually provided through 'third sector' services, and they agreed that healthcare professionals should give women information about how to contact local and national services. Although there was little evidence on partners' experiences of peer support, in the committee's experience, some partners find peer support services for partners helpful.

How the recommendations might affect practice

The recommendations reflect current best practice.

Return to recommendations

Sleep position

Recommendations 1.3.24 and 1.3.25

Why the committee made the recommendations

The evidence suggested that there is an increased risk of stillbirth and babies being born small for gestational age after 28 weeks if women fall asleep on their backs. The committee agreed that there is some uncertainty about this risk because the evidence was from relatively small studies whose design made it difficult to assume that sleep position caused the adverse outcomes. The committee recognised that further research is unlikely because conducting sufficiently powered prospective cohort studies is not

feasible given the relatively low incidence of stillbirth (1 in every 244 births in England and Wales according to 2018 Office for National Statistics [ONS] data). The committee also noted that not all the included studies used the same definition of stillbirth and that only 1 study reported data according to whether the stillbirth occurred at term or at preterm. On balance, the committee agreed that the evidence was strong enough to advise women to try to avoid going to sleep on their back after 28 weeks.

The committee knew from their experience that providing practical advice about risk reduction is extremely important for pregnant women. They discussed reassuring women about sleep positions, aids that could make it easier for pregnant women not to go to sleep on their backs and maintain this position when sleeping, for example, by using pillows.

The committee also agreed that the reason for this advice should be explained, and they recognised the potential anxiety and feelings of guilt that women may experience, for example, if they wake up on their backs.

How the recommendations might affect practice

Healthcare professionals may need to spend more time talking to women about sleep position in pregnancy, but the recommendations are not expected to have a significant cost or resource impact.

Return to recommendations

Nausea and vomiting

Recommendations 1.4.1 to 1.4.7

Why the committee made the recommendations

Nausea and vomiting in pregnancy can affect daily functioning and quality of life, and can cause significant worry and upset. Based on their knowledge and experience, the committee agreed that it is important to reassure pregnant women who experience mild-to-moderate nausea and vomiting that these are common symptoms in early pregnancy and will usually settle later in the second trimester.

However, the committee recognised that many pregnant women expect nausea and

vomiting in pregnancy and might even tolerate significant symptoms and try various self-help approaches before seeking medical advice. It is therefore important to take it seriously when women do seek help.

Some women prefer to use non-pharmacological treatments whereas others may prefer pharmacological treatments, so both options are recommended.

There was some evidence that ginger is effective in treating mild-to-moderate nausea and vomiting in pregnancy compared with placebo, and this may be an option particularly for women who want to try a non-pharmacological option.

There was evidence on a wide variety of pharmacological treatments, many of which are commonly used in current practice. The evidence on the medicines varied in quality and for some medicines, no evidence was found. Metoclopramide hydrochloride was supported by good quality evidence showing that it was effective in improving symptoms. Ondansetron was also found to be effective in improving symptoms. A combination drug with pyridoxine and doxylamine is currently the only drug licensed for this indication, but the evidence is very old and of low quality and did not show a convincing effect on symptom improvement. Evidence on histamine H1 receptor antagonists was of very low quality and not particularly convincing. Studies on pyridoxine hydrochloride showed differing results, with larger trials showing no improvement in symptoms. No evidence was identified on the effectiveness of cyclizine hydrochloride alone in pregnant women, so the committee made a research recommendation on the effectiveness of medication for women with nausea and vomiting in pregnancy.

The treatment options have different advantages and disadvantages, including effectiveness in relieving symptoms, safety and other considerations, which have been summarised in a table to help with decision making. The committee used information available from the British National Formulary (BNF), the UK Teratology Information Service monographs and patient information leaflets, and the manufacturers' summaries of product characteristics to inform women about the potential effects on the baby. The committee recognised that women are often concerned about the possible adverse effects of medicines on the baby and that these should be discussed in the context of understanding the small risk of adverse outcomes unrelated to medicine use.

The evidence for treating the more severe form of nausea and vomiting in pregnancy did not generally support any different treatment options from those used for mild and moderate nausea and vomiting in pregnancy. An exception was for acupressure combined