

Scientific Advisory Committee on Nutrition

9th MEETING OF THE SUBGROUP ON MATERNAL AND CHILD NUTRITION

19 May 2008, Department of Health,
Wellington House, 133-155 Waterloo Road, SE1 8UG

FINAL MINUTES

Attendees:

Dr Anthony Williams (Chair)
Professor Alan Jackson
Professor Peter Aggett
Professor Annie Anderson
Mrs Stella Walsh
Dr Robert Fraser
Dr Ann Prentice

Secretariat:

Dr Sheela Reddy (DH)
Rachel Coomber (DH)
Dr Elaine Stone (FSA) (AOB only)
Heike Stolte (FSA)

Observers:

Susan Sky (Welsh Assembly)
Dr Fiona Bisset (Scottish Government)

Chair's Introduction

1. The Chair welcomed Members to the ninth meeting of the Subgroup on Maternal and Child Nutrition. Apologies were received from Dr Tim Key.

AGENDA ITEM 1 – Minutes of last meeting

2. Members were invited to comment on the minutes of the meeting on 14 September 2007 (SMCN/07/min02). Minutes were agreed as a correct record of the meeting.

Matters arising

3. The Chair invited Dr Sheela Reddy to report progress on matters arising from the previous meeting.
4. At a previous meeting, Members had asked the Secretariat to draft Terms of Reference for the paper '*Risks associated with not breastfeeding*'. Members were informed that the Secretariat would begin drafting this report once the current report '*The influence of maternal, fetal and child nutrition on the development of disease in later life*' was nearer completion, primarily due to resource limitations.
5. Members noted that, unlike other reports of the Committee, the Joint SACN/RCPCH report '*Application of the WHO Growth Standards in the UK*' had not been published in hard copy. The Secretariat agreed to consult RCPCH and consider publishing hard copies of the report.
6. Members also noted that at the last meeting there had been a similar discussion concerning publication, where members had proposed there might be a central government web-based publishing database for such reports. The Secretariat agreed to enquire and report back to the Committee.

Action: Secretariat will consider publishing hard copies of the *WHO Growth Standards* report, and to enquire about a central online database for the publication of reports.

AGENDA ITEM 2 – The influence of maternal, fetal and child nutrition on the development of disease in later life (SMCN/08/01)

7. The Chair introduced the paper *The influence of maternal, fetal and child nutrition on the development of disease in later life*. Members were reminded that SACN had delegated this report to the Subgroup and that drafting had originally been contracted out to members of the Department of Community Health Sciences at St George's, University of London. The original draft

largely reflected the epidemiology published at the time and Members had noted a need to balance this with consideration of plausible mechanisms, incorporating evidence from experimental animal and human studies.

8. The changes made were highlighted. The Chair noted that although there was still considerable technical work to be done, the Secretariat were seeking agreement on the revised structure and organisation of the report.
9. Members agreed that the structure had improved but that the text was currently too complex and would need further editing, particularly to ensure consistency in the language and terminology used. Members noted that care should be taken when interpreting the evidence.
10. It was suggested that the report currently read too much like a 'text book'. Members clarified that the report is an attempt to look beyond widely accepted evidence and to explain various underlying concepts.
11. Members recognised the complexity of the question in hand and suggested that the report needs to offer a statement recognising the different forms evidence can take. A degree of uncertainty in much of the scientific work was also noted, which means advice on infant feeding is not always taken up. Members emphasised the need for the Subgroup to consider the available evidence and make clear recommendations, so that advice can be given to inform policy makers.
12. Members also emphasised the importance of focusing on diet and the quality of the diet. National dietary surveys show that the overall quality of the population's diet is poor and this poses a degree of risk to individuals and their children. It was agreed that a simple position statement on how we can encourage the population to move towards better dietary practices is also required.
13. There was a detailed discussion on the revised draft. The main drafting points were as follows:

- Include an explanation of fetal and infant development at the beginning of the report, before the methodological considerations, to provide clarity and to offer a framework for interpretation. It was agreed this should be relatively brief and should signal further detail in the Appendices.
 - Amend introduction according to Terms of Reference i.e. clarify 'early childhood'.
 - Include a statement about secular trends in birth weight and achieved adult height.
 - Revisit the headings/subheadings to ensure these reflect the content of the report.
 - Move Figure 1 to the *Background* and expand to include more explanation of the underlying mechanisms. Amend figure title.
 - Introduce birth size/birth weight earlier on i.e. in the *Background*.
 - Consider further the impact of weight gain on pregnancy, if evidence is available.
 - Explore intergenerational associations.
 - Consider carefully any negative reference to breastfeeding.
 - Check several highlighted references and ensure evidence is interpreted correctly. Members agreed to review the work by Weiler et al. 2005 (paragraph 170) and send comments to the Secretariat.
 - Mention some of the large cohorts on pregnant women in Chapter 5: *Maternal and Child Nutritional Status in the UK*. In addition, include reference to some of the positive findings from the National Diet and Nutrition Survey (NDNS).
 - Although a direct association may not always be possible, it should be appreciated that the evidence can be used to assess plausibility.
14. The Subgroup requested to see a copy of the referenced Baker et al. 2008 research on teenage pregnancies. Dr Reddy informed Members that this had not yet been published but had been submitted for publication, and the Secretariat would seek the author's permission to provide Members with a copy prior to publication.

Action: Secretariat will seek permission to circulate the Baker et al. 2008 work on teenage pregnancies to Members before publication.

15. Members questioned whether the Secretariat had sufficient resources or expertise to carry out this work. It was suggested the Secretariat consider having a drafting group, which would involve individual Members from the Subgroup for their input.

16. Members were content with the structure of the report and agreed the Secretariat should continue drafting the report in its current format. It was suggested that the Secretariat circulate each chapter as it develops, via correspondence, so that Members could provide feedback.

Action: Secretariat will continue drafting the report, incorporating comments from Members and circulate chapters for comment as they develop.

AGENDA ITEM 3 – SACN’s statement on nutrition requirements for multiple pregnancies (SMCN/08/02)

17. The Chair introduced the paper and outlined the background to the statement on nutrition requirements for multiple pregnancies. The Department of Health had sought SACN’s advice on whether women with multiple pregnancies should be advised to consume more food than women with singleton pregnancy and SACN had given preliminary advice to support the debate on the Health and Social Care Bill on 25th March 2008. The Chair explained that the advice given to Ministers was to be reflected in a statement, and noted that a draft had already been circulated to Members. Members were requested to agree the final statement so that this could be made public and placed on the SACN website.

18. Members were reminded that the Subgroup had only reviewed the evidence provided by the Twins and Multiple Births Association (TAMBA). The Subgroup’s conclusion, based on this evidence, was consistent with previous

conclusions i.e. the data are insufficient to justify additional nutrient requirements for multiple (as opposed to singleton) pregnancies, although Members noted there might be additional evidence to that provided by TAMBA. It was also noted that Luke et al mentioned planning of a randomized controlled trial in one of their publications. It was suggested that the Secretariat contact the authors to ascertain what progress has been made. It was also agreed that these uncertainties should be recognised by modifying paragraph 7 of the statement, to avoid misinterpretation. Paragraph 7 was amended to read:

“The Committee therefore highlights obvious limitations to the evidence provided. The case for this specific nutritional intervention should be based on totality of evidence that includes observational studies and well-designed randomised controlled trials, such as those we understand are underway.”

19. Members also agreed that the amended paragraph should now form part of the *Conclusions*. Dr Reddy clarified for Members that reference to this statement would be made in the Subgroup’s report *The influence of maternal, fetal and child nutrition on the development of disease in later life*.

Action: Secretariat will contact Dr Barbara Luke to enquire whether further information from RCTs is available, will alter the statement as agreed by Members, and place the amended statement on the SACN website.

Following the meeting, the Secretariat contacted Dr Barbara Luke and it appears there are no RCTs currently underway. The statement was amended accordingly:

“The Committee therefore highlights obvious limitations to the evidence provided. The case for this specific nutritional intervention should be based on totality of evidence from observational studies and any forthcoming well-designed randomised controlled trials.”

20. The Chair then invited Members to comment on the approach taken by the Secretariat for making the statement.
21. It was suggested that the original statement should have been circulated to all Members. Members were informed that such a request requires a timely response and that contingencies to deal with similar situations should be

considered. However, Dr Reddy explained that this urgent request from Ministers had been an extraordinary circumstance and that a rapid response had been required. It is extremely difficult to expect all Members to comment within what can be a short time for response, and that confidence in the ability of individual Members to make good judgment and to advise on areas within their expertise is required.

22. Members agreed that in situations where the Committee's advice or comment is needed at a period of short notice, the Secretariat should, where possible, seek the opinion of all Members. However, Members recognised that this is not always possible, primarily due to time constraints, and in this case the Secretariat should approach individual Member/s with relevant expertise to take the lead and keep other Members informed of the request.
23. The Chair thanked Members for their comments and that these were helpful for informing action in future situations.

AGENDA ITEM 4 – Healthy Start Evaluation (SMCN/08/03)

24. The Chair reminded Members that the last meeting in September, Christine McGuire from the Department of Health's Policy Research Programme (Research and Development Directorate) had provided an update on the progress of the evaluation of Healthy Start. Members had requested to see the final draft of the scoping study for the evaluation, undertaken by the Public Health Research Consortium (PHC) and this paper had been circulated for information. The Chair highlighted the objectives of the evaluation (page 5 of PHC's report), noting that these had not all been addressed. The Chair also noted that some individual Members had been approached to independently peer review an initial draft, but that not all comments had been incorporated into the final draft.
25. Members were also provided with a summary of the rapid evaluation of Phase 1 of Healthy Start, published in 2006. Members noted the positive findings of

this initial evaluation and that this was useful for informing a larger scale evaluation of Healthy Start.

26. Dr Robert Fraser declared his interest, informing Members of his involvement in a cohort study evaluating Healthy Start, at the University of Sheffield.

27. The Chair introduced the paper and informed Members that a draft scope, outlining some initial ideas for evaluation and taking into account the options proposed by PHC, had been drawn up following PHC's final report. The Chair invited Members to discuss and comment on these ideas.

- It is important to evaluate the educational component of Healthy Start. Members noted that NICE had attempted to draw out the educational value of Healthy Start in their recently published guidance on Maternal and Child Nutrition. Dr Reddy explained that capturing information is difficult to achieve in such a transient population and that the Department would like a rolling programme for evaluation. It would be particularly difficult to capture this information without undertaking a study, and the educational value had already been taken into account in point IV of the draft scope. It was suggested that this should be expanded.
- The evaluation should also measure how many vouchers should be/are given out. Dr Reddy explained that the Department is currently trying to obtain this information from the Department of Working Pensions (DWP), at least in terms of job seekers, but that its completeness would be questionable.
- There are potential problems with evaluating the uptake and usage of vouchers. For example, recipients who buy fruit and vegetables with the vouchers they receive might therefore purchase less fruit and vegetables with their household income, and the total fruit and vegetable purchase could potentially be unchanged.
- A qualitative study could describe the usage of Healthy Start vouchers. Information obtained could be supported by retail data. Dr Reddy informed

Members that there might be potential to send out a questionnaire via the new Healthy Start contractor.

- There are concerns that increases in fruit and vegetable consumption brought about by Healthy Start may not be sustainable once people stop using the vouchers. It was suggested that it might be possible to track any consumption change in low-income groups through other surveys.
- Information to ascertain who is claiming the vouchers i.e. breastfeeding mothers or formula feeding mothers, should be considered. It may be possible to obtain this information through the Infant Feeding Survey and may also be picked up in new dietary surveys of infant and young children.
- Information regarding the purchase of vitamins other than the Healthy Start vitamins should be captured.
- The *enhancement of nutrition* has never been defined, although it can be defined in terms of process and of outcome. The aims and objectives of the evaluation need to be clear.
- There is no clear control group and the opportunity for a before and after study has passed. Members asked if there was anything to learn from the evaluation of the Welfare Food Scheme but it was confirmed that there had been no clear control group for that evaluation.
- It was suggested that there might be potential to follow up the work of the Sheffield cohort study (although this work has not yet been published), following children up to 4 years of age.
- Members asked if any guidance was issued to women with the Health in Pregnancy Grant about how to spend the money. Dr Reddy agreed to find out and report back to the Committee.

Action: Secretariat will find out if any guidance is issued with the Health in Pregnancy Grant on how to spend the money, and to report back to the Committee.

28. Dr Reddy informed Members that the Department of Health are currently discussing dietary surveys for infants and young children that would recruit children aged 0-18 months and that these data could be useful for the evaluation of Healthy Start. It was clarified that the surveys will cover the

whole of the UK. Members asked if this would be at a stage to go to SMCN for discussion at the next meeting and Dr Reddy explained that once a draft scope had been drawn up, this would be circulated to the Committee for comment. Members asked if the surveys would include pregnant women - Dr Reddy explained the difficulty in doing so and that there would need to be a separate survey.

29. Members were informed that the Department of Health's Research and Development team would draw up a scope for the evaluation and the Secretariat would then circulate to the Committee for comment.

Action: Once drawn up by the Department's Research and Development team, the Secretariat will circulate the draft scope for evaluation to Members for comment.

AGENDA ITEM 5 – Updates on Activities related to Maternal and Child Nutrition (SMCN/08/04)

DH Update

30. Dr Reddy introduced the paper and provided an update on current DH activities related to Maternal and Child Nutrition, highlighting the following points:

- National Breastfeeding Awareness Week (NBAW) was successfully held from 11-17th May and was supported with a breastfeeding conference, PR activities and materials for health professionals to run activities at a local level. This year's theme was to encourage continuation of breastfeeding and support the new breastfeeding indicator *prevalence of breastfeeding at 6-8 weeks*.
- The Department has appointed two Infant Feeding Best Practice Advisors, seconded from the Breastfeeding Network. The advisors work on a job share basis to help deliver key breastfeeding initiatives.

- An Independent Review Panel has been set up to assess whether the controls on infant formula and follow-on formula are working as expected or whether further action is needed. The first meeting will be held shortly.

31. The Chair invited Members to comment or raise any questions. Members were interested to know how Children's Centres are funded. Dr Reddy explained that the Department is working with the Department for Children, Schools and Families (DCSF) to provide the funding and there are ongoing discussions around how this will happen. There was concern that if funding is provided through DH/DCSF, then additional funding may be withdrawn from the main PCT budget for these Centres. It is important that this funding is protected. Dr Reddy explained that the Child Health Public Service Agreement (PSA) is DCSF led and therefore will explore the potential for safe-guarding the funding. Dr Reddy agreed to take this back to DCSF and feedback comments to Members.

Action: Secretariat will pass onto DCSF the Committee's concerns regarding the protection of PCT funding for Children's Centres.

Welsh Assembly Update

32. Susan Sky gave an update on activities relating to Maternal and Child Nutrition in Wales, highlighting the following:

- Wales have received more funding this year to support the Baby Friendly Initiative and to enhance the Breastfeeding Support Grant Scheme.
- The Welsh Assembly Government have funded a pilot scheme in Caerphilly Borough to test the feasibility of collecting data on breastfeeding. This pilot will be reviewed and then eventually expanded across Wales.

33. Susan Sky circulated copies of the *Evaluation of the Breastfeeding Support Grant Scheme* and of a range of breastfeeding materials produced by the Welsh Assembly.

Scottish Executive

34. Dr Fiona Bisset gave an update on activities relating to Maternal and Child Nutrition in Scotland, highlighting the following:

- An Infant Nutrition Co-ordinator for Scotland has been appointed for 2 years to lead the development of the infant nutrition strategy, providing advice to all those involved in infant nutrition.

AOB

Questions on vitamin D from the Scottish Health Department

35. The Chair informed members that following publication of SACN's position statement *Update on Vitamin D* last year, the Scottish Health Department had sent some questions relating to vitamin D and public health for SACN to consider. The Chair explained to members that SMCN's initial comments were sought as several members of the Subgroup had been closely involved with drafting the report. The Chair noted that further discussion at the SACN main meeting in June, requested by the Scottish Health Department, may not be necessary if the points at issue could be satisfactorily resolved.

36. The Committee were asked to discuss and answer the questions posed by the Scottish Health Department. Members comments are outlined below:

Question 1: The type of supplement recommended (vitamin D2 or vitamin D3?). Are there quality assurance data available on current preparations to ensure the correct dose?

- Members clarified that vitamin D supplements are available in both the form of a food supplement and medicinal supplement, however, many supplements are available by prescription only. Quality assurance for licensed supplements is a matter for MHRA. Food supplements are covered under the Food Act, which states that all food on sale should be safe.
- From early literature on anti-rachitic activity, the metabolites of vitamin D2 and D3 are regarded as equipotent at the tissue level. However, it has been suggested that vitamin D3 may increase plasma 25-hydroxyvitamin D concentrations more efficiently than D2 (Trang *et al*, 1998; Armas *et al*, 2004; Romagnoli *et al* 2008) and that the dose required to achieve comparable biochemical status may be different. However, other evidence suggests that vitamin D2 and D3 supplementation can achieve similar concentrations of 25-hydroxyvitamin D (Holick *et al* 2007). Members quoted recent population-based evidence that suggests vitamin D2 is as effective as D3 in maintaining 25-hydroxyvitamin D levels (Holick *et al*, 2007; Gordon *et al*, 2008).

References:

Armas LA, Hollis BW & Heaney RP (2004) Vitamin D2 is much less effective than vitamin D3 in humans. *J Clin Endocrinol Metab* 89: 5387-5391.

Gordon CM, Williams AL, Feldman HA, May J, Sinclair L, Vasquez A, Cox JE (2008) Treatment of Hypovitaminosis D in Infants and Toddlers. *J Clin Endocrin Metab*. [Epub ahead of print]

Holick MF, Biancuzzo RM, Chen TC, Klein EK, Young A, Bibuld D, Reitz R, Salameh W, Ameri A & Tannenbaum AD (2007) Vitamin D2 is as effective as vitamin D3 in maintaining circulating concentrations of 25-hydroxy vitamin D. *J Clin Endocrin Metab* 93:677-681

Romagnoli E, Mascia L, Cipriani C, Fassino V, Mazzei F, D'Erasmo E, Carnevale V, Scillitani A & Minisola S (2008) Short and long term variations in serum calciotropic hormones after a single very large dose of ergocalciferol (vitamin D2) or cholecalciferol (vitamin D3) in the elderly. *J Clin Endocrin Metab* [Epub ahead of print]

Trang HM, Cole DE, Rubin LA, Pierratos A, Siu S & Vieth R (1998) Evidence that vitamin D3 increases serum 25-hydroxyvitamin D more efficiently than does vitamin D2. *Am J Clin Nutr* 68: 854-858.

Question 2: Dosing regimen. Daily is implied but would monthly, 3 monthly or annually be more appropriate and would this depend on the population group?

- There is evidence for daily oral vitamin D supplementation in the elderly being more effective in producing a steady vitamin D status than weekly and monthly oral administration (Chel *et al*, 2008). Members were not aware of any data for infancy and pregnancy¹.
- There was a discussion around alternative forms of vitamin D supplementation i.e. intramuscular injection, to overcome any problems with providing oral supplements on a daily basis. Members noted that if the currently recommended lower threshold of a plasma 25-hydroxyvitamin D concentration of 25nmol/l is to be achieved, then all methods of supplementation are likely to be effective.

References:

Chel V, Wijnhoven AH, Smit JH, Ooms M & Lips P (2008) Efficacy of different doses and time intervals of oral vitamin D supplementation with or without calcium in elderly nursing home residents. *Osteoporos Int* 19:663-671

Gordon CM, Williams AL, Feldman HA, May J, Sinclair L, Vasquez A, Cox JE (2008) Treatment of Hypovitaminosis D in Infants and Toddlers. *J Clin Endocrin Metab*. [Epub ahead of print]

Question 3: Would SACN recommend assessing vitamin D status before supplementation? If so should the time of year be specified?

and

Question 4: What level of vitamin D (should this be D3 only) would be aimed for? Is this the same for all age groups? And would this be at a particular time of year? And using a particular assay?

- If this question refers to screening a target population, then this would not be necessary as an assessment of risk has already been made in order to recognise vulnerable groups. In addition, members noted that there are already recommendations for those groups expected to be at risk of vitamin D deficiency.

¹ Note: Since the meeting, a very recent paper on treatment of hypovitaminosis D in infants and toddlers was found, comparing the safety and efficacy of daily (50µg D2 or D3) and weekly (1400µg D2) supplementation in ages 8-24 months (Gordon et al, 2008). This showed the dosing regime did not significantly influence the concentration of 25-hydroxyvitamin D achieved, and no difference in the efficacy and safety was noted between the three common treatment regimens.

- Members stressed the considerable practical problems, which would be associated with biochemical screening. These arise from considerable variation between assays used to assess vitamin D status; there is a need to standardise laboratory methods for assessing vitamin D status. This recommendation formed part of the Committee's conclusions in their *Update on Vitamin D* (paragraph 122).
- There are also problems with using assays to assess the clinical significance of an *individual's* plasma 25-hydroxyvitamin D concentration. Concentrations vary depending on the time of each assessment, because they are influenced by the time of year and recent UVB sunshine exposure i.e. an individual's plasma concentration might be different in August compared to December. The concentration at one time may not predict that at another. Therefore screening prior to supplementation is not recommended.
- In addition, the interpretation of plasma 25-hydroxyvitamin D concentration in terms of functional outcomes is difficult (Prentice *et al*, 2008). A plasma concentration of 25-hydroxyvitamin D above 25nmol/l is recommended to prevent rickets and osteomalacia. As described in the Committee's *Update on Vitamin D* accumulating evidence suggests that vitamin D may be important for other health outcomes and that plasma concentrations of 25-hydroxyvitamin D above 25nmol/l may be required for optimal health but that current data are insufficient to revise recommendations (paragraph 118).
- Recommendations for supplementation in other groups (i.e. 4–64 years of age) have not been made, as there are no Reference Nutrient Intakes set for these groups on grounds of age. Supplementation is advised, however, for any who are at risk by virtue of other criteria – for example insufficient exposure of the skin to sunlight.
- Members noted several ongoing studies, commissioned by the Food Standards Agency, that will hopefully provide further information with regards to vitamin D. These are due to report in a couple of years.

References:

Prentice A, Goldberg GR & Schoenmakers I (2008) Vitamin D across the lifecycle: physiology and biomarkers. *Am J Clin Nutr* [in press]

37. In addition, the Scottish Health Department also sought comment on the following points. Members comments are outlined below:

1. Simultaneous supplementation with calcium for some or all groups.

- Simultaneous calcium supplementation is currently not recommended for any population groups as there is no robust evidence to support this. There would need to be a full risk assessment before recommending calcium supplementation for other population groups Combined calcium and vitamin D supplementation is used clinically as an adjunct to the treatment of osteoporosis in the elderly.

2. Vitamin D levels are low in older children and young adults. Has the omission of these key groups from the recommendation been an oversight as it appears they are not getting enough sunshine to maintain vitamin D levels?

- There are no set Reference Nutrient Intakes for the general population aged 4-64 years, except those at risk by virtue of lifestyle or other factors, and there is currently insufficient evidence to set recommended intakes for these groups on grounds of age alone. There is a Reference Nutrient Intake for those people at risk of inadequate UVB exposure from sunlight and a recommendation to use supplements to achieve this intake. This recommendation, originally set by COMA in 1991, is reiterated in SACN's position statement (paragraph 120).

3. Sunlight is the main source of vitamin D for most people. Should there be population recommendations with regard to sunlight exposure? Should this differ depending on skin type, latitude, age, use of sun-screen, amount of skin exposed?

- Members agreed that population recommendations with regard to sunlight exposure should be made. This again, forms part of the Committee's conclusions in their position statement on vitamin D (paragraph 119). In addition, members also agreed that any recommendations for sunlight exposure might differ with varying factors, but noted that setting these recommendations was beyond the Committee's remit and ventured in to risk management

4. Recent work relating maternal vitamin D status during pregnancy to childhood respiratory disease and the possible role of early life vitamin D intake by children and childhood asthma.

- Members commented that the work referred to (Willers *et al.* 2007) looked at maternal dietary intakes and found an association between fish consumption and reduced risk of childhood asthma and allergic conditions - the paper does not allude to vitamin D specifically. However, members noted that in contrast to this, other work has suggested an association between high maternal 25-hydroxyvitamin D concentrations and an increased risk of atopic disorders in children (Gale, *et al.* 2008). It is therefore too early to make conclusions about vitamin D and childhood outcomes.
- Since SACN published its position statement on vitamin D, there are two large ongoing trials on vitamin D and pregnancy, one in the UK (the MAVIDOS Study, lead by Professor Cyrus Cooper) and one in the United States (lead by Dr Bruce Hollis). Dr Ann Prentice agreed to review these studies when results become available and send any comments to the Secretariat.
- Members noted again, that the FSA have commissioned five studies to look at vitamin D, some of which will look at vitamin D and chronic disease, and these are due to report in the next couple of years.

References:

Gale, *et al.* (2008) Maternal vitamin D status during pregnancy and child outcomes. *Eur J Clin Nutr* 62:68-77

Willers *et al.* (2007) Maternal food consumption during pregnancy and asthma, respiratory and atopic symptoms in 5-year old children. *Thorax* 62: 773-779

38. Members recognised the uncertainties around vitamin D and noted that these uncertainties, with subsequent recommendations, are outlined in their position statement on vitamin D. Members highlighted the considerable public health effort made since the Second World War, to prevent rickets in the UK and that the Committee are keen to ensure that these steps taken remain in place. The Committee have made clear in their position statement that evidence is currently insufficient to revise recommended vitamin D intakes and that they cannot go beyond the recommendations they have made. In addition, Members reiterated that a full risk assessment, following research currently underway, will be required before making any further recommendations for supplementation for other population groups.

NICE Maternal and Child Nutrition Guidance

39. The Chair informed members that the NICE guidance on Maternal and Child Nutrition had been published on 25th March 2008 and was available to download on the NICE website www.nice.org.uk.

Next meeting

40. The next Subgroup meeting will be held on 17th September 2008.