Healthy pregnancy profile

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This profile uses inclusive terminology wherever possible. Some datasets, however, are published using sex-based categories such as "women", particularly for screening programmes. In these cases, original dataset terms are used to ensure accuracy and comparability, while recognising that not all people who need these services identify with those identities.

Executive Summary

A healthy pregnancy helps keep both the birthing person and the baby safe, lowers the chance of complications, and provides the early support and prevention that shape a child's long-term health from the very start.

However, the pregnancy journey is often affected by a combination of health and social challenges (many of them preventable) pointing to a clear need for more comprehensive support from preconception through to birth.

Suffolk has a sizeable population for whom this support is directly relevant. Based on 2024 mid-year population estimates, just under 1 in 3 residents (32.6%, n=256,660) are of typical reproductive age (estimated 16-44 years), comprising 31.8% (n=127,099) of females and 33.5% (n=129,561) of males, and 6,583 live births were recorded in 2024.

This profile brings together data and evidence across the healthy pregnancy journey- from preconception through to birth outcomes- to identify where targeted prevention and support can make the greatest difference for families in Suffolk.

Section 1: Preconception health

Preconception health refers to the health of all prospective parents- both birthing and non-birthing partners- during their reproductive years. The health of both partners during their reproductive years influences fertility, pregnancy, and child outcomes, making this an important public health consideration.

Health behaviours

The months and years before conception represent a critical window in which health behaviours can shape fertility, pregnancy outcomes, and the lifelong health of the next generation.

Preconception health is influenced by more than women and birthing people alone; the health of non-birthing partners also has a measurable influence on fertility, conception, and the health of any resulting child.

Modifiable behaviours such as physical activity, weight management, smoking, alcohol consumption, sexual health practices, and uptake of routine screening can all be optimised in this period to give prospective parents- and their future children- the best possible start.

This summary draws on Suffolk-specific data covering adults of reproductive age to identify where the local population is faring well, where it lags behind national benchmarks, and where

targeted support could most meaningfully improve preconception outcomes. Where data permits, figures are reported separately for women and men (or birthing and non-birthing partners) to reflect the distinct biological pathways through which each behaviour affects reproductive health. Ideally, all indicators would be reported for the 16-44 age range that most closely reflects the reproductive years; where datasets are not disaggregated in this way, the closest available age band has been used to ensure the figures remain as representative as possible of the population of interest.

Key population level statistics

- **Physical activity, 2023/24:**
  - Over 1 in 3 (35.8%) females aged 16+ years in Suffolk did not meet the Chief Medical Officers' recommended physical activity targets
  - Around 1 in 3 (33.0%) of males aged 16+ in Suffolk did not meet the recommended 150 minutes or more per week
- **Living with overweight and obesity, as of April 2025:**
  - Over half (56.7%) of females aged 18-64 years registered with a GP in Suffolk had a recorded BMI classification of overweight or obese
  - Over half (61.3%) of males aged 18-64 years registered with a GP in Suffolk had a recorded BMI classification of overweight or obese
- **Smoking, 2024:**
  - Over 1 in 10 (10.5%) of Suffolk residents aged 18 years and over smoke, statistically similar to England, but more than double the national 2030 smokefree target of 5%
- **Alcohol misuse, 2023/24:**
  - The rate of hospital admission episodes for alcohol-related conditions for Suffolk females under 40 years of age is 144.6 per 100,000, statistically significantly worse than the England rate
  - The rate of hospital admission episodes for alcohol-related conditions for Suffolk males under 40 years of age is 196.7 per 100,000, statistically similar to the England rate
- **Sexual health, 2024:**
  - The rate of new sexually transmitted infections (STI) diagnoses in Suffolk was 314.4 per 100,000, statistically significantly lower than England and declining over time
  - However, STI testing rates (excluding chlamydia testing for under-25s) were 1,864.7 per 100,000- statistically significantly worse than England estimates
  - Test positivity (excluding chlamydia testing for under-25s) in Suffolk was 4.8%, also statistically significantly lower than the England
  - Lower diagnosis rates in Suffolk sit alongside lower testing rates, which may limit case detection. However, lower test positivity indicates that the overall level of undetected infection is uncertain and should not be inferred directly from these data.
- **Cervical screening, 2024:**
  - Almost 3 in 4 (73.3%) women aged 25-49 in Suffolk who were eligible for cervical screening were adequately screened within the previous 3.5 years, statistically significantly better than the England estimate
  - However, coverage has fallen by 4.5 percentage points since 2010 (from 77.8%), a statistically significant decline

So what?

Preconception health in Suffolk is shaped by the behaviours of both birthing and non-birthing partners, and the data points to several areas where prospective parents may benefit from support before conception. These include maintaining a healthy weight and being physically active, stopping smoking, moderating alcohol intake (particularly among younger women), engaging with sexual health testing, and keeping up to date with cervical screening. Supporting prospective parents to optimise these modifiable behaviours in the preconception period offers an opportunity to improve fertility, reduce the likelihood of pregnancy complications, and contribute to better long-term health outcomes for the next generation of Suffolk residents.

Pre-existing health conditions

Pre-existing health conditions play an important role in shaping fertility, pregnancy outcomes, and the long-term health of any future child.

For women and birthing people, well-managed conditions before conception can reduce the risk of complications during pregnancy and improve outcomes for both parent and baby.

For non-birthing partners, certain conditions can also affect fertility, require management before trying to conceive, or benefit from early support to reduce potential intergenerational health risks.

This summary draws on Suffolk-specific data, supplemented by national evidence where local data is unavailable, to give a picture of the prevalence of key pre-existing conditions among adults of reproductive age. Where data permits, figures are reported separately for women and men (or birthing and non-birthing partners) to reflect the distinct ways in which different conditions can affect each. Ideally, all indicators would be reported for the 16–44 age range that most closely reflects the reproductive years; where datasets are not disaggregated in this way, the closest available age band has been used to ensure the figures remain as representative as possible of the population of interest.

Key statistics

- **Human immunodeficiency virus (HIV), 2024:**
    - Suffolk's diagnosed HIV prevalence rate in people aged 15–59 was 1.3 per 1,000, below the NICE benchmark goal of 2 per 1,000
    - Between 2022 and 2024, over half (60.0%) of HIV diagnoses in heterosexual men and of diagnoses in heterosexual and bisexual women (53.8%) in Suffolk were classified as 'late'- well above the NICE benchmark of 25%. Late diagnosis means the virus has already caused significant damage to the immune system before the individual is aware they are infected
- **Mental health, as of December 2025:**
    - Over 1 in 3 females (35.9%, n= 35,847) females aged 16-44 years registered with a GP in Suffolk had a recorded mental health flag (one or more recorded diagnosis of depression, anxiety, low mood, or serious mental illness)
    - Over 1 in 5 males (21.0%, n= 21,961) males aged 16-44 years registered with a GP in Suffolk had a recorded mental health flag
- **Cardiovascular disease, as of December 2025:**
    - 0.4% (n= 400) females aged 16-44 years registered with a GP in Suffolk had a record indicating the presence of cardiovascular disease

  - Cardiac disease was the principal cause of indirect maternal death in the most recent national reporting period (2021-23)
- **Diabetes, as of December 2025:**
  - 1.5% (n= 1,499) females aged 16-44 years registered with a GP in Suffolk had a diabetes diagnosis
- **Epilepsy, as of December 2025:**
  - 1.1% (n= 1,099) females aged 16-44 years registered with a GP in Suffolk had a recorded diagnosis of epilepsy
  - Epilepsy was the fifth leading cause of indirect maternal death in the most recent national reporting period (2021-23)
- **Pelvic inflammatory disease (PID), 2023/24:**
  - Suffolk's PID admissions rate for people aged 15-44 was 186.0 per 100,000, statistically significantly lower than the England estimates
  - Recent trends show no significant change
- **Fibroids:**
  - No Suffolk-specific data available. National evidence suggests around two in three women or birthing people will develop at least one uterine fibroid in their lifetime, with Black women and birthing people more likely to be affected and to experience fibroids that are larger, more numerous, and more severe
- **Polyendocrine Metabolic Ovarian Syndrome (PMOS):**
  - No Suffolk-specific data available. National prevalence estimates range from 2.2% to 26% depending on the diagnostic criteria and population studied, with many affected individuals undiagnosed. Applied to ONS mid-2024 population estimates, this equates to between 2,796 and 33,046 females aged 16-44 in Suffolk
- **Endometriosis:**
  - No Suffolk-specific data available. National estimates suggest endometriosis affects around 10% of women and birthing people of reproductive age, equating to an estimated 12,710 females aged 16–44 in Suffolk
- **Thyroid disorders:**
  - No Suffolk-specific data available. National prevalence of hypothyroidism is estimated at 1–2%, equating to between 1,271 and 2,542 females aged 16-44 in Suffolk
  - National prevalence of overt hyperthyroidism is estimated at 0.2–1.3%, equating to between 254 and 1,652 females aged 16–44 in Suffolk

So what?

A proportion of adults of reproductive age in Suffolk are living with pre-existing conditions that can influence fertility, pregnancy, and the health of a future child. Mental ill-health is the most prevalent issue identified locally, with over a third of women and one in five men aged 16–44 having this flag in their GP record- highlighting the value of early support and prevention, given the increased risk of mental ill-health that children of affected parents can face.

Conditions such as diabetes, epilepsy, and cardiovascular disease, although affecting smaller numbers, carry significant implications during pregnancy and benefit from being well managed before conception. HIV prevalence in Suffolk remains low and although the proportion of late diagnoses is high, this reflects a small number of cases overall; nonetheless, earlier identification continues to be important for individuals planning a family.

For several conditions- notably PMOS, endometriosis, fibroids, and thyroid disorders- local data is limited, but national estimates suggest that thousands of women and birthing people in Suffolk are likely to be affected, often without a confirmed diagnosis. Prospective parents may benefit from awareness of these conditions, opportunities to discuss symptoms or concerns with their GP, and timely access to diagnosis and management where needed.

Folic acid supplementation

Folic acid is a long-standing and well-evidenced preconception intervention, shown to reduce the risk of neural tube defects such as spina bifida when taken daily before conception and through the first 12 weeks of pregnancy.

Figures on pre-pregnancy folic acid supplementation in Suffolk are drawn from data reported at the first antenatal appointment, covering 2019/20 to 2023/24, with comparisons to England where available. Data quality should be considered when interpreting these figures, as the Maternity Services Data Set (MSDS) v2.0 began in April 2019 and completeness has improved year-on-year; the indicator is classed as 'in development'.

Key statistics

- In 2023/24, just under 1 in 3 pregnant women and birthing people in Suffolk reported taking folic acid before pregnancy- statistically significantly higher compared to England
- Uptake has statistically significantly increased from 23.1% in 2019/20 to 31.7% in 2023/24- an 8.6 percentage point rise
- Despite this improvement, this still means 68.3% of pregnant women and birthing people in Suffolk were not taking folic acid before conception in 2023/24

So what?

Suffolk is performing better than England on pre-pregnancy folic acid uptake, and the upward trend is a positive sign that awareness may increasing. However, over two-thirds of women and birthing people still enter pregnancy without having taken a folic acid supplement, pointing to a gap between clinical guidance and actual practice for those who could benefit. Given that the neural tube develops very early (often before pregnancy is confirmed) there is value in supporting women and birthing people who are planning or open to the possibility of pregnancy to access timely information about folic acid, alongside wider preconception health conversations in primary care and community settings.

Section 2: Maternal health

Maternal health refers to the health of a woman or birthing person during pregnancy, childbirth, and the postnatal period, and plays a vital role in the wellbeing of both parent and child. A healthy pregnancy supports the healthy growth and development of the baby and can reduce the risk of infant mortality and morbidity. The term 'maternal health' is used here in line with national reporting, while recognising that pregnancy and birth are experienced by people of different gender identities.

This summary provides an overview of maternal health across Suffolk, examining key indicators throughout pregnancy, birth, and the postnatal period, to help identify areas where additional investigation or support could improve outcomes for women and birthing people and their babies.

Maternal health during pregnancy

The health status of women and birthing people entering pregnancy plays an important role in shaping maternal outcomes, with medical comorbidities accounting for an estimated 66% of the increased risk of maternal death in the UK.

National data from MBRRACE-UK (2021–23) on the characteristics of women or birthing people who died during pregnancy or within six weeks of birth illustrates this:

- 64.6% were either overweight (27.2%) or obese (37.4%)
- 57.2% had a pre-existing medical condition (excluding obesity)
- 45.5% had a mental health condition or psychiatric disorder
- 23.7% were known to smoke during pregnancy
- 16.7% had reports of known substance use.

Taken together, these figures suggest that women and birthing people with medical comorbidities, mental health conditions, and health-related behaviours such as smoking and substance use may be overrepresented among maternal deaths, and that identifying and supporting these groups before and during pregnancy could play an important role in improving outcomes locally.

The sections that follow look at maternal health behaviours and pregnancy complications among women and birthing people in Suffolk, highlighting local areas where additional support may help to improve outcomes.

Maternal Health Behaviours

The behaviours and lifestyle factors of women and birthing people during pregnancy have a direct and lasting influence on the health of both parent and baby, with effects that can extend well beyond birth. Modifiable behaviours such as smoking, alcohol and drug use, diet, weight gain, physical activity, breastfeeding, and uptake of maternal vaccinations all play a role in shaping pregnancy outcomes, infant health, and longer-term wellbeing.

This summary draws on Suffolk-specific data where available, supplemented by national evidence applied to local population estimates. Some indicators are drawn from the Maternity Services Data Set (MSDS) v2.0, which began in April 2019; data quality and completeness have improved year-on-year, but several indicators remain classed as 'in development' and should be interpreted with caution.

Key statistics

- **Smoking at time of delivery, 2024/25:**
    - 4.9% of mothers or birthing people in Suffolk were known to smoke at delivery- the lowest recorded percentage to date, and statistically significantly better than England (6.5%)
    - A statistically significant decrease of 1.5 percentage points from 2023/24 (6.4%) to 2024/25 (4.9%)
    - A contributing factor to the reduction seen may be attributed to the roll-out of the Smoke-free pregnancy incentive scheme across Ipswich and West Suffolk, alongside existing treatment for tobacco dependence delivered through maternity services
    - Despite efforts, around 1 in 20 babies in Suffolk are still exposed to tobacco smoke in utero

- **Gestational weight, 2022/23:**
  - Over 1 in 4 (27.2%) of pregnant women or birthing people in Suffolk were living with obesity, statistically significantly higher than the England estimate
  - 2023/24 data was not available due to data quality issues; the indicator is classed as 'in development'
- **Breastfeeding initiation (first feed breastmilk), 2023/24:**
  - Over 3 in 4 (75.8%) babies in Suffolk had breastmilk as their first feed, statistically significantly higher than the England estimate
- **Breastfeeding at 6-8 weeks, 2024/25:**
  - Over half (54.0%) of infants in Suffolk were totally or partially breastfed at 6-8 weeks. Although this represents a statistically significant increase from 2023/4 (51.1%), 2024/25 data shows that Suffolk's breastfeeding at 6-8 weeks is statistically significantly lower than England
- **Alcohol use in pregnancy**
  - No Suffolk-specific data available. A global systematic review and meta-analysis estimated that the UK had the 4th highest rate of prenatal alcohol use at an estimated 41%. Applied to Suffolk's 2024 live births, this equates to around 2,699 pregnancies potentially involving alcohol exposure
  - UK prevalence estimates suggest 2–4% of children have foetal alcohol spectrum disorder (FASD)- equating to around 3,045–6,090 Suffolk children aged 0–17
  - Among Looked After Children, FASD prevalence rises to 30–33%- equating to around 300 Children in Care in Suffolk. Most are likely undiagnosed, as there is no established local diagnostic pathway
- **Illicit drug use in pregnancy:**
  - No Suffolk-specific data available. National Maternity Service Data Set (MSDS) booking data suggests 1.2% of women or birthing people report current misuse of illicit drugs, solvents or medicines, with 3.3% describing previous misuse prior to pregnancy. Applied to Suffolk's 2024 live births, this equates to around 79 pregnancies involving current misuse and around 217 involving previous misuse
- **Physical activity in pregnancy:**
  - No Suffolk-specific data available. National survey data (2024) found that:
    - around 40% of pregnant women or birthing people and 27% of postnatal women or birthing people felt they had the opportunity to be active
    - 35% of women or birthing people had the confidence to be active
    - 8% of pregnant women or birthing people and 10% of postnatal women or birthing people felt supported to be active
    - 59% reported pelvic floor or abdominal wall issues during or after pregnancy, with 58% of these not consulting a specialist physiotherapist.
    - Physical activity was discussed with only 13% of women at their 6–8 week postnatal check
- **Healthy Start Scheme uptake, Suffolk:**
  - Uptake increased from 61% in March 2023 to 77% in March 2024, estimated to have added a minimum of £600,000 into the pockets of Suffolk families
  - Voucher values are set to increase from April 2026 (£4.65 per week for pregnant women and children aged 1 to under 4; £9.30 per week for children under 1)

  - More recent local uptake data has been paused due to source quality issues
- **Maternal vaccination and lower respiratory tract infections (LRTIs) in under-5s:**
  - In 2024/25, emergency LRTI admissions in children under 5 in Suffolk were 249.3 per 10,000- statistically significantly worse than the England estimate. Trends show that the rate is also statistically significantly increasing and getting worse
  - Infants under 6 months, and particularly those aged 0–3 months, consistently show the highest LRTI admission peaks each year
  - RSV bronchiolitis is the leading driver of winter LRTI admissions in young children, with predictable seasonal peaks placing considerable demand on healthcare services
  - A reduction in LRTI admission rates for infants aged 0–3 months was observed in 2024/25 - in line with the introduction of the maternal RSV vaccination in Suffolk in September 2024. This reduction was not statistically significant, which could reflect limited follow-up time and small numbers in the first year of the programme
  - Average maternal RSV vaccination uptake across Suffolk GP practices was approximately 64%, statistically similar to the national average of 63.6%
  - Preterm birth, low birth weight, maternal asthma, and current smoker status were all statistically significantly more prevalent among children admitted with LRTI compared with the Suffolk (excluding Waveney) under-5 population overall

So what?

Maternal health in Suffolk is shaped by a range of behaviours during and after pregnancy, and the data points to a number of areas where women and birthing people may benefit from additional support. These include stopping smoking, supporting healthy weight gain in pregnancy, continuing breastfeeding beyond the early days, moderating alcohol intake, being physically active where possible, and engaging with the recommended maternal vaccinations. Supporting women and birthing people to optimise these modifiable behaviours throughout pregnancy and the postnatal period offers an opportunity to improve pregnancy outcomes, reduce the likelihood of complications for parent and baby, and contribute to better long-term health for the next generation of Suffolk residents.

Pregnancy complications

Pregnancy complications can affect the immediate health of women, birthing people, and their babies, and in some cases carry long-term implications that extend well beyond pregnancy itself.

This summary draws on Suffolk-specific data where available, supplemented by national prevalence estimates applied to local birth figures where local data is limited, to give a picture of the most common complications affecting women and birthing people during pregnancy and the postnatal period.

Key statistics

- **Hypertensive disorders of pregnancy (HDP):**
  - Women or birthing people with a history or diagnosis of HDPs represent an identifiable cohort at elevated risk of hypertension, stroke and cardiovascular disease

  - No Suffolk-specific data available. National evidence shows that HDP affects around 8–10% of pregnancies in the UK, equating to approximately 527 to 658 Suffolk pregnancies based on 2024 live births
- **Gestational diabetes mellitus (GDM):**
  - Women or birthing people with a history or diagnosis of GDM represent an identifiable cohort at high risk of type 2 diabetes and cardiovascular disease. Despite their increased risk there are clear gaps in postnatal monitoring and low engagement with diabetes prevention programmes
  - No Suffolk-specific data available. National evidence shows that up to 5% of pregnancies in England and Wales involve pre-existing or gestational diabetes, with around 87.5% of these being GDM- equating to approximately 288 Suffolk pregnancies based on 2024 live births
- **Maternal mental health:**
  - Nationally, maternal mental health conditions affect as many as 1 in 4 women and birthing people and are more common than gestational diabetes or pre-eclampsia
  - Around 12% of women experience depression and 13% experience anxiety during pregnancy; 15–20% experience these conditions in the first year after childbirth
  - Postpartum psychosis affects 1-2 in 1,000 women, with higher risk among those with bipolar disorder
  - In Suffolk (2019), 26.2% of women or birthing people were estimated to experience perinatal mental health conditions- placing Suffolk in the middle quintile of upper-tier local authorities in England. Estimates have remained broadly stable since 2016 (26.5%)
  - Research suggests 70% of women hide or downplay their mental ill-health due to fear of judgment, stigma, or concerns about social services involvement
  - Mental health conditions account for over one third of maternal deaths between 6 weeks and 1 year postpartum, with suicide now the leading cause of maternal death in this period

So what?

Pregnancy complications affect a proportion of women and birthing people in Suffolk, with implications that often extend well beyond pregnancy itself. Hypertensive disorders and gestational diabetes are both relatively common and carry significant long-term cardiovascular and metabolic risks, meaning that the antenatal and postnatal period offers an important opportunity to identify and support women whose future health may be affected- particularly given national audit data pointing to substantial gaps in postnatal follow-up for women with GDM.

Maternal mental health stands out as both common and consequential, affecting roughly a quarter of women in Suffolk and now the leading driver of maternal deaths in the year after pregnancy. With evidence that many women hide or downplay symptoms, normalising conversations about mental wellbeing across antenatal and postnatal care, ensuring support is accessible and non-judgmental, and including partners and non-birthing parents where appropriate are likely to remain important focuses.

Taken together, the data suggests that pregnancy complications represent a window of opportunity not only to manage immediate risks but also to support the longer-term physical and mental health of women and birthing people in Suffolk.

Births, birth characteristics and immediate birth outcomes

Births, birth characteristics, and immediate birth outcomes provide important insight into the health of women, birthing people, and babies at delivery and during the critical first two weeks of life. These indicators reflect the effectiveness of antenatal care, the complexity of pregnancies in the local population, the demands placed on maternity services, and the needs of newborns- and can help identify areas where additional investigation or support may improve outcomes for women, birthing people, and babies in Suffolk.

Key statistics

- **Live birth rates and fertility rates, Suffolk:**
  - There were 6,583 live births in Suffolk in 2024, 32 fewer than in 2023 (6,651), and a 15.5% decrease since 2013 (7,792)
  - In 2023, Suffolk's general fertility rate (GFR) was 51.1 per 1,000 females aged 15–44, statistically significantly higher than England but the lowest rate for Suffolk on record locally
  - The GFR in Suffolk has declined significantly from its peak of 65.2 per 1,000 in 2011 to 51.1 per 1,000 in 2023
- **Caesarean section deliveries, 2023/24:**
  - 36.9% of deliveries in Suffolk were by caesarean section (2,090 deliveries), statistically significantly lower than the England estimate of 40.9%
  - Recent trends show a statistically significant increase in caesarean deliveries in Suffolk over time
- **Multiple births, 2023:**
  - The multiple birth rate in Suffolk was 14.3 per 1,000 maternities (94 births), statistically similar to the England estimate of 14.5 per 1,000
  - Recent trends show no statistically significant change
- **Premature births, 2020-22:**
  - 75.8 per 1,000 live births and stillbirths in Suffolk were premature (1,572 births), statistically similar to the England estimate of 77.0 per 1,000
  - There has been a statistically significant decrease from 2018–20 (85.9 per 1,000) to 2020–22
- **Low birth weight (under 2,500g):**
  - In 2023, 7.0% of all births in Suffolk (430 births) had a recorded birth weight under 2,500g, statistically similar to the England estimate of 7.4%
  - In 2024, 3.0% of live term births in Suffolk (171 births) had a birth weight under 2,500g, matching the England estimate
  - Recent trends show no statistically significant change
- **Very low birth weight (under 1,500g), 2023:**
  - 0.9% of all births in Suffolk (57 births) had a birth weight under 1,500g, statistically similar to the England estimate of 1.1%
  - Recent trends show no significant change
- **Emergency admissions of babies aged 0-13 days, 2023/24:**
  - 132.5 per 1,000 babies aged 0–13 days in Suffolk were admitted to hospital, statistically significantly higher than the England estimate of 88.7 per 1,000

- Rates have statistically significantly increased from 2017/18 (100.7 per 1,000) to 2023/24, although no statistically significant change has been seen in the most recent years

So what?

Births and birth outcomes in Suffolk show a mixed picture. The number of live births and the general fertility rate continue to decline, in line with wider national trends, while caesarean section rates are lower than England but rising over time. Premature births, multiple births, and low and very low birth weight rates are broadly in line with national figures, with no significant recent changes. The most notable local outlier is the rate of emergency admissions of babies aged 0–13 days, which is significantly higher than the national average and has risen over recent years- pointing to an area where further investigation into the drivers of early admissions may be valuable.

Given that birth weight, prematurity, and early neonatal admissions are all shaped by maternal health and antenatal care, supporting modifiable factors before and during pregnancy (including smoking, alcohol, nutrition, and management of pre-existing conditions) is likely to remain an important contributor to improving immediate birth outcomes for babies in Suffolk.

Pregnancy loss

Pregnancy loss (including miscarriage, stillbirth, and ectopic pregnancy) is a common experience that affects individuals and families across Suffolk. National data indicates an estimated 254,000 babies die in pregnancy or at birth each year in the UK.

While the data and definitions used in this summary necessarily use clinical language, it is important to recognise that pregnancy loss can be a deeply distressing experience for those affected, with consequences that are both physical and psychological and that can extend to partners and non-birthing parents.

This summary draws on Suffolk-specific data where available, supplemented by national prevalence estimates, to give a picture of the scale of pregnancy loss locally and the mental health impacts that can follow.

Key statistics

- **Miscarriage:**
  - No Suffolk-specific data available. National evidence shows that:
    - Miscarriage occurs in an estimated 8–24% of clinically recognised pregnancies, with most (around 80%) occurring in the first trimester
    - About 25% of women will experience a miscarriage in their lifetime
    - Recurrent miscarriage affects about 1% of couples trying to conceive
    - Early pregnancy loss accounts for over 50,000 hospital admissions in the UK each year
    - The risk of future miscarriage rises with each previous loss (from 11.3% with no previous miscarriages to 63.9% after six)
- **Stillbirth, 2022-24:**
  - Legally defined as when a baby is born after 24 weeks of pregnancy with no signs of life
  - Suffolk's stillbirth rate for all maternal ages was 4.3 per 1,000 births, statistically similar to England

  - Recent trends show no significant change
- **Ectopic pregnancy, 2023/24:**
  - Suffolk's ectopic pregnancy admissions rate in women aged 15–44 was 89.1 per 100,000, statistically similar to the England estimate of 95.8 per 100,000
  - Recent trends show no significant change
  - Ectopic pregnancy remains the most frequent cause of maternal death in early pregnancy across the UK and Ireland. The MBRRACE-UK 2024 report found that 12 women died from ectopic pregnancy across the UK and Ireland between 2020 and 2022 (almost twice the 2018–20 rate) and that improvements in care may have made a difference to the outcome for 9 of the 12 women (75%)
- **Mental health after pregnancy loss:**
  - No Suffolk-specific data available. National evidence shows that:
    - Around 1 in 5 women (20%) who experience miscarriage develop symptoms of depression and/or anxiety, with symptoms potentially persisting for up to 3 years
    - A multi-centre London study found that 29% of women met criteria for post-traumatic stress disorder (PTSD) one month after early pregnancy loss (18% at nine months), 24% had moderate/severe anxiety (17% at nine months), and 11% had moderate/severe depression (6% at nine months)
    - A Mariposa Trust survey of 340 people who had experienced pregnancy loss found 49.4% had considered ending their life, 47% had been diagnosed with depression, 63.8% reported undiagnosed depression, and 69.1% reported long-term mental health issues
    - 16.5% of respondents reported their partners had experienced suicidal thoughts following baby loss, and 41.4% reported their partners had experienced mental health issues

So what?

Pregnancy loss is common, often deeply distressing, and affects many families in Suffolk each year. While local rates of stillbirth and ectopic pregnancy admissions are broadly in line with national figures, national evidence on miscarriage suggests that a significant proportion of Suffolk women and birthing people will experience pregnancy loss at some point- and that the mental health impact can be substantial and long-lasting for both birthing parents and their partners. Recent policy developments, including the national rollout of Maternal Mental Health Services and the National Bereavement Care Pathway, reflect growing recognition of the need for accessible, consistent support after loss.

The data points to the value of ensuring that mental health check-ups are routinely offered to both birthing parents and partners following a loss, that pathways to specialist support are clear and well-signposted, and that those at higher risk (including women experiencing recurrent loss, those without living children, and those facing social isolation or relationship difficulties) receive timely and tailored care.

Continued focus on awareness of ectopic pregnancy symptoms among both clinicians and the public, supporting earlier conversations about loss, and recognising the often-overlooked impact on partners and non-birthing parents should remain important areas of focus in Suffolk.

Termination of pregnancy

Termination of pregnancy is a safe and legally regulated healthcare intervention that forms part of comprehensive reproductive care. While the data and definitions used in this summary necessarily use clinical language, it is important to recognise that termination of pregnancy can be a deeply personal and at times distressing experience for those affected.

Recent changes in the law mean that women in England and Wales will no longer face criminal prosecution for ending their own pregnancies. However, the existing legal framework for abortion care i.e. the Abortion Act 1967 (including the 24-week limit and how services are regulated and delivered) remains in place.

This summary draws on Suffolk-specific data where available to give a picture of local termination rates, timing, and method, alongside national evidence on the mental health considerations that may follow.

Key statistics

- **Total abortion rate, 2021:**
    - The total abortion rate in Suffolk was 14.5 per 1,000 females aged 15–44, statistically significantly lower than the England estimate
    - Recent trends show no significant change from 2020 to 202
- **Timing of abortion, 2021:**
    - 87.6% of abortions in Suffolk were completed under 10 weeks, statistically similar to the England estimate of 88.6%
    - The percentage of earlier abortions in Suffolk has statistically significantly improved from 69.5% in 2012 to 87.6% in 2021- an 18 percentage point increase
- **Method of abortion, 2021:**
    - 97.6% of abortions under 10 weeks in Suffolk were medical, statistically significantly higher than the England estimate of 95.5%
    - The percentage of medical abortions under 10 weeks in Suffolk has statistically significantly increased from 94.3% in 2020 to 97.6% in 2021- a 3.3 percentage point increase
- **Mental health after termination of pregnancy:**
    - No Suffolk-specific data available. National evidence shows that:
        - Mental health outcomes following induced abortion are influenced more by the context and circumstances surrounding the pregnancy than by the abortion procedure itself
        - Women experiencing an unwanted pregnancy show similar rates of mental health difficulties whether they continue the pregnancy or have an induced abortion
        - Factors associated with poorer mental health outcomes include a history of mental health problems, negative attitudes towards abortion, partner pressure to terminate, and negative experiences during or after the procedure
        - Women and birthing people experiencing therapeutic abortion (for medical reasons such as severe foetal anomalies or to preserve the mother's life), as well as their partners or non-birthing parents, may face an emotional context similar to that of pregnancy loss, with grief, anxiety, and depression all potentially affecting both parties

So what?

The data on termination of pregnancy in Suffolk reflects a service that is being accessed earlier, more often medically, and at a lower overall rate than the national average. The substantial increase in abortions completed under 10 weeks since 2012, alongside a high proportion of medical procedures, points to improvements in timely access. This is important because complication risks rise as gestation advances, and earlier access supports both safety and patient choice. At the same time, ensuring that women and birthing people retain a balanced choice between medical and surgical options remains an important part of high-quality, person-centred care.

National evidence suggests that mental health outcomes after termination are shaped more by surrounding circumstances than by the procedure itself, and that women or birthing people facing unwanted pregnancy experience similar rates of mental health difficulties regardless of the decision they make. This points to the value of supporting informed, non-judgmental decision-making, identifying those who may be at higher risk of poorer outcomes (including women or birthing people with a history of mental ill-health, those experiencing pressure from a partner, or those undergoing therapeutic abortion) and ensuring that accessible mental health support is available to all who may benefit, including partners and non-birthing parents who may also be affected. Continued attention to timely access, patient choice, and holistic wellbeing throughout the care pathway should remain an important focus.

Section 3: Demographic differences

Pregnancy outcomes and experiences of maternity care vary across the population, with evidence indicating that demographic characteristics such as age, ethnicity, socioeconomic circumstances, and disability status are associated with different patterns of risk, access to services, and health outcomes throughout the pregnancy journey. Women and birthing people from certain demographic groups may experience higher rates of pregnancy complications, adverse birth outcomes, and maternal mortality, as well as barriers to accessing timely, appropriate, and culturally competent care. These differences reflect a complex interplay of biological, social, structural, and service-related factors, with characteristics often intersecting to create varying patterns of experience and outcome.

This summary examines local and national data across these four key dimensions and considers the implications for maternity care delivery in Suffolk.

Age

Both teenage pregnancy and advanced maternal age (35 years and over) are associated with distinct patterns of risk for women or birthing person and baby.

Younger parents may face challenges including reduced educational attainment, economic disadvantage, and poorer physical and mental health, while their children face higher risks of preterm birth, low birth weight, and intergenerational disadvantage.

Pregnancies at age 35 and over carry an independently higher risk of complications including pre-eclampsia, gestational diabetes, stillbirth, and maternal mortality, with risks rising sharply after age 40.

This summary draws on Suffolk-specific data on under-18 conceptions and deliveries to women aged 35 and over, with comparisons to England and national context on outcomes. It is worth noting that the proportion of under-18 conceptions ending in abortion is used as a proxy for

unplanned pregnancy; the decision to terminate a pregnancy is often complex and shaped by a range of factors beyond whether a pregnancy was planned, including access to services, social and family circumstances, and personal beliefs.

Key statistics

- **Under-18 conceptions in Suffolk:**
    - In 2022, the under-18 conception rate in Suffolk was 14.6 per 1,000, statistically similar to the England estimate of 13.9 per 1,000
    - The rate has fallen statistically significantly over the last decade (from 24.9 per 1,000 in 2012), though a small recent uptick (from 12.2 per 1,000 in 2021) is worth monitoring- although not statistically significant
    - In 2022, 46.1% of conceptions to those aged under 18 in Suffolk led to abortion- statistically significantly lower than the England percentage of 58.2%
    - Nationally in 2022, 61% of conceptions to under-16s and 58% of conceptions to under-18s ended in abortion, compared with around 18% among women aged 30–34
- **Advanced maternal age in Suffolk:**
    - In 2023/24, 20.5% of deliveries in Suffolk were to women or birthing people aged 35 and above- placing Suffolk in the bottom 40% of upper-tier local authorities in England for older maternal age profile
    - The percentage of deliveries to women aged 35 and over in Suffolk has increased by 13.9% from 2010/11 (18.0%) to 2023/24 (20.5%)
    - Nationally, the percentage of deliveries to women aged 35+ has increased by 26.0% from 2010/11 (19.6%) to 2023/24 (24.7%)
    - Compared to women aged 25–29, those aged 35+ face nearly double the risk of maternal mortality, with women aged 40+ facing nearly a 3-fold increased risk

So what?

Suffolk's maternal age profile differs from England's in both directions: under-18 conception rates have fallen substantially over the past decade and remain in line with the national average, while deliveries to women aged 35 and over are lower than nationally but rising. Both ends of the age spectrum carry distinct implications for maternity care. The recent uptick in under-18 conceptions, although not statistically significant, is worth keeping under review, and continued investment in comprehensive relationships and sex education, accessible contraception and sexual health services, and coordinated support for young parents is likely to remain important. At the same time, the rising proportion of pregnancies at age 35 and over points to a growing need for tailored antenatal surveillance and clinical management to identify and manage the elevated risks of complications and adverse outcomes that accompany advanced maternal age.

Ethnicity

Pregnancy outcomes in the UK vary across ethnic groups, reflecting a complex interplay of biological, cultural, structural, and service-related factors. Differences emerge across the full pregnancy continuum- from fertility and access to assisted reproduction, through antenatal care engagement, to pregnancy complications, birth outcomes, and maternal mortality. Understanding these patterns is important for delivering equitable, culturally competent maternity care.

This summary draws on Suffolk-specific data on the ethnicity profile of deliveries, supplemented by national evidence on disparities in access, experience, and outcomes. It is worth noting that local maternity outcomes are not routinely reported by ethnicity in publicly available datasets, and the National review of maternity services in England 2022 to 2024 found considerable variation in how trusts collect and use ethnicity data- meaning that some local disparities may be present but not currently visible in the available data.

Key statistics

- **Ethnicity profile of deliveries in Suffolk:**
    - In 2023/24, over 1 in 10 deliveries in Suffolk (11.3%) were to women or birthing people from ethnic minority groups
    - Suffolk has a less ethnically diverse profile at delivery than England overall, with the percentage of ethnic minority residents consistently ranking in the bottom 40% of England counties over time.
    - The percentage of deliveries to women from ethnic minority groups in Suffolk has increased by almost three-quarters (73.9%) from 2010/11 (6.5%) to 2023/24 (11.3%)
    - Local PHM data (Suffolk excluding Waveney, November 2024–October 2025) recorded 4,410 birth episodes, of which 16.8% were to women or birthing people from ethnic minority groups: 72.4% White British/Irish, 10.7% White Other, 8.2% Asian, 4.2% Black, 2.5% Mixed ethnicity, and 1.8% Other Ethnic Group
- **National disparities in pregnancy and birth outcomes:**
    - IVF birth rates among women aged 18–37 are 23% for Black patients, 24% for Asian patients, and 32% for White patients per embryo transferred
    - NHS funding for fertility treatment (2021): 41% of Black patients, 49% of Asian patients, and 53% of White patients
    - Between 2021–23, Black women or birthing people were nearly 3 times more likely than White women or birthing people to experience thrombosis and thromboembolism, and more than twice as likely to suffer from cardiac disease during pregnancy. Asian women showed notably elevated COVID-19-related complications at nearly 3 times the rate of White women
    - Caribbean (Black or Black British) women or birthing people are more likely than British White women to receive general anaesthesia for caesarean births (58% and 10% respectively for elective caesareans)
    - Babies born to women from Black ethnic groups experience the highest rates of stillbirths and infant deaths, with babies from Asian ethnic groups consistently the second highest
    - Maternal mortality (2025 MBRRACE-UK report): Asian women or birthing people experienced 1.35 times higher maternal mortality rates, while Black women faced 2.27 times higher rates, compared with White women- although mortality for Black women has decreased to its lowest level since 2013–15

So what?

Suffolk has a less ethnically diverse maternal population than England overall, but the proportion of deliveries to women from ethnic minority groups has grown substantially over the past decade and continues to rise. National evidence highlights persistent ethnic disparities across the full pregnancy continuum from fertility treatment access and outcomes, through antenatal care engagement and pregnancy complications, to birth outcomes and maternal

mortality. These disparities have been shown to be driven by a combination of biological, structural, and service-related factors including language barriers, cultural needs not being met, experiences of racism and stereotyping, and lack of continuity of care.

As Suffolk's maternal population becomes more diverse, ensuring that local services are culturally competent, that ethnicity data is collected and used consistently to identify disparities, and that clinical training and assessment tools account for ethnic variation in presentation are likely to remain important areas of focus. Attention to building trust, supporting continuity of care, and ensuring accessible interpreting and culturally appropriate support may help reduce the risk of women from ethnic minority groups delaying or disengaging from care.

Deprivation

Socioeconomic deprivation remains a significant determinant of maternal health outcomes in England, shaping risk factors, health-promoting behaviours, access to care, and clinical outcomes across the full pregnancy journey. National evidence shows higher risks of stillbirth, preterm birth, foetal growth restriction, and maternal mortality among women living in the most deprived areas, with the gap widening over time.

This summary uses Suffolk-specific PHM data (Suffolk excluding Waveney, November 2024–October 2025) where available, alongside national evidence. Local deprivation deciles are classified using the Index of Multiple Deprivation 2025, while national figures use the Index of Multiple Deprivation 2019; the two are not directly comparable but both show the same overall pattern of disadvantage.

Key statistics

- **Maternal mortality and deprivation (England, 2021-23, MBRRACE-UK):**
    - Women or birthing people living in the most deprived areas had a maternal mortality rate nearly two times higher than women living in the least deprived areas
    - Over a quarter (27%) of all maternal deaths occurred in the most deprived quintile, despite this group representing only 20% of the population
    - While mortality rates have increased across all groups over time, the absolute difference between the most and least deprived has grown
- **Preconception and behaviours (national, 2022 and 2023/24):**
    - In 2022, the most deprived areas had 2.3 times higher under-18 conception rates compared to the least deprived areas
    - In 2023/24, the least deprived areas (27.9%) had a 2.8 times higher percentage of women taking folic acid supplements before pregnancy compared to the most deprived areas (10.1%)
    - In 2023/24, the most deprived areas (20.8%) had a 2.9 times higher percentage of pregnant women who smoke in early pregnancy compared to the least deprived areas (7.2%)
    - In 2023/24, the most deprived areas (32.4%) had a 1.6 times higher percentage of pregnant women living with obesity compared to the least deprived areas (19.8%)
    - In 2023/24, the least deprived areas (69.6%) had a 1.2 times higher percentage of women whose booking appointment occurred within 10 completed weeks compared to the most deprived areas (56.9%)

  - In 2023/24, the least deprived areas (81.3%) had a 1.4 times higher percentage of women whose baby's first feed was breastmilk compared to the most deprived areas (59.1%)
- **Local data for Suffolk (excluding Waveney, December 2024- October 2025):**
  - Smoking at time of birth was 7.9% in the most deprived decile (1) and 1.7% in the least deprived decile (10)- the most deprived decile was 4.6 times higher than the least deprived
  - Booking appointments before 10 weeks were 73.9% in the most deprived decile and 86.2% in the least deprived- the least deprived was 1.2 times higher (a 12.3 percentage point difference). The lowest percentage was in decile 3 at 71.6%.
  - Breastfeeding as first feed was 59.3% in the most deprived decile and 72.0% in the least deprived- the least deprived was 1.2 times higher (a 12.7 percentage point difference). The highest percentage was in decile 7 at 76.5%
  - Presentation at antenatal care with any complex social factors was 22.4% in the most deprived decile and 5.2% in the least deprived- the most deprived was 4.3 times higher (a 17.2 percentage point difference). The lowest percentage was in decile 9 at 3.7%

So what?

Deprivation shapes the pregnancy journey from preconception through to birth and beyond, with consistent gradients seen both nationally and locally in Suffolk. Women and birthing people in the most deprived areas of Suffolk are substantially more likely to smoke during pregnancy, to book their first midwife appointment later, to be less likely to initiate breastfeeding, and to present for antenatal care with complex social factors such as substance use, domestic abuse, mental health diagnoses, or migration-related challenges.

National evidence also points to substantially higher risks of adverse outcomes and maternal mortality among women in the most deprived areas, with this gap widening over time. The MBRRACE-UK 2025 confidential enquiry highlights that women with complex social circumstances often interact with multiple, siloed services without adequate coordination, suggesting that joined-up, multi-agency working and continuity of care may be particularly valuable for this group.

Reducing inequalities in maternity outcomes in Suffolk is likely to require sustained attention not only to clinical care but also to the wider social, economic, and structural factors that shape women's lives before and during pregnancy.

Disability

Disabled women make up an estimated 20% of women of reproductive age in the UK, equating to around 2.9 million women. Emerging evidence highlights that disabled women experience worse maternity care access, experiences, and outcomes compared to non-disabled women, with disparities seen across antenatal behaviours, clinical care, birth outcomes, and postnatal recovery.

This summary draws on national evidence, primarily from the London School of Hygiene & Tropical Medicine (LSHTM) and Missing Billion Initiative report Disparities in maternity care for disabled women in the UK. Local data on maternity care for disabled women in Suffolk is not currently available in publicly reported datasets, which itself reflects a wider gap in how disability is captured and reported across maternity services. It is also worth noting that

disability is diverse, and women and birthing people with different impairments may experience very different barriers- the figures below describe broad patterns rather than a single shared experience.

Key statistics

- **National outcomes for disabled women and birthing people (LSHTM/Missing Billion Initiative):**
    - 44% higher odds of stillbirth or neonatal mortality for infants born to disabled mothers or birthing people
    - 30–69% higher odds of caesarean birth
    - 35–70% lower odds of breastfeeding
    - 51–111% higher odds of longer postnatal hospital stays
    - Higher rates of smoking during pregnancy, with some evidence pointing to greater likelihood of illegal/recreational drug use, poor diet, low exercise, and lack of folic acid supplementation
- **Attention to disability in national maternity guidance**
    - Of 67 Royal College of Obstetricians and Gynaecologists reports reviewed, only 2 mentioned disability
    - Of 30 NICE guidance documents on fertility, pregnancy and childbirth reviewed, only 6 made any reference to disability, and these mentions were typically brief with limited detail on maternity care for disabled women

So what?

Disabled women and birthing people experience significantly worse maternity outcomes nationally, including substantially higher odds of stillbirth, caesarean birth, and longer postnatal stays, alongside lower odds of breastfeeding and engagement with health-promoting behaviours during pregnancy.

Qualitative evidence points to consistent barriers including difficulty understanding written and verbal information, physical accessibility issues, staff lacking knowledge or holding unhelpful attitudes, lack of continuity of care, and concerns about stigmatisation when disclosing disability.

NHS Trusts have legal obligations under equality and human rights law to make reasonable adjustments (including longer appointments, accessible information formats, physical accommodations, and enhanced communication support) and emerging initiatives such as disability pregnancy passports show promise in supporting continuity and communication. However, the limited attention to disability in national maternity guidance suggests that addressing inequities for disabled women requires broader action across workforce training, policy development, facility accessibility, and the integration of disability considerations throughout local maternity care pathways.

Strengthening local data collection on disability status in maternity services may also help identify where Suffolk's disabled women and birthing people would most value additional support.

Section 4: Wider determinants

Individual health behaviours and medical conditions are important factors in a healthy pregnancy journey, but they exist within a broader social, economic, and environmental

context. Wider determinants of health (including financial stability, employment, education, housing, and environment) shape people's ability to access care before, during, and after pregnancy, make healthy choices, and maintain wellbeing from conception through the early postnatal period. These factors also influence reproductive decisions themselves, with research from the UCL Centre for Longitudinal Studies identifying financial pressures and career considerations as the main reasons people are not currently trying to have children or add to their family.

This summary examines how wider determinants influence a healthy pregnancy journey in Suffolk, drawing on local data where available and supplementing with national evidence where local data is limited.

Financial stability

Financial stability is important throughout the pregnancy journey because it reduces stress and provides consistent access to essential resources like medication, nutritious food, and stable housing. Research demonstrates that income disparities significantly affect access to timely prenatal care, with women from lower-income backgrounds often experiencing delayed initiation of care and fewer prenatal visits, increasing the likelihood of adverse outcomes.

This summary draws on Suffolk-specific data on worklessness, low pay, and child poverty, alongside national evidence on the cost of raising a child and the impact of financial strain on maternal and infant outcomes.

Key statistics

- **Cost of raising a child and family income (national, 2025):**
    - The total cost of raising a child to age 18 is over £250,000 for a couple and nearly £290,000 for a lone parent (Child Poverty Action Group)
    - Non-working couples with two children (aged 3 and 7) can cover just 37% of minimum family costs (a 63% shortfall); non-working lone parents can cover 44% (a 56% shortfall)
    - Even when working full-time on median wage, couples fall 2% short of minimum needs, and lone parents fall 21% short
    - Statutory maternity pay equates to just 47% of the National Living Wage
    - 71% of women worried 'a lot' about money during pregnancy or maternity leave; 58% returned to work earlier than planned for financial reasons (Maternity Action)
    - Average earnings losses following adverse pregnancy events included £13,581 following stillbirth, £12,441 following neonatal death, and £3,511–£4,101 following miscarriage (ONS, April 2014–December 2022)
- **Local financial pressures in Suffolk:**
    - In Suffolk between January and December 2023, over 1 in 10 households (13.0%, 30,300) with at least one person aged 16–64 were workless households
    - In 2025, approximately 15.6% of Suffolk employees (around 50,000 jobs) earned below the Living Wage Foundation's living wage of £12.60
    - In 2023/24, 20.4% of children under 16 in Suffolk (27,143 people) were in relative low income families, statistically significantly better than the England estimate of 22.1%, but with a statistically significantly worsening trend
    - In 2023/24, 17.2% of children under 16 in Suffolk (22,884 people) were in absolute low income families, statistically significantly better than the England estimate of 19.1%, but again with a statistically significantly worsening trend

So what?

While Suffolk performs better than England on headline child poverty measures, both relative and absolute low-income figures are rising over time, and one in five children under 16 in Suffolk is still growing up in a low-income family.

National evidence shows that financial strain during pregnancy is associated with lower birth weight, increased depressive symptoms, and pregnancy-specific distress, and that adverse pregnancy events such as stillbirth and miscarriage carry significant and lasting earnings losses.

Local levels of worklessness and low pay, combined with worsening child poverty trends, suggest that financial pressure is a meaningful and growing context for many Suffolk families navigating the pregnancy journey.

Supporting families through accessible benefits, schemes such as Healthy Start, and integrated support that recognises the link between financial pressure and maternal and infant outcomes is likely to remain an important focus.

Employment

Employment and work conditions influence the pregnancy journey from preconception through to the postnatal period, with job security, workplace policies, and physical demands all shaping health outcomes. Supportive workplaces (including access to maternity leave, flexible working, and ergonomic adjustments) can promote maternal wellbeing, while strenuous environments, limited paid leave, and job insecurity can contribute to stress and adverse outcomes.

This summary draws on Suffolk-specific data on female employment, alongside national evidence on workplace conditions, pregnancy discrimination, and the relationship between employment and pregnancy outcomes.

Key statistics

- **National evidence on employment and pregnancy:**
    - 77% of mothers reported a negative or potentially discriminatory experience during pregnancy, maternity leave, and/or on return from maternity leave (Equality and Human Rights Commission)
    - Around 1 in 9 mothers (11%) reported they felt forced to leave their job
    - 1 in 5 mothers experienced harassment or negative comments related to pregnancy or flexible working
    - 1 in 10 mothers were discouraged from attending antenatal appointments
    - In April–June 2021, 75.6% of women or birthing people with dependent children were in work in the UK, the highest level in the equivalent quarter over the last 20 years (66.5% in 2002)- with the employment rate for mothers and birthing people higher than for women or men without dependent children since 2017
    - A third (33.3%) of women or birthing people with dependent children reported having agreed special working arrangements in their job
- **Local employment data for Suffolk:**
    - In 2024/25, over half (57.1%) of all females aged 16 years or over in Suffolk were in employment (182,000 people)
    - Recent trends show no significant change

So what?

Employment shapes the pregnancy journey both directly, through workplace conditions and access to leave, and indirectly, through financial security and stress. While maternal employment has reached historic highs nationally, national survey evidence shows that pregnancy discrimination, inflexible working arrangements, and inadequate support remain widespread, with three in four mothers reporting a negative or potentially discriminatory experience.

Workplace barriers can affect attempts to conceive, access to antenatal appointments, and recovery in the postnatal period, with lasting impacts on earnings- particularly for those experiencing adverse pregnancy events.

Locally, female employment in Suffolk has remained stable over recent years. Supporting women and birthing people to access flexible, secure, and supportive employment throughout the pregnancy journey, and ensuring awareness of employment rights and protections, is likely to remain an important contributor to maternal and infant wellbeing.

Education

Educational attainment is recognised as a social determinant of maternal health, with international evidence suggesting that lower educational levels are associated with worse pregnancy outcomes, particularly stillbirth and the risk of having a "small vulnerable newborn" (a composite of preterm birth, low birth weight, and small-for-gestational-age).

This summary draws on Suffolk-specific data on female educational attainment from the 2021 Census, alongside international evidence on the relationship between education and pregnancy outcomes. It is worth noting that the international meta-analysis cited includes data from low-, middle- and high-income countries, so the magnitude of effects may not translate directly to a UK context; however, the association between maternal education and stillbirth remained significant when analysis was restricted to high-income countries.

Key statistics

- **International evidence on education and pregnancy outcomes (meta-analysis of 2,356,402 pregnancies, 2025):**
    - Compared to women with tertiary education, women with lower educational levels had higher estimated risks of maternal death (27% higher for secondary education and approximately double for informal or primary education), although these estimates were imprecise and not statistically significant due to the low frequency of maternal death in the study
    - Significant and consistent associations were found for stillbirth in a dose-response pattern: a 25% increased risk for women with secondary education and a twofold increased risk for women with informal or primary education. This association remained significant when analysis was restricted to high-income countries
    - Lower educational attainment was also significantly associated with a higher risk of having a small vulnerable newborn: a 12% increased risk for secondary education and a 20% increased risk for informal or primary education
    - No significant association was found between maternal education and preeclampsia

- **Education attainment of females aged 16-44 years in Suffolk (2021 Census):**
  - 9.7% had qualifications at primary level (no qualifications)- 6.5 percentage points higher than England estimates
  - 50.4% had qualifications at secondary level (Level 1, 2, and 3 qualifications)- 7.3 percentage points higher than England estimates
  - 39.9% had qualifications at tertiary level (Level 4 and apprenticeships, vocational or work-related qualifications)- 13.7 percentage points lower than England estimates

So what?

Suffolk has a less qualified female population of reproductive age than England overall, with higher proportions at primary and secondary education levels and a notably lower proportion at tertiary level. International evidence highlights education as an important social determinant of maternal health, with the strongest and most consistent associations seen for stillbirth and for having a small vulnerable newborn- both showing a clear dose-response pattern.

While the UK context differs from the global picture, the association between maternal education and stillbirth persisted even in analyses restricted to high-income countries, suggesting that the relationship is unlikely to be explained by setting alone. This points to the value of ensuring that maternity services in Suffolk are accessible, easy to navigate, and supportive for women and birthing people across all educational backgrounds. Clear, plain-language information, opportunities to ask questions, and active support in navigating services may be particularly important locally, alongside wider efforts to improve educational and vocational opportunities for women and birthing people across the life course.

Housing and environment

Housing, neighbourhood conditions, and environmental exposures are important social determinants that can influence maternal health outcomes throughout the pregnancy journey. Poor housing (including damp, mould, overcrowding, and lack of sanitation) has been linked to adverse birth outcomes and to the psychological stress associated with insecure or substandard living conditions. Air pollution is an emerging area of concern, though current evidence is not yet considered robust enough to inform policy.

This summary draws on Suffolk-specific data from the Suffolk Housing and Health Needs Assessment, alongside national and international evidence on the relationships between housing, air pollution, and pregnancy outcomes.

Key statistics

- **National and international evidence on housing and pregnancy outcomes:**
  - Serious mould problems in housing are associated with approximately doubled risk of low birthweight and small-for-gestational-age births, even after adjustment for maternal, sociodemographic, and other housing factors
  - Crowding (defined as more than one person per room) is associated with increased risk of small-for-gestational-age births
- **Local housing data for Suffolk:**
  - An estimated 12,675 households in Suffolk may suffer from any form of damp
  - Dwellings built pre-1919 have the highest prevalence of damp and mould at 11.0%, and almost 1 in 5 (18%) of Suffolk's housing stock is estimated to have been built prior to 1914

  - Approximately 1,445 Suffolk residents are living in overcrowded, non-decent homes that do not meet the Decent Home Standard
- **Air pollution and pregnancy outcomes (Committee on the Medical Effects of Air Pollutants, 2024 review):**
  - Some evidence suggests links between air pollutants (PM2.5, PM10, and ozone) and adverse outcomes including preterm birth, low birthweight, and stillbirth
  - The Committee noted that current evidence is not considered robust enough for government policy decisions, and that established risk factors such as smoking during pregnancy likely pose higher risks than typical outdoor air pollution levels in the UK

So what?

Housing conditions in Suffolk reflect both the age of local housing stock and the realities of damp, mould, and overcrowding for a meaningful number of households. Although the numbers affected are not large in population terms, the impact on those households can be significant, with national evidence showing approximately doubled risks of low birthweight and small-for-gestational-age births in homes with serious mould, and associations between overcrowding and adverse birth outcomes. The psychological stress of insecure or substandard housing can also contribute to poorer maternal mental health and pregnancy outcomes.

While air pollution evidence is still developing and currently considered less robust than evidence on other modifiable risk factors such as smoking, it remains an emerging area worth monitoring.

Joined up working between maternity services, housing teams, and environmental health may help identify families whose home environments could be affecting their pregnancy or postnatal experience and ensure that support is available where it is most needed.

Conclusion

A healthy pregnancy journey begins long before conception and continues beyond birth, shaped at every stage by the health of both birthing and non-birthing people, the conditions in which they live, and the services available to support them. The evidence in this report paints a picture of where Suffolk is faring well, where it is keeping pace with England, and where targeted attention could most meaningfully improve outcomes for women, birthing people, partners, and babies.

There is genuine progress to recognise. Smoking at delivery is at its lowest recorded level, breastfeeding initiation and folic acid uptake outperform the national average, and cervical screening and abortion services are being accessed in ways that compare favourably with England. The Healthy Start Scheme has reached more families locally, and early signals on the maternal RSV vaccination programme are promising. These are meaningful wins that reflect sustained local effort and offer foundations to build on.

At the same time, the data points to areas where additional focus could make a difference. The majority of adults of reproductive age in Suffolk are living with overweight or obesity, mental health is the most prevalent pre-existing condition identified locally, and continued breastfeeding to 6–8 weeks remains below the national average. Emergency admissions of babies in the first two weeks of life and LRTI admissions in young children are significantly

higher than England and worsening. For several important areas (including alcohol and drug use in pregnancy, physical activity, and the prevalence of conditions such as endometriosis, fibroids, and thyroid disorders) local data is limited, and national estimates suggest substantial unmet need that is not currently visible in local datasets.

The report also highlights how outcomes vary across the population. Women and birthing people in the most deprived areas of Suffolk, those from ethnic minority groups, those with disabilities, and those facing complex social factors consistently experience poorer outcomes and greater barriers to accessing timely, appropriate care. These patterns are shaped not only by clinical factors but by the wider social, economic, and environmental context (financial pressure, employment conditions, educational opportunity, and housing) all of which influence the pregnancy journey from preconception onwards.

Taken together, the findings suggest that supporting healthy pregnancy outcomes in Suffolk is most effective when framed around the whole journey, both parents, and the wider context in which families live. This means investing in early support and prevention before conception, providing accessible and joined-up care during pregnancy and the postnatal period, recognising and responding to inequalities, and continuing to strengthen local data so that future need can be identified and met.

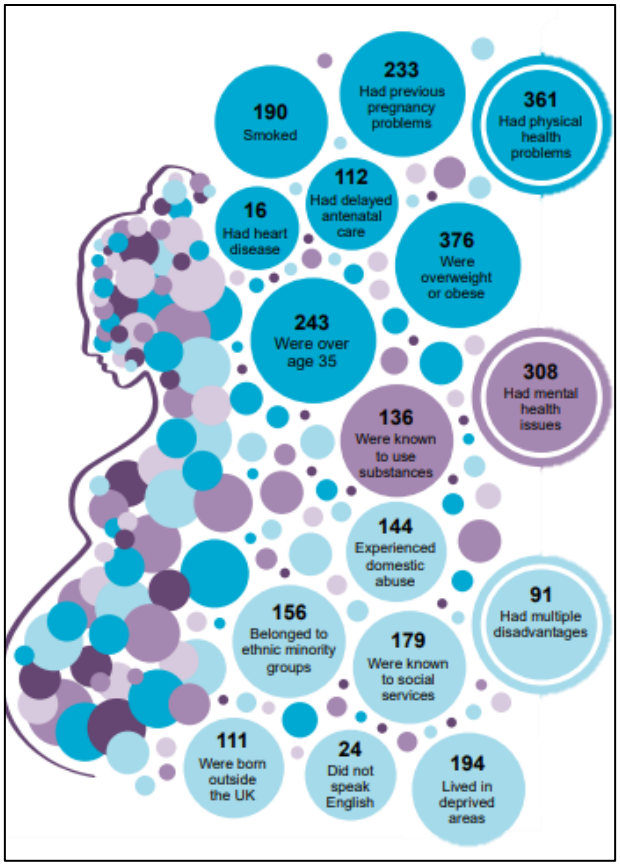
A healthy pregnancy journey is a shared responsibility. With coordinated effort across health, local government, Voluntary, Community, Faith and Social Enterprise (VCFSE) partners and communities, Suffolk can continue to improve outcomes, reduce inequalities and support residents to start family life with the best possible foundation for long-term health and wellbeing.

The importance of a healthy pregnancy journey

A healthy pregnancy helps keep both the birthing person and the baby safe, lowers the chance of complications, and sets up the child's long-term health from the very start[1].

The national MBRRACE-UK 2025 report: Saving Lives, Improving Mothers' Care details the care of 643 women or birthing people who died during or up to one year after pregnancy in the UK and Ireland between 2021 and 2023. Of these women or birthing people 583 (91%) faced multiple interrelated challenges- shown in figure 1. The visual highlights a cluster of overlapping risks affecting people during pregnancy, including physical and mental ill-health, delayed or limited access to care, and social disadvantages such as deprivation, abuse, or involvement with social services. Many also faced behavioural or structural challenges- like smoking, substance use, language barriers, or being new to the UK- that compound vulnerability and can worsen health outcomes.

Figure 1: Multiple interrelated challenges faced by women or birthing people who died during or up to one year after pregnancy in the UK and Ireland between 2021 and 2023



Source: MBRRACE-UK

This combination of health and social challenges suggests that maternal mortality is often influenced by multiple, interconnected factors, rather than a single cause. These issues may be preventable and highlight a need for more comprehensive support throughout the pregnancy journey from conception to birth.

Section 1: Preconception health

Preconception health describes **the health of all prospective parents**- both birthing and non-birthing partners**- during their reproductive years, which are the years when they are typically most likely to have a child** (estimated age range: 16-44 years old[2]). Although much of the focus traditionally falls on the birthing partner, the health of the non-birthing partner also influences fertility, pregnancy, and child outcomes[3]. Supporting all individuals to achieve and maintain good health during this period is therefore an important public health consideration, as it influences outcomes for themselves, their partners, and any future children[4].

This section reviews preconception health in Suffolk for birthing and non-birthing partners of reproductive age (16–44). It covers health behaviours and pre-existing conditions in both partners that may affect fertility, pregnancy outcomes, or the child's later health, as well as conditions specific to the birthing partner that could influence pregnancy outcomes. Data on preconception supplement use are also included. The aim is to identify where prevention and early support could help ensure that pregnancy, when desired, occurs in the best possible health. Where data is not broken down by age or biological sex, whole-population figures are used.

Health behaviours

Health behaviours during reproductive years play an important role in pregnancy outcomes and the health of future children. Behaviours such as physical activity levels [5,6], living with an unhealthy weight[7], smoking[8,9] and alcohol[10,11] can influence fertility, pregnancy complications, and long-term health of both the parents (non-birthing and birthing) and child. Equally, sexual health practices[12] and participation in screening programmes[13] contribute to overall reproductive health.

Table 1 summarises key health behaviours among Suffolk residents (both birthing and non-birthing partners) during their reproductive years, highlighting areas where additional support may help improve health before pregnancy. Where data is not broken down by age or biological sex, whole-population figures are used. Where datasets are published using sex-based categories such as “female” or “male” original dataset terms are used to ensure accuracy and comparability.

Table 1: Key population level health behaviours among Suffolk adults and their potential impact on prospective parents

Health behaviour	Impact on prospective parents	Suffolk Statistics	Further information
Physical activity	• Staying active can improve fertility[5]. • Women or birthing people who do regular, moderate exercise get pregnant quicker than those who do not exercise regularly[5]. • Men or non-birthing partners who complete moderate consistent exercise significantly improve sperm	• In 2023/24, over 1 in 3 (35.8%) females in Suffolk aged 16 and over did not reach the Chief Medical Officers recommended physical activity targets. • In 2023/24, around 1 in 3 (33.0%) males in Suffolk aged 16 and over did not reach the Chief Medical Officers recommended physical	Suffolk’s Physical Activity Profile

Health behaviour	Impact on prospective parents	Suffolk Statistics	Further information
	quality, volume, and motility[5,6].	activity targets (150 minutes or more per week)	
Living with overweight or obesity	• Higher body weight is associated with hormonal changes and increased inflammation, which may affect ovarian function, egg quality, and endometrial receptivity, contributing to reduced fertility and lower success rates for assisted reproductive treatments[7]. • Higher body weight is associated with lower testosterone levels and changes in sperm quality, which may affect fertility. There is also emerging evidence that parental health can influence longer-term outcomes for children, although these relationships are complex and not fully understood[7].	• Over half (56.7%) of female patients aged18-64 years registered to a GP in Ipswich and East Suffolk, and West Suffolk Alliances, have a recorded BMI classification of overweight or obese as of April 2025. • Over half (61.3%) of male patients aged18-64 years registered to a GP in Ipswich and East Suffolk, and West Suffolk Alliances, have a recorded BMI classification of overweight or obese as of April 2025.	Suffolk's Healthy Weight Health Needs Assessment.
Smoking	• Smoking is associated with adverse effects on multiple aspects of female fertility, including reduced ovarian reserve (the number of eggs remaining in the ovaries), hormonal changes, and impaired reproductive tract function, which may affect the likelihood of conception[8]. • Exposure to second-hand smoke is also associated with reduced fertility and other adverse outcomes, and avoiding tobacco smoke before conception is recommended[8]. • Smoking harms male fertility- lowers sperm count, motility, and quality. It reduced IVF and ICSI success rates even when only the male/ non-birthing partner smokes[9].	• In Suffolk, 2024, smoking prevalence in residents aged 18 and over was 10.5%, statistically similar to England estimates. Just over double the national smokefree target of 5% set for 2030.	Suffolk's Smoking and Vaping Health Needs Assessment
Alcohol misuse	• Alcohol use is associated with reduced fertility, particularly at moderate and higher levels of	• In 2023/24 the rate of hospital admission episodes for alcohol related conditions for Suffolk females under 40	Fingertips

Health behaviour	Impact on prospective parents	Suffolk Statistics	Further information
	consumption. Evidence at lower levels is less clear, but avoiding alcohol when trying to conceive is recommended to support fertility[11]. • Alcohol affects male fertility too- female partners of men who have a high intake of alcohol are less likely to become pregnant[10].	years was 144.6 per 100,000 statistically significantly higher (worse) than England estimates. • In 2023/24 the rate of hospital admission episodes for alcohol related conditions for Suffolk males under 40 years was 196.7 per 100,000 statistically similar to England estimates.	
Sexual health	• Sexually transmitted infections (STIs) can have a direct impact on reproductive health for both males and females through[12]: ○ Infertility ○ Cancers ○ Pregnancy complications ○ Increased risk of HIV • It is advised for individuals (and all sexual partners) to undergo sexual health screening- and receive treatment if necessary- for STIs prior to attempting to conceive[12].	• In 2024, the rate of new STI diagnoses in Suffolk was 314.4 per 100,000 population, statistically significantly lower than the England estimate and continuing a downward trend. • While diagnosis rates are lower than England, this does not necessarily indicate better sexual health outcomes. Suffolk's STI testing rate (excluding chlamydia in those aged under 25) was also statistically significantly lower than England (1,864.7 per 100,000), suggesting that lower diagnosis rates may partly reflect lower levels of testing. • This interpretation is supported by a lower test positivity (4.8% in Suffolk compared to 6.4% in England). Taken together, lower testing and lower positivity may reflect differences in testing patterns, with the potential for some infections to go undiagnosed.	Fingertips
Cervical screening	• Cervical screening checks the health of the cervix (the opening to the womb from the vagina) by looking for abnormal cells that can be a sign of cancer[13]. • It is advisable for women and birthing people to have this screening before pregnancy, if possible, as pregnancy can complicate the	• In 2024, nearly 3 out of 4 (73.3%) women aged 25-49 years eligible for cervical screening in Suffolk were being screened adequately within the previous 3.5 year period- statistically significantly better than the England estimate (66.1%). • However, trends in cervical screening coverage across	Fingertips

Health behaviour	Impact on prospective parents	Suffolk Statistics	Further information
	interpretation of test results[13].	Suffolk show a statistically significant decrease overtime- with a 4.5 percentage point decrease since 2010 (from 77.8% to 73.3%),	

Pre-existing health conditions

Managing pre-existing health conditions before pregnancy is essential for reducing the risk of adverse outcomes for the birthing partner and baby. Conditions in the non-birthing partner may also affect fertility, require management before pregnancy, or benefit from early support to aid prevention and reduce potential intergenerational health risks.

Table 2 summarises pre-existing health conditions in both birthing and non-birthing partners that may affect fertility or the future child's health. Where data is not broken down by age or biological sex, whole-population figures are used. Where datasets are published using sex-based categories such as “female” or “male” original dataset terms are used to ensure accuracy and comparability.

Table 2: Pre-existing health conditions that may affect fertility and future child health in Suffolk adult population

Condition	Impact on prospective parents	Statistics	Further information
Human immunodeficiency virus (HIV)	• Individuals with HIV should plan their pregnancies wherever possible. HIV weakens the immune system and spreads through blood or body fluids- via sexual contact or shared needles [14]. Individuals-irrespective of gender- living with HIV may experience increased difficulty conceiving, as the condition can influence hormone levels impacting fertility[15,16] • However, it is completely possible for people living with HIV in the UK to have children naturally and safely without transmitting the virus to their partner or baby. The following conditions need to be met[17]: ○ The partner with HIV is on treatment and taking it as prescribed	• In 2024, Suffolk’s HIV diagnosed prevalence rate in individuals aged 15 to 59 years was 1.3 per 1,000 lower than the NICE benchmark goal of 2. • Notably, between 2022 and 2024, over half (60.0%) of HIV diagnoses in heterosexual men and over half (53.8%) of HIV diagnoses in heterosexual and bisexual women in Suffolk were classified as ‘late’, both higher than the NICE benchmarking goal of 25%. A late HIV diagnosis is defined as having	• Benchmarked from: NICE HIV testing guidelines • Terrence Higgins Trust • Tommy's The pregnancy and baby charity

	○ They have had an undetectable viral load for at least 6 months ○ Neither has had any other sexually transmitted infections	a CD4 count below 350 cells within 91 days of diagnosis. Being diagnosed late mea ns that the virus has already caused significant damage to the immune system's CD4 'protective cells' before the individual is even aware they are infected.	
Mental health	• Parental mental health has consistently been identified as a risk factor, conferring a broad vulnerability to mental health difficulties in children and young people, rather than being associated with specific challenges[18–23] • Both maternal and paternal mental health independently influence outcomes- children with one affected parent face roughly double the risk of mental ill-health, and triple the risk when both parents are affected[21–23]	• As of December 2025, over 1 in 3 (35.9%, n= 35,847) of patients identified as female, aged 16-44 years registered to a GP in Suffolk have a recorded mental health flag (defined as having one or more recorded diagnosis of depression, anxiety, low mood, or serious mental illness). • As of December 2025, over 1 in 5 (21.0%, n= 21,961) of patients identified as male, aged 16-44 years registered to a GP in Suffolk have a recorded mental health flag.	• Mental Health Needs Assessment (2026) • Tommy's charity Understanding how severe mental illness affects women through pregnancy • NHS Getting pregnant if you have a mental health condition

Table 3 summarises pre-existing health conditions that notably affect fertility or pregnancy outcomes for birthing partners. Local statistics are used where available; otherwise, national data provides context. Sex-based terms such as "female" are retained when datasets use them, to ensure accuracy and comparability.

Table 3: Pre-existing health conditions that may influence the pregnancy journeys of women or birthing people in Suffolk

Condition	Impact on women or birthing person	Statistics	Further information
Heart Conditions	• In the most recent reporting period (2021-23) cardiac disease remained the principal cause of indirect maternal death during pregnancy or within six weeks postpartum. Most maternal cardiac deaths during 2021-23 were attributed to acquired heart disease, defined as any heart condition that develops before pregnancy often due to factors like high blood pressure, diabetes, or previous rheumatic fever, or one that develops during pregnancy itself[24].	• 0.4% (n= 400) females, aged 16-44 years, registered to a GP in Suffolk have a marker in record to indicate the presence of cardiovascular disease as of December 2025.	• Suffolk's Cardiovascular Disease Profile. • NHS Coronary heart disease and pregnancy • British Heart Foundation Pregnancy and your heart: why it's important to plan ahead • Tommy's charity Heart conditions in pregnancy
Diabetes	• Poorly managed diabetes increases the risk of health complications for both parent and child [25]. • Potential issues include delivering a large baby (foetal macrosomia- which can complicate labour), an increased risk of miscarriage, birth defects, and stillbirth[26].	• 1.5% (n= 1,499) females, aged 16-44 years, registered to a GP in Suffolk have a marker in record to indicate the presence of diabetes between as of December 2025.	• NHS Diabetes and Pregnancy • Tommy's charity planning a pregnancy with type 1 or 2 diabetes
Epilepsy	• In 2021-23, Epilepsy was reported as the fifth leading cause of maternal death in the UK[24]. • Well controlled seizures prior to conception can reduce the risk of episodes during pregnancy.	• 1.1% (n= 1,099) females, aged 16-44 years, registered to a GP in Suffolk have a diagnosis of epilepsy as of December 2025.	• NHS Epilepsy and pregnancy • Epilepsy action Fertility and planning a baby • Tommy's charity Epilepsy and planning a pregnancy
Pelvic inflammatory disease (PID)	• PID can impact fertility and increase the risk of ectopic pregnancy due to scarring of the fallopian tubes, particularly if treatment is delayed or if there are repeated episodes. However, successful treatment of PID with antibiotics can significantly improve long-term pregnancy rates, and	• In 2023/24 Suffolk had a PID admissions rate (for people ages 15-44 years) of 186.0 per 100,000 people, statistically significantly lower than England estimates (247.5 per 100,000). • Recent trends show no significant change.	• NHS Pelvic inflammatory disease • Fingertips

Condition	Impact on women or birthing person	Statistics	Further information
	most women and birthing people with PID can still get pregnant. Early diagnosis and treatment are crucial to minimise damage[27].		
Fibroids	• While many individuals with fibroids experience no noticeable symptoms, these growths can sometimes lead to complications. The likelihood and nature of any issues depend on factors such as the size and location of the fibroids. For instance, when fibroids protrude into the central cavity of the uterus, they may hinder an embryo's ability to implant within the uterine lining, this can increase the risk of early pregnancy loss and preterm birth[28].	• Research shows that around two in three women or birthing people will develop at least one uterine fibroid in their lifetime[29]. • Additionally, Black women and birthing people are more likely to have uterine fibroids, and they tend to be greater in size, number and severity compared to those found women and birthing people of in other ethnic groups[29].	• NICE's Women's and reproductive health guidelines • The Royal College of General Practitioners • Royal College of Obstetricians and Gynaecologists • the Faculty of Sexual and Reproductive Health
Polyendocrine Metabolic Ovarian Syndrome (PMOS)	• As of 12 May 2026, polycystic ovary syndrome (PCOS) has been officially renamed **polyendocrine metabolic ovarian syndrome (PMOS)**, following a global consensus published in The Lancet. The renaming was the result of a 14-year process, with input from more than 14,000 patients and health professionals[30]. • PMOS can lead to an irregular menstrual cycle and disrupt the growth and release of eggs from the ovaries (ovulation). Without ovulation conception cannot occur, therefore, women and birthing people with PMOS are more likely to have trouble conceiving than those without[31].	• PMOS is one of the most common endocrine disorders affecting women and birthing people of reproductive age[32–35]. • Although local data is limited, research shows that the prevalence ranges from 2.2–26% (depending on the criteria used and the population studied)[32,33,36], with many affected women and birthing people undiagnosed[37]. • Using ONS Mid-2024 population estimates this equates to an estimate range of 2,796- 33,046 females aged 16 years to 44 years in Suffolk. • Evidence from a systematic review and meta-analysis suggests the lowest prevalence in Chinese	• NHS Polycystic ovary syndrome • Tommy's charity PMOS and fertility: everything you need to know • NICE's Women's and reproductive health guidelines • The Royal College of General Practitioners • Royal College of Obstetricians and Gynaecologists • the Faculty of Sexual and Reproductive Health

Condition	Impact on women or birthing person	Statistics	Further information
		women and birthing people, and then in ascending order of increasing prevalence for Caucasian, Middle Eastern, and Black women and birthing people[38].	
Endometriosis	• Endometriosis can negatively impact fertility by lowering the number of available eggs and affecting ovarian function. While endometriosis can make it more difficult to conceive, the majority of individuals with mild forms of the condition remain fertile[39].	• Endometriosis is one of the most common gynaecological disorders in women and birthing people of reproductive age. • Endometriosis is estimated to affect approximately 10% of women and birthing people of reproductive age[40]. • Using ONS Mid-2024 population estimates this equates to an estimate of 12,710 females aged 16 years to 44 years in Suffolk. • True prevalence is difficult to determine because a definitive diagnosis requires direct visualisation at laparoscopy[41]. Its presentation is variable and delayed diagnosis common, and prevalence varies with the population studied. It is most commonly diagnosed between the ages of 18 and 29 years[42]. Women and birthing people with a first-degree relative with endometriosis have a 7 to 10-fold increased risk of developing the condition[43].	• Endometriosis UK Endometriosis, fertility and pregnancy • Tommy's charity How does endometriosis affect fertility? • NHS Endometriosis • NICE's Women's and reproductive health guidelines • The Royal College of General Practitioners • Royal College of Obstetricians and Gynaecologists • the Faculty of Sexual and Reproductive Health
Thyroid disorders	• Proper thyroid hormone levels ensure regular ovulation (the release of an egg from the ovary)[44]. If the thyroid isn't functioning correctly, ovulation can	• The prevalence of hypothyroidism (underactive thyroid) in the literature varies according to the definition used, the	• British Thyroid Foundation Pregnancy and fertility in thyroid disorders

Condition	Impact on women or birthing person	Statistics	Further information
	become irregular or stop altogether, making it more difficult to get pregnant. Key thyroid disorders that can impact fertility include: ○ Hypothyroidism: Low levels of thyroid hormones can disrupt your menstrual cycle and interfere with the release of eggs, reducing fertility. Fatigue, weight gain, and depression often accompany hypothyroidism[45]. ○ Hyperthyroidism: An overproduction of thyroid hormones may cause irregular cycles or even stop menstruation temporarily. Other symptoms include restlessness, weight loss, and heat intolerance[46].	population characteristics, and the geographical area studied. In areas where dietary iodine is adequate, such as the UK, the prevalence of spontaneous hypothyroidism (hypothyroidism that develops naturally from intrinsic thyroid dysfunction, rather than from medical intervention) is suggested to be around 1–2%. It is up to 10 times more common in women and birthing people than in men and risk increases with age[47,48]. • Using ONS Mid-2024 population estimates this equates to an estimate range of 1,271- 2,542 females aged 16 years to 44 years in Suffolk. • Equally, the prevalence of hyperthyroidism (overactive thyroid) in the literature varies according to the definition used, the population characteristics, and the geographical area studied. In areas where there is sufficient iodine, such as the UK, available the prevalence of overt hyperthyroidism is 0.2% to 1.3%. The prevalence of hyperthyroidism increases with age[49]. • Using ONS Mid-2024 population estimates this equates to an estimate range of 254 and 1,652 females aged	• Thyroid UK Conception • NHS Underactive thyroid • NHS Overactive thyroid • NICE's Hypothyroidism and Hyperthyroidism

Condition	Impact on women or birthing person	Statistics	Further information
		16 years to 44 years in Suffolk.	

Tommy's charity online page provides further details on health conditions and planning for pregnancy for those not highlighted in table 3 that may need specific management and consideration when planning a pregnancy.

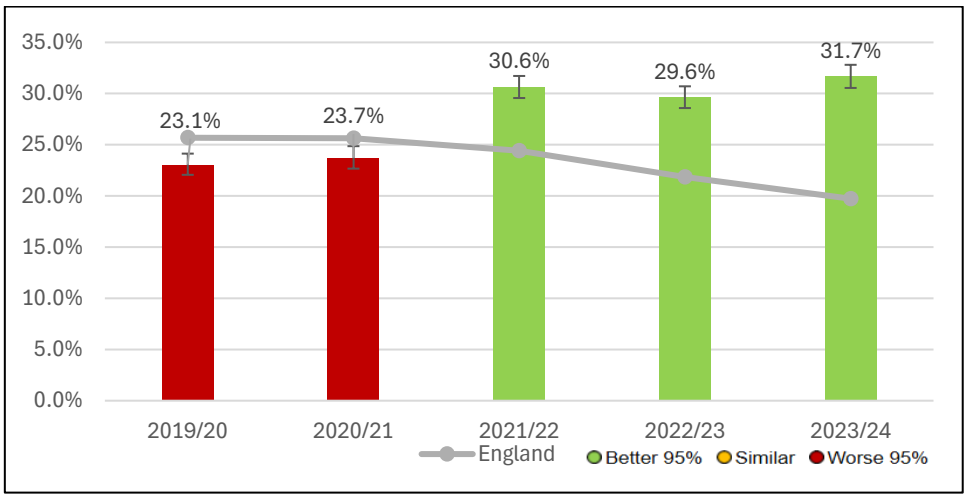
Folic acid supplementation

Folic acid supplementation is a long-standing and well-evidenced preconception intervention, with strong evidence that taking a daily 400 microgram supplement before conception and through the first 12 weeks of pregnancy significantly reduces the risk of neural tube defects (NTDs) such as spina bifida in the developing baby. National guidelines therefore recommend that all women and birthing people who could become pregnant take folic acid daily during this critical window. Because the neural tube develops very early- often before pregnancy is confirmed- uptake before conception, rather than only after a positive pregnancy test, is key to maximising the protective benefit[50].

Figure 2 shows the percentage of pregnant women and birthing people in Suffolk who started taking folic acid prior to pregnancy as reported at the time of their first antenatal appointment from 2019/20 to 2023/24. Results show that:

- In 2023/24 Suffolk uptake was 31.7%, statistically significantly higher than England estimates at 19.7%
- Uptake has statistically significantly increased from 23.1% in 2019/20 to 31.7% in 2023/24- an 8.6 percentage point difference (although it is recognised that earlier year's data may have more data quality issues and should be interpreted with caution)
- Despite this improvement, this still means that 68.3% are not taking the supplement before conception

Figure 2: Percentage of pregnant women and birthing people in Suffolk who started taking folic acid prior to pregnancy as reported at the time of their first antenatal appointment from 2019/20 to 2023/24, compared to England*



**data quality for this indicator should be considered. The Maternity Service Data Set (MSDS) v2.0 began in April 2019, with quality and completeness improving year-on-year. Earlier years may have more data*

quality issues and should be interpreted with caution. This indicator is therefore classed as 'in development'. Further detail on data quality can be found in the NHS Maternity Statistics, England.
Source: Fingertips

Section 2: Maternal health

Maternal health refers to the **health of a woman during pregnancy, childbirth and the postnatal period**. Maternal health plays a vital role in ensuring the health and wellbeing of both the mother or birthing person and the child. A healthy pregnancy is essential for the healthy growth and development of the foetus, and it can reduce the risk of infant mortality and morbidity[51].

This section provides an overview of maternal health across Suffolk, examining key indicators throughout pregnancy, birth and the postnatal period, to help identify areas where additional investigation or support can be provided to ensure the best possible outcomes for mothers or birthing people and their babies. The term 'maternal health' is used here in line with national reporting, but we recognise that pregnancy and birth are experienced by people of different gender identities.

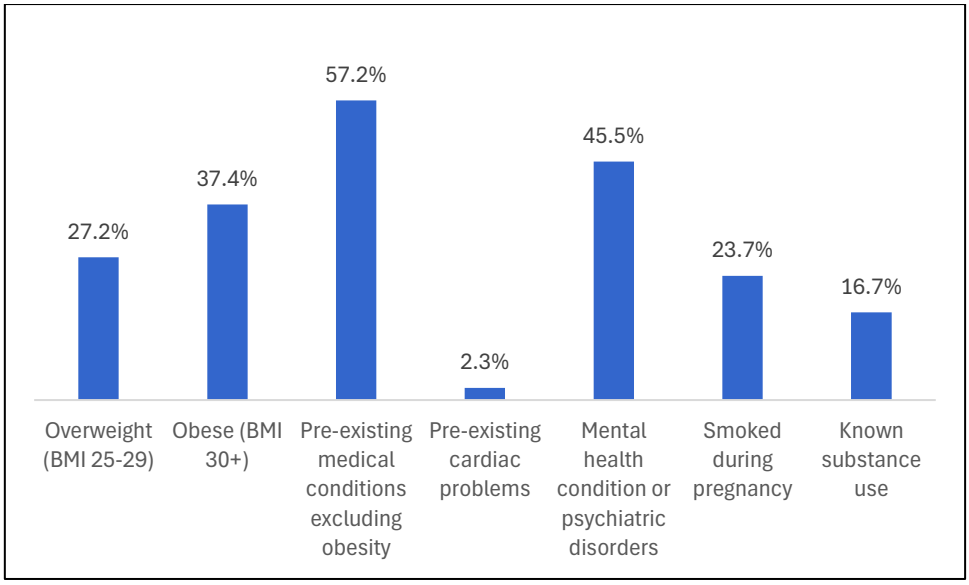
Maternal health during pregnancy

Medical comorbidities account for an estimated 66% of the increased risk of maternal death in the UK[24]. This highlights the important role that the health status of women and birthing people entering pregnancy can play in shaping maternal outcomes.

Figure 3 shows selected medical and pregnancy-related characteristics of the women or birthing people who died during pregnancy or within six weeks of birth in the UK, between 2021 and 2023. Key findings include:

- Almost two thirds (64.6%) of women or birthing people were either overweight (27.2%) or obese (37.4%)- as defined by body mass index classification.
- Over half (57.2%) had a pre-existing medical condition (excluding obesity).
- Just under half (45.5%) had a mental health condition or a psychiatric disorder.
- Almost one in four (23.7%) were known to smoke during pregnancy
- Over 1 in 10 (16.7%) had reports of known substance use

Figure 3: Selected characteristics of women or birthing people who died during pregnancy or 6 weeks after birth, UK, 2021-23



Source: MBRRACE-UK

Taken together, these figures suggest that women and birthing people with medical comorbidities, mental health conditions, and health-related behaviours such as smoking and substance use may be overrepresented among maternal deaths. Identifying and supporting these groups before and during pregnancy could therefore contribute to improving outcomes.

The following section looks at maternal health behaviours, mental health conditions, and pregnancy complications among women and birthing people in Suffolk, highlighting local areas where additional support may help to improve pregnancy and maternal outcomes.

Health behaviours

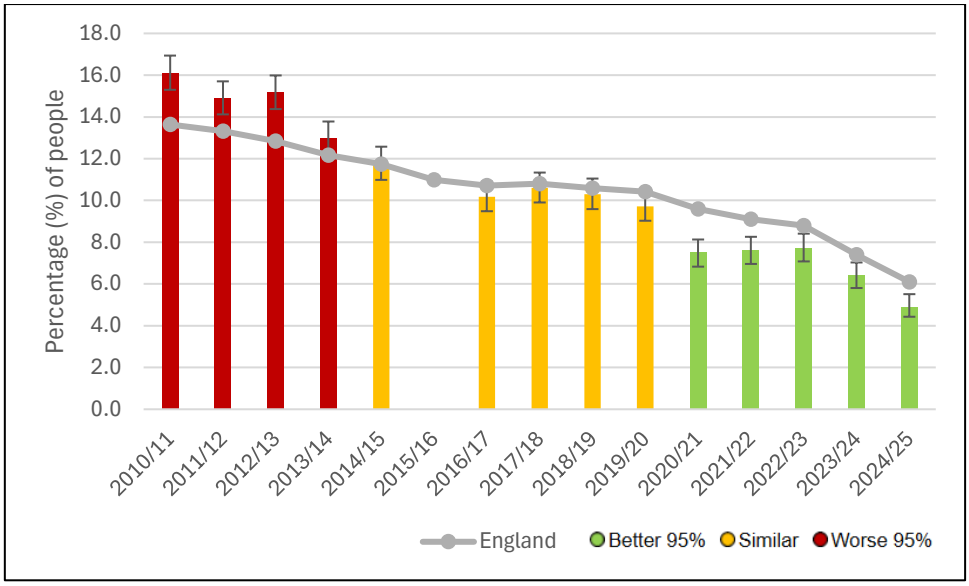
Smoking

Cigarettes contain thousands of harmful chemicals, and smoking during pregnancy can harm the baby by reducing oxygen and nutrients, increasing the risk of complications [52].

Figure 4 shows the percentage of mothers or birthing people known to be smokers at the time of delivery in Suffolk between 2010/11 and 2024/25 compared to England. Results show that:

- In 2024/25, 4.9% of mothers or birthing people were known to smoke at the time of delivery in Suffolk, the lowest recorded percentage to date and statistically significantly better than the England estimate of 6.5%.
- Recent trends show that the percentage of mothers or birthing people known to smoke at time of delivery in Suffolk is statistically significantly decreasing and getting better, decreasing by 1.5 percentage points from 2023/24 (6.4%) to 2024/25 (4.9%).

Figure 4: The percentage of mothers or birthing people known to be smokers at the time of delivery in Suffolk, between 2010/11 and 2024/25, compared to England



Source: Fingertips

A contributing factor to reductions seen across Suffolk may be roll-out of NHS England's Smoke-free Pregnancy Incentive Scheme across Ipswich and West Suffolk. The scheme offers pregnant women up to £400 in shopping vouchers for engaging with local stop smoking support and being verified as smoke-free throughout pregnancy and the post-partum period, alongside existing treatment for tobacco dependence delivered through maternity services such as opt-out referrals at the first antenatal appointment.

While decreasing prevalence to 4.9% in 2024/25 reflects strong progress, it still means around 1 in 20 babies in Suffolk are exposed to mothers or birthing people's tobacco smoke during pregnancy.

Second-hand smoke

Second-hand smoke, or passive smoking, can harm both pregnant individuals and their babies. Breathing in tobacco smoke during pregnancy allows harmful substances to reach the unborn child, which research links to higher risks of stillbirth, premature birth, low birth weight, and sudden infant death syndrome (SIDS)[53,54]. Smoking indoors exposes others regardless of precautions- opening windows or smoking in another room does not remove the danger, as smoke lingers for hours after a cigarette is out[55].

NHS Passive smoking and Tommy's charity The risks of second-hand smoke online pages provide further information and support.

Vaping and e-cigarettes

Vaping and e-cigarette use is considered to be less harmful to both the expectant mother or birthing person and the baby than smoking traditional cigarettes[56]. Vapes do not emit carbon monoxide, a substance particularly dangerous to a developing baby in the womb. However, the vapour from an e-cigarette has been shown to contain some of the potentially harmful chemicals found in cigarette smoke, but at much lower levels[57]. Due to limitations in evidence quality and exposure assessment, it is not possible to draw clear conclusions about the risks of exclusive vaping during pregnancy[58].

The National Institute for Health and Care Excellence (NICE) does not recommend e-cigarettes for use in pregnancy due to a lack of evidence on their safety. Instead, licensed nicotine

replacement therapy (NRT) products like patches and gum alongside behavioural support are recommended to help mothers and birthing people quit smoking. However, if a pregnant person chooses to use an e-cigarette to quit, they should be supported as it is likely much safer than continuing to smoke cigarettes.

Gestational weight

Most women or birthing people should gain weight during pregnancy. Typically, presenting with an increase of between 10kg and 12.5kg (22lb to 28lb), with the majority of this weight being gained after the twentieth week. A large portion of this additional weight results from the baby's development, while the body also accumulates fat in preparation for producing breast milk once the baby is born[59].

However, a UK-based population cohort study analysing 7,769 pregnancies found that over half (57.3%) of the women or birthing people gained more weight than recommended[60]. Gaining excessive weight may contribute to health concerns for both the woman or birthing person and the unborn child. Research shows that excess weight gain during pregnancy is associated with adverse outcomes such as gestational hypertension, gestational diabetes and the baby being large for gestational age. Those with a pre-pregnancy body mass index (BMI) classified as overweight or obese were shown to be most affected, although an impact was also seen in those with a pre-pregnancy BMI in the healthy weight category[61].

Research also shows that women or birthing people who are living with overweight or obesity have an increased risk of diabetes, thromboembolism, miscarriage and maternal death during pregnancy and birth. Babies born to women living with obesity were also shown to have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity[62].

In Suffolk, 2022/23, 27.2% of pregnant women or birthing people were living with obesity (as defined by BMI classifications), statistically significantly higher than the England estimated prevalence (25.4%). However, the prevalence of pregnant women living with obesity in Suffolk for 2023/24 was not available due to data quality issues. The indicator is therefore classed as an official statistic in development. The quality of this indicator is expected to improve overtime.

It is important to note that each individual's pregnancy is unique, meaning that the typical recommended weight gain during pregnancy largely varies. NICE recommendations on maternal and child weight management state that health care professionals should utilise individual assessment over rigid weight targets, monitoring progress through routine antenatal appointments, prioritising the quality of weight gain rather than simply tracking numbers on a scale[63].

Maintaining a nutritious diet and remaining physically active throughout pregnancy generally helps to ensure weight gain remains within a healthy and safe range for both the woman or birthing person and the baby. If there is any uncertainty, a midwife can offer personalised guidance[64].

Breastfeeding

Breastfeeding in the first hour helps provide colostrum to the newborn. It also helps prevent newborn infections such as pneumonia and diarrhoea, thereby reducing the risk of neonatal

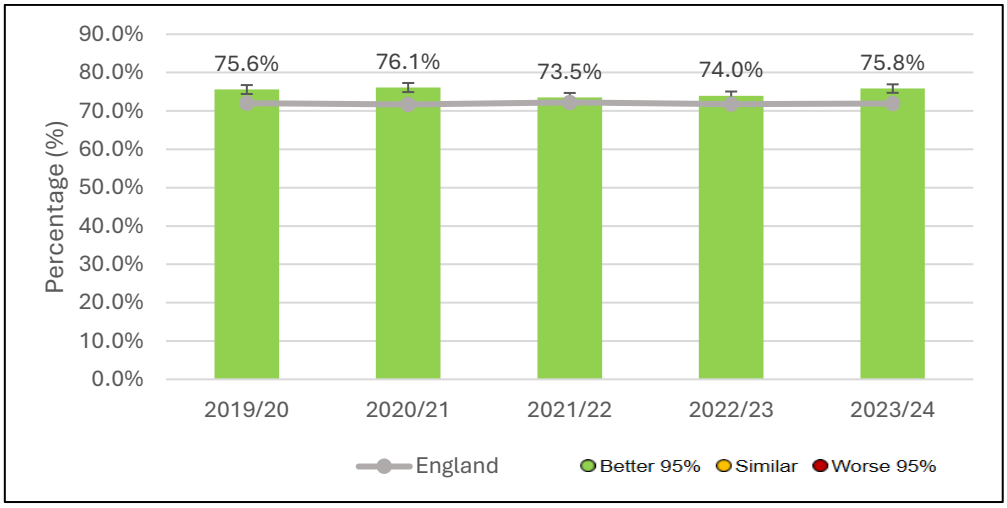
mortality. Early initiation can also support sustained breastfeeding with long-term benefits for the mother[65].

The International Federation of Gynaecology and Obstetrics (FIGO) recognises breastfeeding as a protective intervention and recommends that it be initiated within the first hour of life[66,67].

Figure 5 presents the percentage of babies whose first feed is breastmilk in Suffolk, between 2019/20 and 2023/24, compared to England. Results show that:

- In 2023/24 75.8% of babies first feed was breastmilk, statistically significantly higher than the England estimate of 71.9%.
- Recent trends show no significant change.

Figure 5: Percentage of babies whose first feed is breastmilk in Suffolk, between 2019/20 and 2023/24, compared to England*



** There are concerns about the quality of the data of this indicator due to the data collection methods. The Maternity Service Data Set (MSDS) v2.0 began in April 2019, with quality and completeness improving year-on-year. Earlier years may have more data quality issues and should be interpreted with caution. This indicator is therefore classed as 'in development'. Further detail on data quality can be found in the NHS Maternity Statistics, England.*

Source: Fingertips

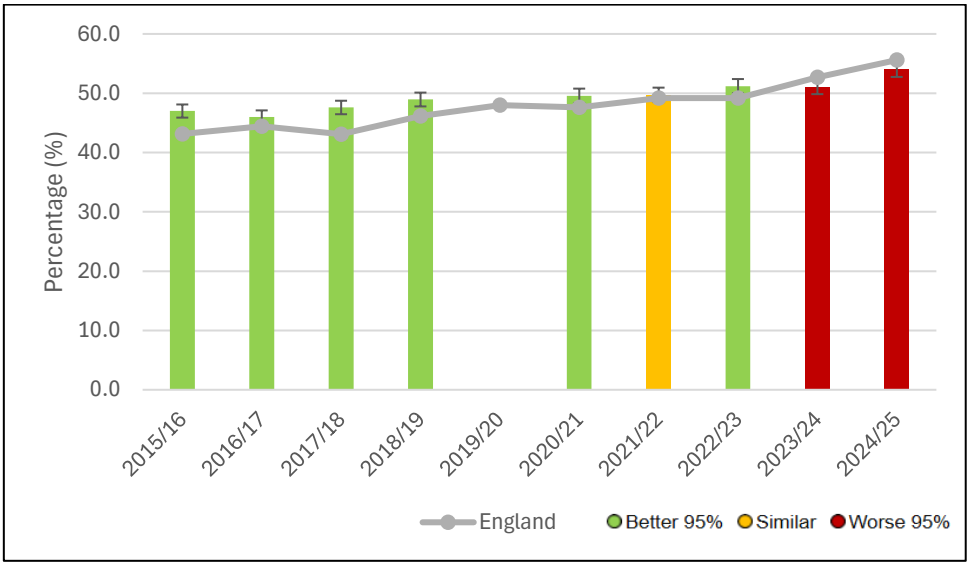
Suffolk's population health management (PHM) data provides the percentage of people in Suffolk (excluding Waveney) who had a birth episode (defined as an individual who gave birth within the reporting year) between September 2024 and August 2025 and who's first feed was breast milk. The data showed that show 72.0% (3,177 people) had a birth episode in this period and initiated breastfeeding.

Beyond the critical first hour, breastfeeding continues to provide health benefits for both the birthing person and their baby[68]. Health professionals recommend exclusive breastfeeding for approximately six months, after which breast milk can continue alongside solid foods for as long as the birthing person and baby wish[68].

Figure 6 presents the percentage of infants that are totally or partially breastfed at age 6 to 8 weeks in Suffolk between 2015/16 and 2024/25, compared to England. Results show that:

- In 2024/25 over half (54.0%) of infants in Suffolk were totally or partially breastfed at ages 6 to 8 weeks, statistically significantly lower than England estimates (55.6%)
- Although recent trends in Suffolk show that the percentage of infants that are totally or partially breastfed at age 6 to 8 weeks has statistically significantly increased compared to 2023/24 (51.1%), recent percentages are statistically significantly lower than England estimates.

Figure 6: the percentage of infants that are totally or partially breastfed at age 6 to 8 weeks in Suffolk between 2015/16 and 2024/25*, compared to England



**2019/20 data not published due to data quality reasons*
Source: Fingertips

While breastfeeding has many benefits, it is important to consider that some women and birthing people face difficulties and medical factors that may prevent breastfeeding or make it more challenging or may choose not to breastfeed. Support is available through midwives, health visitors and breastfeeding specialists who can help address many common problems. When breastfeeding isn't possible or chosen, infant formula provides complete nutrition though lacks the living cells, hormones, and antibodies found in breastmilk. Healthcare professionals can guide safe formula preparation and feeding techniques[69].

Alcohol

Alcohol intake during pregnancy can lead to lasting harm, and the risk increases with the quantity consumed[70].

A systematic review and meta-analysis estimating prevalence of alcohol use during pregnancy found that the UK has the 4th highest rate of prenatal alcohol use globally, with the prevalence of alcohol use during pregnancy in the UK at 41%[71]. Applying this to the number of live births in Suffolk 2024, an estimated 2,699 pregnancies may have involved alcohol exposure.

Prenatal alcohol exposure can lead to miscarriage, preterm birth, and lifelong neurodevelopmental conditions known as foetal alcohol spectrum disorder (FASD)[72]. Research shows that 2% - 4% of children in the UK general population are thought to have FASD[73–75]. Applying these prevalence estimates to ONS Mid-2024 population estimates, it would suggest that around 3,045- 6,090 Suffolk children (ages 0-17 years) may have FASD.

The evidence base also suggests that the prevalence of FASD rises to nearly 1 in 3 (30-33%) among Looked After Children[76]. Using local 2023/24 Children in care data, this equates to around 300 Looked After Children / Children in Care (CiC) in Suffolk.

Most of these children are potentially undiagnosed, as there is currently no established local diagnostic pathway. This may result in Suffolk children receiving support for other conditions without recognition of underlying FASD, affecting the effectiveness of interventions across education, health, and social care services. The condition is preventable through avoiding alcohol during pregnancy, and early diagnosis has been shown to improve outcomes and reduce secondary disabilities[77].

Illicit drugs

Illicit drug use during pregnancy is associated with increased risks to both the parent and baby. Many substances can cross the placenta and affect foetal development. Evidence indicates that use during pregnancy is linked to higher risks of stillbirth, neonatal death, preterm birth, low birth weight, and developmental or growth concerns for the child[78–80].

A Public Health England report, published in November 2019, analysing the Maternity Service Dataset (MSDS) antenatal booking data found that 1.2% of women reported that they were currently misusing illicit drugs, solvents or medicines and around 3.3% described themselves as previously misusing these substances. The majority of women (95.5%) reported that they had never taken drugs[81]. Applying this to the number of live births in Suffolk 2024, an estimated 79 pregnancies may have involved misuse of illicit drugs, solvents or medicines and around 217 may have been previously misusing illicit substances.

Individuals who regularly use substances like cocaine, heroin, or other opiates and opioids should not attempt to stop or reduce their intake without first consulting a medical professional. It is essential that withdrawal from these drugs is managed appropriately to minimise risks to both the mother and the baby.

Physical Activity

Pregnancy provides a unique opportunity to promote physical activity behaviour change, as many women are highly motivated to optimise their lifestyle and there is an increased contact with health care professionals[82].

Research shows that there are several physical health benefits to being active during pregnancy including reduced risk of[83,84]:

- Gestational diabetes
- Hypertensive disorders
- Excessive gestational weight gain
- Preeclampsia

Physical activity during pregnancy has also been shown to benefit the mental health of women and birthing people as well as physical health. Research indicates that physical activity during pregnancy is associated with a lower risk and severity of prenatal depression, anxiety, and stress, and an improved quality of life[85]. Moderate exercise in the first two trimesters has also been shown to promote better sleep[86].

In addition to mental and physical health benefits, regular physical activity has also been associated with positive delivery outcomes. Evidence shows that regular physical activity is associated with an increased likelihood of normal vaginal delivery and a shorter first stage of labour[87].

In systematic reviews completed by the Department of Health and Social Care, no evidence of adverse maternal or infant outcomes were associated with completing physical activity during pregnancy. This supports the recommendation that physical activity in pregnancy should be encouraged[82].

Although physical activity has been shown to provide many benefits during pregnancy, evidence has highlighted that health care professionals may have limited confidence and resources to deliver appropriate physical activity advice to pregnant women[88]. In response, a Physical Activity and Pregnancy Study provided evidence based recommendations in the form of an infographic- shown in figure 7- that is now included in the Chief Medical Officers Physical Activity Guidelines . The results indicated that pregnant women or birthing people should[82]:

- Aim for at least 150 minutes of moderate-intensity activity spread across a week
- Include muscle-strengthening activities on 2 days per week
- If not active before pregnancy, start gradually; if already active, continue with adaptations as needed
- Choose activities that avoid risk of falls or abdominal trauma (“don’t bump the bump”)
- Listen to your body and adjust activity as pregnancy progresses

Figure 7: UK Chief Medical Officers’ Physical Activity Guidelines for pregnancy, 2019

Source: [Department of Health and Social Care]

Engaging in physical activity following pregnancy has also been shown to be beneficial for maintaining health and adapting to the body's postnatal changes. Research shows that engaging in physical activity during the postpartum period is associated with improved mental health[89,90], reduced severity of existing postpartum depressive symptoms, anxiety symptoms[91], enhanced sleep quality[92] and reduced weight gain or retention[93].

Similar to during pregnancy, the Department of Health and Social Care produced an infographic explaining the physical activity needed for general health benefits for women and birthing people after giving birth- shown in figure 8[82].

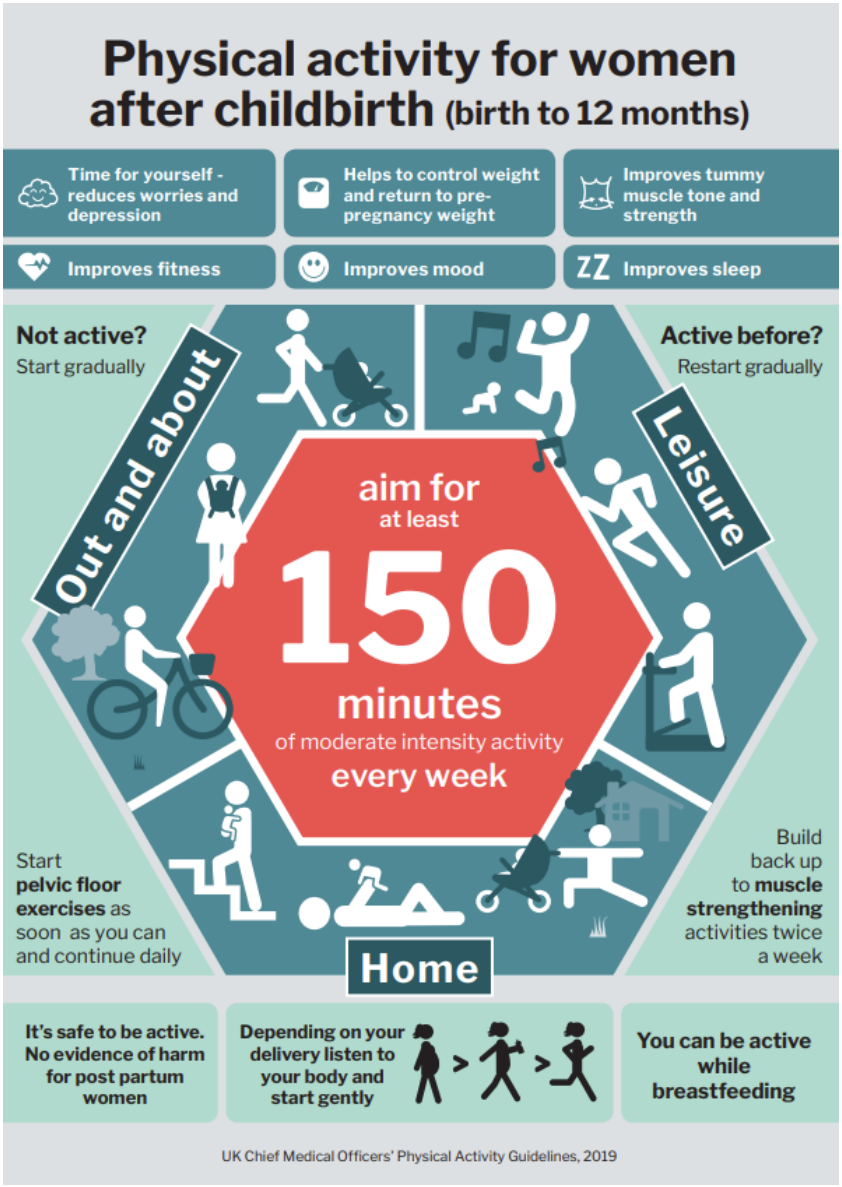
Individuals are encouraged to begin with gentle forms of exercise after childbirth, such as walking and performing basic core and abdominal movements. Regular pelvic floor exercises are important for restoring strength and function after childbirth and should be continued daily. These activities can be started at home. High-impact exercises, such as aerobics and running, should be postponed until after the 6-week postnatal check[82].

Following the 6-week assessment, it is advisable to progressively increase the intensity and duration of low-impact exercises. Strength training should be incorporated twice weekly, with a

slow and steady progression in overall activity, ensuring that exercise is discontinued if any pain arises[82].

Swimming may be resumed once all postnatal bleeding has stopped and wounds have healed. If any concerns or uncertainties arise, individuals are advised to consult their midwife, health visitor, or GP for guidance[82].

Figure 8: UK Chief Medical Officers' Physical Activity Guidelines for after childbirth, 2019



Source: Department of Health and Social Care

Although there is limited data on local physical activity levels in pregnant and postpartum women and birthing people the report MOMentum Lost: Unpicking Maternal Physical Activity Patterns, published in June 2024, showed that[94]:

- Around 40% of pregnant women or birthing people and 27% of postnatal women or birthing people felt they **had the opportunity** to be active.
- Fewer than 50% of women felt they **were able** to be physically active.
- Only 35% had the confidence to be active and many felt guilty when they were not physically active.

- Nearly two thirds of women (59%) stated that they had experienced some form of pelvic floor and/or abdominal wall issue during or after pregnancy. The majority of these women (58%) did not consult with a specialist pelvic health physiotherapist about their concerns. Of those women who sought further advice, most (63%) paid privately to obtain professional help.
- Half of the respondents wanted to be more active, but only 8% of pregnant and 10% of postnatal women felt supported to be active.
- Less than half of the participants received advice about physical activity during pregnancy, with midwives and fitness professionals most commonly providing this advice.
- Postnatally, of the 76% of women who had had their 6-8 week check; physical activity was discussed with only 13% of women during that appointment, and 63% of women had not been given any advice about returning to physical activity.

Diet

Consuming a balanced and nutritious diet is crucial, as the baby depends on the mother or birthing person to supply the essential nutrients necessary for healthy growth and development. Evidence shows that maternal nutrition not only shapes the baby's health during pregnancy, but also influences outcomes throughout childhood and beyond, potentially affecting future generations[95,96].

Research shows that maternal undernutrition can affect metabolism and functional capabilities of offspring[97]. However, achieving a balanced and nutritious diet during pregnancy does not mean going on a specialist, complicated diet. By following general guidance, such as The Eatwell guide, women and birthing people can help support the healthy development of their baby. It is also advised to consider the amount of ultra-processed foods consumed, a processed food is any food that has been changed in some way during preparation, these foods tend to have sugar and salt added. Instead, it's better to choose foods that are as unprocessed as possible, including:

- fruit and vegetables
- pulses, nuts and seeds
- meat, fish and eggs
- milk, cheese and yoghurt
- carbohydrates, such as potato, brown rice and wholegrain pasta.

Specific micronutrients are also important during pregnancy, table 4 outlines the Association of UK Dietitians vitamin supplement recommendations.

Table 4: Nutrition supplements recommended during pregnancy and benefits

Micronutrient	Benefits
Folic acid	Is a key vitamin that can lower the likelihood of a baby developing neural tube defects. It is recommended that individuals take a daily supplement containing 400 micrograms of folic acid from the time they begin planning a pregnancy (immediately after stopping contraception) until the 12th week of gestation. Those who have an increased risk of having a baby with a neural tube defect may require a higher dosage.
Vitamin D	Essential for the absorption of calcium and plays a significant role in supporting bone health. Insufficient vitamin D may result in rickets in the baby. A supplement providing 10 micrograms of vitamin D each day is advised throughout pregnancy and while breastfeeding. Certain groups- such as people with darker skin, reduced sunlight exposure, those who are socially excluded, or individuals living with obesity- are likely

Micronutrient	Benefits
	to need higher amounts (25 micrograms), although additional research is necessary to confirm this guidance.
Iodine	Requirements are higher for those planning a pregnancy, pregnant, or breastfeeding. These needs can generally be met by consuming foods like fish, milk, and dairy products. However, vegans and those with a limited nutritional intake are advised to take a supplement containing 150 micrograms of iodine daily. Individuals with pre-existing thyroid conditions should consult their GP or a maternal dietitian regarding their iodine intake.

Source: The Association of UK Dietitians

While following the Eat Well Guide is advised during pregnancy, it is important to note that certain foods and drinks are best avoided or limited due to potential risks to the baby. Although it may seem daunting when faced with numerous dietary restrictions, there remain plenty of safe and nutritious options available. Some foods require specific preparation or cooking methods, while others should be excluded altogether. Information can be found on Tommy's Are there foods and drinks I should avoid in pregnancy? online page.

Additionally, despite the common myth, being pregnant does not mean women or birthing people need to "eat for two", managing portions is an important part of eating a balance diet. Maternal overconsumption has been shown to increase inflammatory and metabolic disease risk in postnatal offspring[98]. For support, the Association of UK Dietitians produced a food fact sheet on portion sizes.

It is also important for pregnant women or birthing people to eat regularly, aiming for three meals each day, with two to three snacks- if necessary. No more than 12 hours should pass between meals. For those who do not typically have breakfast, beginning the day with a small snack is recommended[99].

Despite widespread recognition of the importance of a healthy, balanced diet, many women in the UK fall short of recommended intakes for important nutrients, including iron, folate, iodine and vitamin D. These shortfalls are particularly evident among nutritionally vulnerable groups, such as teenagers, women from lower-income households and those experiencing food insecurity; such groups may face barriers to accessing healthy foods and adhering to supplementation guidance[95].

To support this within the UK, the NHS Healthy Start Scheme allows eligible families to receive a pre-paid Healthy Start card with money topped up monthly, to purchase healthy foods and access to free vitamins. The scheme acts as a nutritional safety net, to support better eating habits in low-income families and in young pregnant women.

These families will be able to use their monthly Healthy Start money to purchase:

- fruit and vegetables
- fresh, dried, or tinned pulses
- plain cow's milk
- infant formula
- free mother and child vitamins

Eligibility for the Healthy Start Scheme is determined by specific criteria. Individuals may qualify if they are pregnant or have children under four years old, provided they are receiving certain benefits, such as Child Tax Credit (where the household income is below £16,190), Income Support, Income-based Jobseekers Allowance, Universal Credit (with a family take-home pay of

less than £408 per month), Income-related Employment and Support Allowance, or if they or their partner receive Working Tax Credit run-on only, or Pension Credit. Furthermore, those who are pregnant and under 18 can apply even if they do not receive benefits. The scheme is also accessible to people unable to claim public funds due to immigration status, as long as they have parental responsibility for at least one British child under four years of age and the family's take-home pay does not exceed £408 per month.

The UK government has announced an increase in the value of Healthy Start vouchers starting in April 2026. This increase is aimed at supporting the poorest families and tackling child poverty. The new value will be £4.65 per week for pregnant women and children aged one or older but under four, up from £4.25. Children under one year old will receive £9.30 per week, an increase from £8.50. This change is part of the government's commitment to ensure that every baby in the UK receives the best possible start in life.

Local promotion of the national Healthy Start Scheme has been underway, with local literature and short information courses delivered to statutory and voluntary organisations building knowledge and confidence in the scheme to increase applications and uptake. Ipswich Markets are now able to accept vouchers. These developments supported the uptake for the Healthy Start Scheme which showed an increase from 61% in March 2023 to 77% in March 2024 in Suffolk. Each family receives approx. £1,000 over 4 years which estimates this increase to have added a minimum of £600,000 into the pockets of Suffolk families. However, more recent local Healthy Start uptake data has been put on hold due to source quality issues.

Maternal vaccination

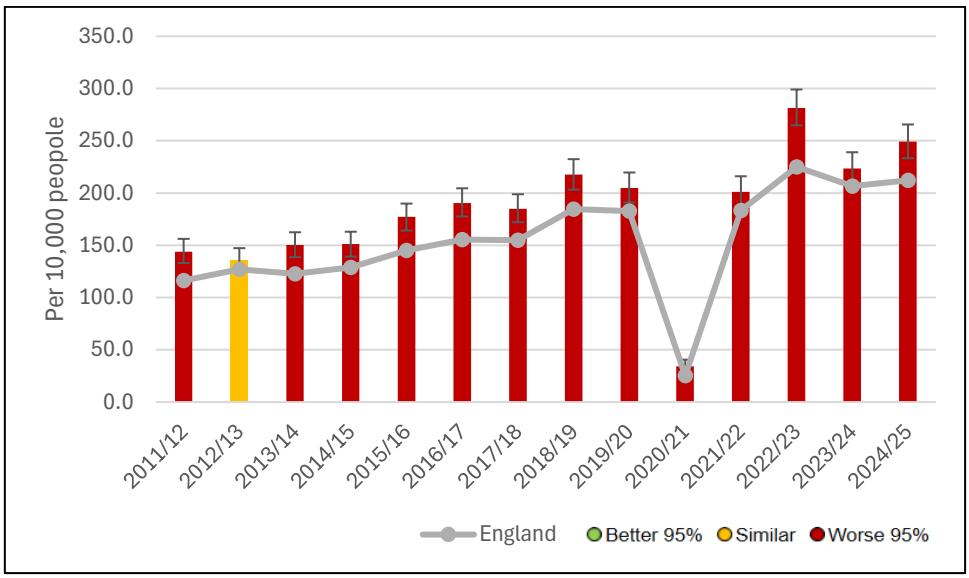
Maternal vaccination is a core component of antenatal care, offering protection to both the pregnant person and the developing infant during a period of heightened immunological vulnerability. The NHS routinely recommends three inactivated vaccines during pregnancy to reduce the risk of server lower respiratory tract infections (LRTI) in the first six months of life, these are [100]:

1. The seasonal influenza (flu) vaccine
2. The pertussis (whooping cough) vaccine
3. The respiratory Syncytial Virus (RSV) vaccine.

Figure 9 shows the emergency admissions for LRTI in children under the age of 5 in Suffolk between 2011/12 and 2024/25, compared to England. Results show that:

- In 2024/25 the rate of emergency admissions for LRTIs in children under 5 in Suffolk was 249.3 per 10,000, statistically significantly worse than the England estimate of 212.0 per 10,000
- Recent trends also show the rate of emergency admissions for LRTIs in children under the age of 5 in Suffolk is statistically significantly increasing and getting worse
- However, it is important to note that higher LRTI emergency admissions in under 5s may partly reflect differences in paediatric clinical pathways, with children more likely to be directly admitted rather than recorded as an emergency attendance.

Figure 9: Rate of emergency admissions for lower respiratory tract infections (0 to 4 years) in Suffolk between 2011/12 and 2024/25, compared to England

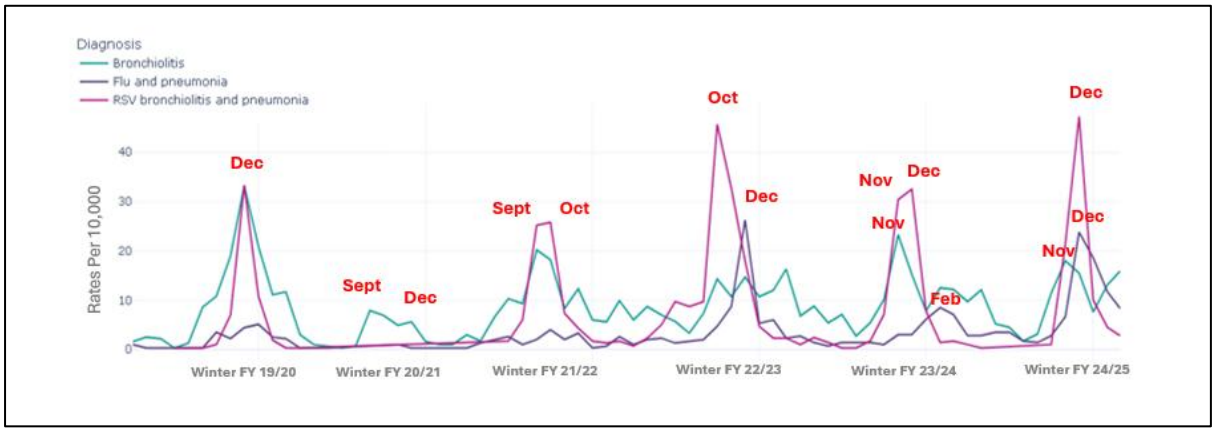


Source: Fingertips

Figure 10 shows the rate of emergency admissions for LRTIs by infection type in children under 5 years old in Suffolk (excluding Waveney) between 2019/20 and 2024/25 (reporting period 1st April 2019 – 31st March 2025). Results show that:

- RSV bronchiolitis is the leading driver of winter admissions in young children. These predictable seasonal peaks place considerable demand on healthcare services, often coinciding with broader winter pressures.
- In more recent years, flu has seen its highest winter peaks, coinciding with RSV bronchiolitis peaks which placing further pressures on healthcare services.
- Bronchiolitis remained consistently present throughout the reporting period.
- Data for 20/21 was impacted by the COVID-19 pandemic and should be interpreted with caution.

Figure 10: Rate of emergency admissions for LRTIs by infection type in children under 5 years old in Suffolk (excluding Waveney) between 2019/20 and 2024/25 (reporting period 1st April 2019 – 31st March 2025)

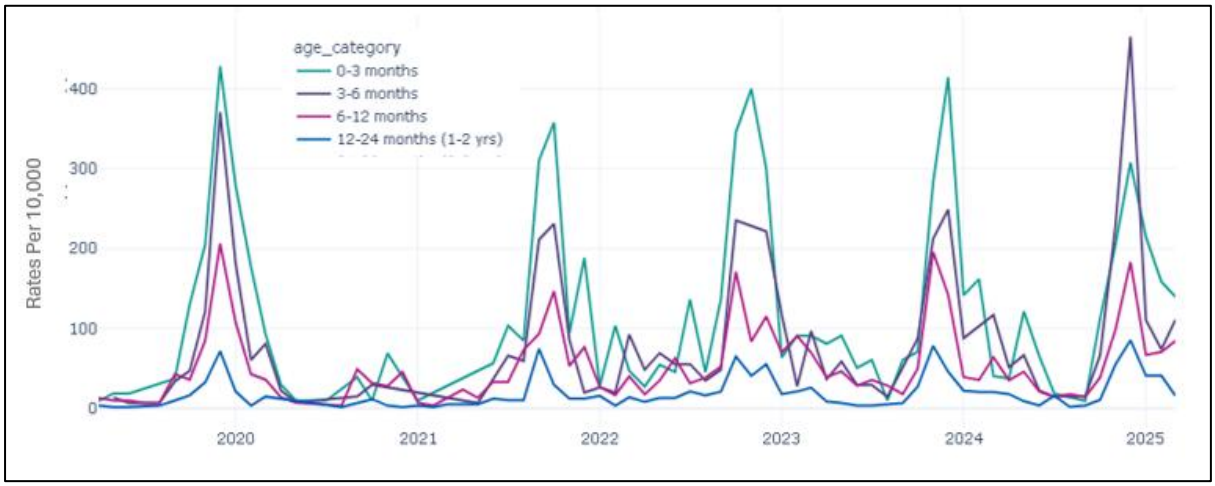


Source: Axym

Figure 11 shows the rate of emergency admission for LRTIs for children under 2 years old in Suffolk (excluding Waveney) split by 3-month age brackets for 2019/20 to 2024/25 (reporting period 1st April 2019 – 31st March 2025). Results show that:

- Infants under 2 years, particularly under 6 months experience pronounced seasonal peaks in LRTI admissions
- Children aged 0–3 months consistently show the highest LRTI admission peaks each year.
- In 2024/25 a reduction in LRTI admission rates for 0-3 months was shown- although not statistically significant.

Figure 11: Rate of emergency admission for LRTIs for children under 2 years old in Suffolk (excluding Waveney) split by 3-month age brackets for 2019/20 to 2024/25 (reporting period 1st April 2019 – 31st March 2025)



Source: Axym

Figure 11 shows a reduction in LRTI admission rates among infants aged 0–3 months in 2024/25. This coincides with the introduction of the maternal RSV vaccination programme in September 2024 [101] in Suffolk. However, this reduction is not statistically significant and should be interpreted with caution, particularly given the limited follow-up period and small numbers in the first year of the programme.

An exploratory analysis of year-on-year percentage change (FY 2023/24 to FY 2024/25) suggests that GP practices with higher RSV vaccination uptake in pregnancy tended to have larger reductions in LRTI admissions among infants aged 0–3 months in Suffolk (excluding Waveney), although this analysis is based on a small sample.

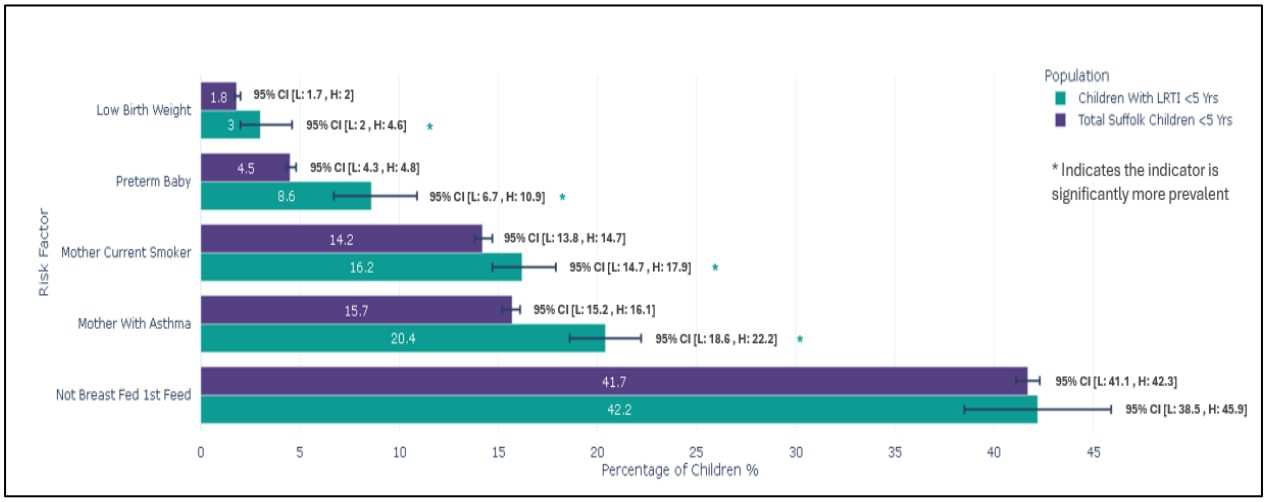
National evidence indicates that maternal RSV vaccination is effective in reducing LRTIs in early infancy. In Suffolk, average maternal RSV vaccination uptake across GP practices was approximately 64%, statistically similar to the national average (63.6%) [102].

Figure 12 shows further analysis investigating the prevalence of risk factors in children under 5 years old in Suffolk (excluding Waveney) with an LRTI admission compared to all under 5s from 2019/20 to 2024/25. Results show that:

- In Suffolk (excluding Waveney), between 2019/20 and 2024/25 preterm birth and low birth weight were statistically significantly more prevalent among children admitted with LRTI compared with the Suffolk child population overall- although numbers are small.

- Maternal asthma and current smoker status were also statistically more prevalent among children admitted with LRTI compared with the Suffolk child population overall (excluding Waveney).

Figure 12: Prevalence of risk factors in children under 5 years old in Suffolk (excluding Waveney) with an LRTI admission compared to all under 5s in Suffolk from 2019/20 to 2024/25 (reporting period 1st April 2019- 31st March 2025)



Source: Axym

Taken together this shows that the antenatal period could offer an important opportunity to reduce LRTI admissions in Suffolk's youngest infants, who carry the greatest burden. Early local findings on maternal RSV vaccination are promising but based on limited data, so continued monitoring is important as the programme matures. Alongside this, supporting uptake of all three recommended pregnancy vaccines, and offering tailored support to those women or birthing people with modifiable risk factors, such as asthma and smoking in pregnancy, may help ease pressure on services over time.

Pregnancy complications

Hypertension

Hypertensive disorders of pregnancy (HDP) are one of the most common complications of pregnancy and are a leading cause of maternal morbidity and mortality globally[103]. Research shows that HDP are associated with perinatal complications, including placental abruption, stillbirth, foetal growth restriction, preterm birth, and neonatal mortality[104–108].

Several different HDPs can complicate pregnancy. NICE uses the following working definitions:

- **Hypertension:** diastolic blood pressure of 90–109 mmHg and/or systolic blood pressure of 140–159 mmHg.
- **Severe hypertension:** diastolic blood pressure of 110 mmHg or greater and/or systolic blood pressure of 160 mmHg or greater.
- **Chronic hypertension:** hypertension that is present at, or prior to the booking visit, or before 20 weeks gestation.
- **Gestational hypertension:** new hypertension presenting after 20 weeks gestation without significant proteinuria (the presence of excess proteins in the urine).

- **Pre-eclampsia:** new hypertension presenting after 20 weeks gestation with significant proteinuria. Pre-eclampsia is a multi-system disorder which can affect the placenta, kidney, liver, brain, and other maternal organs.
    - HELLP syndrome (Haemolysis, Elevated Liver enzymes, and Low Platelets syndrome) is a severe form of pre-eclampsia.
- **Eclampsia** is the occurrence of one or more seizures in a woman with pre-eclampsia.

HDPs affect about 8–10% of pregnancies in the UK. Applying this to the number of live births in Suffolk 2024, this equates to approximately 527- 658 pregnancies.

However, the prevalence varies by specific condition. For example[109]:

- Chronic hypertension has been reported to complicate 0.6–2.7% of pregnancies
- Gestational hypertension has recorded rates between 4.2–7.9%
- Pre-eclampsia rates range from 1.5–7.7% but depend on parity: 4.1% of women in their first pregnancy and 1.7% of women in their second pregnancy
- HELLP incidence estimates vary from 0.5–7.6 per 1000 deliveries, and between 8–24% of cases with severe pre-eclampsia/eclampsia.
- Between April 2023 and March 2024, 270 deliveries in England were complicated by eclampsia, equivalent to 5 per 10,000 births. Based on the eclampsia data, the estimated HELLP syndrome cases in England (2023-2024) would be approximately 22-65 cases if using the percentage of severe pre-eclampsia/eclampsia relationship

Evidence also shows that HDPs are associated with lifelong adverse health implications. Table 5 shows the increased risk of long-term health implications for women or birthing people diagnosed with an HDP. Results show that gestational hypertension, chronic hypertension and pre-eclampsia all increase the risk of developing long-term hypertension, stroke and future major adverse cardiovascular events. Pre-eclampsia developed before 37 weeks was shown to increase the risk of future major adverse cardiovascular events more than pre-eclampsia developed after 37 weeks[109].

Table 5: Long-term health implications of HDPs as reported by NICE last revised in January 2025

	Hypertension	Stroke	Future major adverse cardiovascular event
Gestational hypertension	2-4 fold increased risk	A possible increased risk	1.5-3 fold increased risk
Chronic hypertension	-	1.8-4 fold increased risk	1.7-2.2 fold increased risk
Pre-eclampsia	2-5 fold increased risk	2-3 fold increased risk	1.5-3 fold increased risk
Pre-eclampsia developed before 37 weeks	2-5 fold increased risk	2-3 fold increased risk	8-fold increased risk

Source: NICE

Gestational diabetes

Gestational Diabetes Mellitus (GDM) is defined as high blood sugar (glucose) that develops during pregnancy and usually disappears after giving birth[110].

GDM is the most common medical condition to affect pregnant women. If it is untreated during pregnancy it can lead to poor maternal and neonatal outcomes. Women who have GDM are at high risk of developing diabetes and cardiovascular disease after pregnancy[111].

Every year in England and Wales, out of the approximate 700,000 women and birthing people, it is estimated that up to 5% have either pre-existing diabetes or gestational diabetes. Of these women or birthing people who have diabetes during pregnancy, it is estimated that approximately 87.5% have gestational diabetes (which may or may not resolve after pregnancy)- this equates to around 30,000 women or birthing people across England and Wales. Applying this to the number of live births in Suffolk 2024, this equates to approximately 288 pregnancies. The incidence of gestational diabetes is also increasing as a result of higher rates of obesity in the general population and more pregnancies in older women[112].

Furthermore, the prevalence of GDM is disproportionately higher among women from ethnic minority groups and those experiencing social deprivation, with under-reporting potentially widening healthcare inequalities[110].

Women or birthing people with a history of GDM have an increased risk of long-term health conditions. Research shows that women or birthing people with a history of GDM have an 8-10-fold higher risk of developing type 2 diabetes compared with women without a history of GDM[113–115]. A meta-analysis involving over 5 million women or birthing people also showed that those with a history of GDM have a 2.3-fold higher risk of developing cardiovascular events in the first decade postpartum compared with women or birthing people without GDM[116].

The 2024-25 National GDM audit revealed that:

- 10.8% of women or birthing people with a GDM diagnosis across England and Wales have developed non-diabetic hyperglycaemia (pre-diabetes) within five years of their GDM diagnosis
- 15.2% of women or birthing people diagnosed with GDM across England and Wales went on to develop type 2 diabetes within 10 years of their GDM diagnosis.

However, the audit recognised that these are likely to be an underestimate due to systematic under recording of GDM prevalence and suboptimal postnatal HbA1c screening. With these underestimates in mind, NHS England suggest that up to 50% of women or birthing people diagnosed with GDM develop type 2 diabetes within 5 years of diagnosis with an ongoing elevated risk thereafter[110].

NICE guidelines for diabetes in pregnancy recommend that all women or birthing people with GDM should be offered a diabetes prevention programme (DPP) referral to reduce development of early-onset type 2 diabetes. Since 2024, women who have had GDM can self-refer to the DPP.

Despite this guidance, there has been limited engagement in postnatal monitoring and DPP across the nation, with only 4.5% of women with a GDM diagnosis ever participating in the DPP. More specifically, the 2024-25 National GDM audit found that:

- 42.6% of women or birthing people with GDM did not receive an annual HbA1c measurement
- 47.9% of women or birthing people with GDM did not have cardiometabolic follow-up blood pressure checks
- 55.3% of women or birthing people with GDM did not have cardiometabolic follow-up BMI assessments

- 64.6% of women or birthing people with GDM did not have cardiometabolic follow-up cholesterol tests

Maternal mental health

Maternal mental health refers to an individual's mental wellbeing during pregnancy and for up to two years following birth. Maternal mental health conditions include depression, anxiety, pregnancy and postpartum psychosis, birth trauma (PTSD), eating disorders, obsessive-compulsive disorder (OCD), and tokophobia (marked fear of pregnancy and birth). The Maternal Mental Health Alliance has found that:

- Maternal mental health conditions affect as many as 1 in 4 women and birthing people.
- It is more common to experience maternal mental ill-health than other pregnancy-related complications like gestational diabetes or pre-eclampsia.
- Some symptoms that suggest a women or birthing person's mental health is under pressure include constant sadness, anxiety, irritability, and difficulty bonding with baby.
- Factors such as hormonal changes, a history of mental illness, physical health, traumatic birth experiences, and sleep deprivation can contribute to these conditions.

During pregnancy and the postnatal period, numerous mental health conditions exhibit characteristics, progression, and risk of relapse comparable to those observed at other times. However, certain differences exist; for example, bipolar disorder demonstrates a heightened incidence of relapse and initial onset during the postnatal period [117].

National statistics show that[117]:

- Depression and anxiety are the most common mental health conditions experienced during pregnancy, with around 12% of women or birthing people experiencing depression and 13% experiencing anxiety at some point.
- Depression and anxiety also affect 15 to 20% of women or birthing people in the first year after childbirth.
- Postpartum psychosis affects between 1 and 2 in 1,000 women or birthing people. Women with bipolar I disorder are at particular risk, but postpartum psychosis can occur in women or birthing people with no previous psychiatric history.

Table 6 provides the most recent estimated prevalence of pre-existing or newly diagnosed mental health conditions during perinatal period for Suffolk compared to England calculated by The Office of Health Improvement and Disparities (OHID). Results show that:

- In 2019, 26.2% of women or birthing people in Suffolk experience perinatal mental health conditions.
- When compared to upper tier local authorities (UTLAs) across England, Suffolk is in the middle quintile, this means that 40% of UTLAs have a lower estimated prevalence, and 40% of UTLAs have a higher estimated prevalence compared to Suffolk.
- There was a small decrease of 0.3% in the estimated prevalence in Suffolk from 2016 to 2019- although not statistically significant.

Table 6: Model-based estimated prevalence of perinatal mental health conditions in Suffolk compared to England for 2016 and 2019

	England	Suffolk
2016	26.2%	26.5%
2019	25.8%	26.2%

Source: Fingertips

Research has also highlighted that many women or birthing people will hide or underplay the severity of their mental -ill health. The Royal College of Midwives (RCM) launched the updated Perinatal Mental Health (PMH) Roadmap and found that 70% of women or birthing people will hide or downplay their mental ill-health, often due to fear of judgment, stigma, or concerns about social services involvement[118].

The impact is evident in maternal mortality statistics, over the past two decades, psychiatric disorder has been a leading cause of maternal mortality, contributing to 15% of all maternal deaths in pregnancy and six months postpartum[119]. 2021-2023 maternal mortality data shows that mental health challenges remain one of the leading contributors to maternal death in the UK. Suicides are now the most common cause of maternal death in the period between six weeks and one year after the end of pregnancy and mental health conditions as a whole account for over one third of deaths in this period[24].

NICE antenatal and postnatal mental health: clinical management and service guidance makes recommendations for the recognition, assessment, care and treatment of mental health conditions in women during pregnancy and the postnatal period (up to 1 year after childbirth) and in women who are planning a pregnancy.

Births, birth characteristics and immediate birth outcomes

Births, birth characteristics and immediate birth outcomes provide a crucial insight into the health of women or birthing people and babies at delivery and during the critical first two weeks of life. Indicators included within this section reflect the effectiveness of antenatal care and the potential needs of newborns. These outcomes may highlight areas where additional investigation or support may help improve outcomes for women or birthing people and babies.

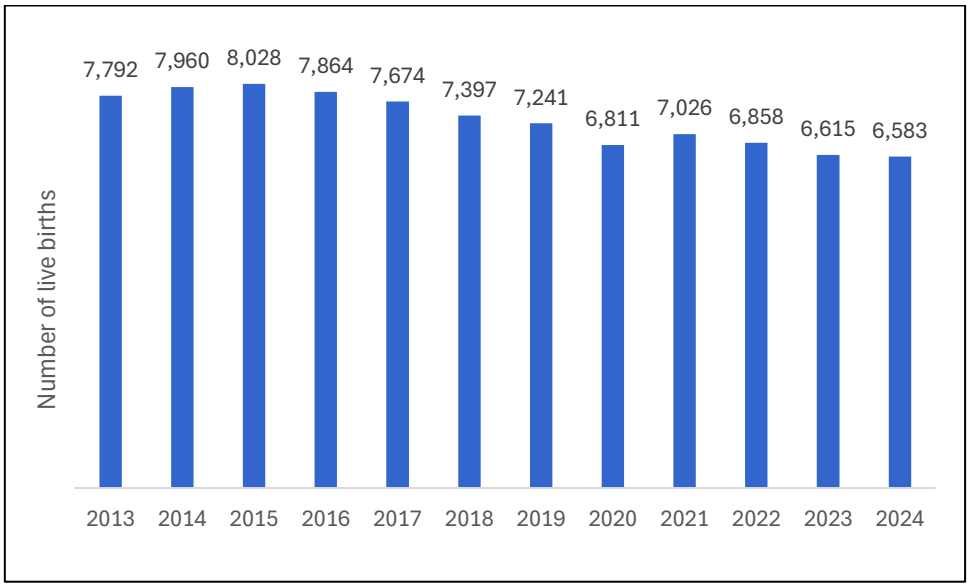
Birth statistics

Birth statistics represent births that occurred in the calendar year but include a very small number of late registrations from the previous year. Figures are compiled from information supplied when births are registered as part of civil registration, a legal requirement.

Figure 13 provides the number of live births in Suffolk by calendar year between 2013 and 2024. Results show that:

- There were 6,583 live births recorded in 2024, 32 less than recorded in 2023 (6,651 live births)
- Since 2013 there has been an approximately 15.5% decrease in the number of live births in Suffolk from 7,792 to 6,583.

Figure 13: Live births in Suffolk between 2013 and 2024

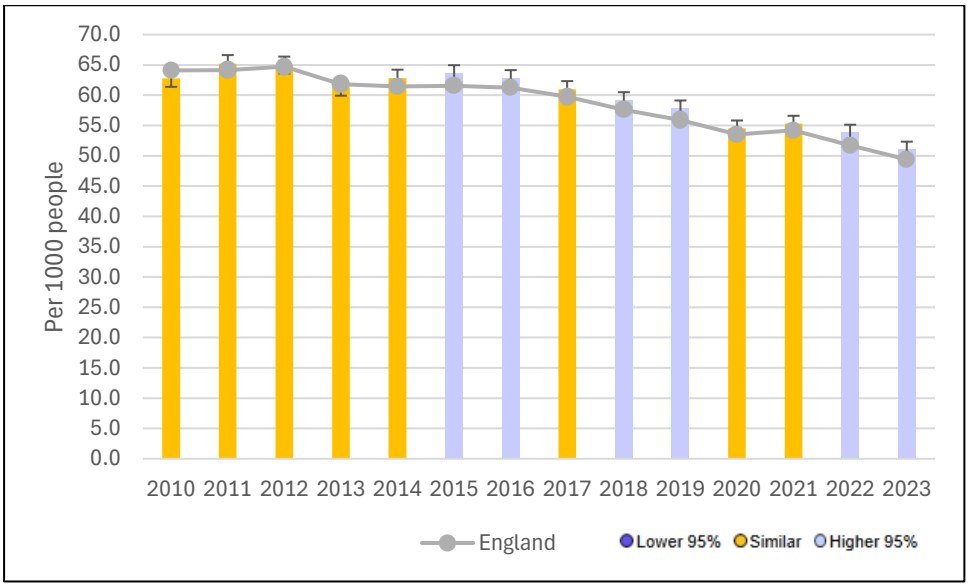


Source: OHID

Figure 14 shows general fertility rate (GFR) of Suffolk between 2010 and 2023, compared to England. The GFR is defined as the birth rate per 1,000 females aged 15 to 44 years. Results show that:

- In 2023 the GFR in Suffolk was 51.1 per 1,000. Although statistically significantly higher than England estimates, the 2023 GFR in Suffolk was the lowest rate on record.
- Overtime the Suffolk GFR has shown a clear decline, decreasing significantly from the highest recorded rate in 2011 (65.2 per 1,000) to 2023 (51.1 per 1,000).

Figure 14: The general fertility rate per 1,000 people in Suffolk (ages 15-44 years) between 2010 and 2023, compared to England



Source: Fingertips

Birth characteristics

Birth characteristics are the observable features and circumstances of how a baby is born. This section examines birth characteristics for deliveries to Suffolk residents, reflecting both the complexity of pregnancies in the population and the demands placed on maternity services.

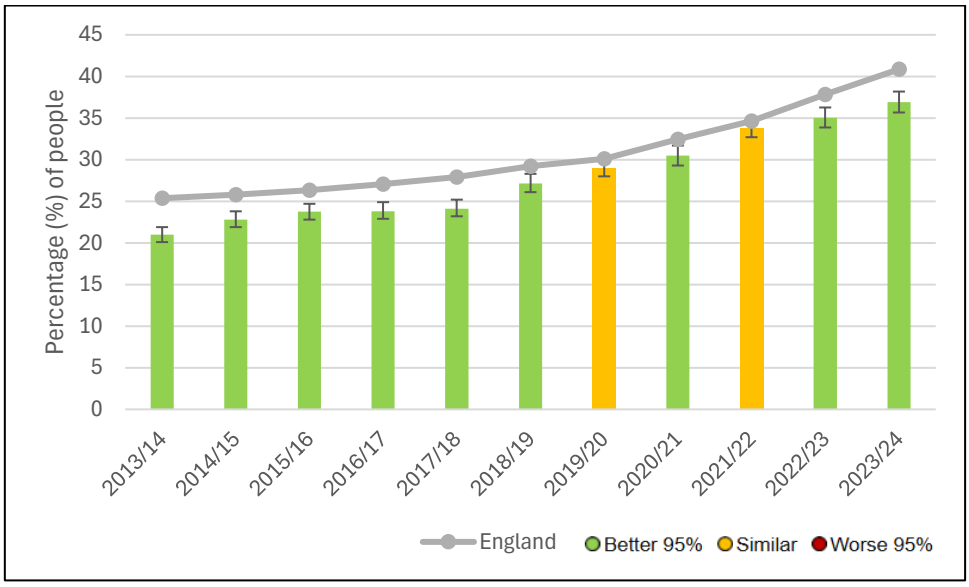
Deliveries by caesarean

A caesarean section is a surgical procedure to deliver a baby through a cut made in the abdomen and womb. Caesarean sections may be planned (elective) if there are known complications or concerns identified during pregnancy, or they may be performed as an emergency during labour if complications arise. Women can also request an elective caesarean section even without medical complications, and healthcare providers should discuss the overall benefits and risks with them to support informed decision-making. Caesarean section rates provide insight into clinical practice patterns[120].

Figure 15 shows the percentage of deliveries by caesarean section in Suffolk between 2013/14 and 2023/24 compared to England. Results show that:

- In 2023/24 36.9% of deliveries were by caesarean section in Suffolk (2,090 deliveries), statistically significantly lower than England estimates of 40.9%.
- Recent trends show that the percentage of deliveries by caesarean section in Suffolk are statistically significantly increasing over time.

Figure 15: Percentage of deliveries by caesarean section in Suffolk, between 2013/14 to 2023/24, compared to England



Source: Fingertips

Multiple births

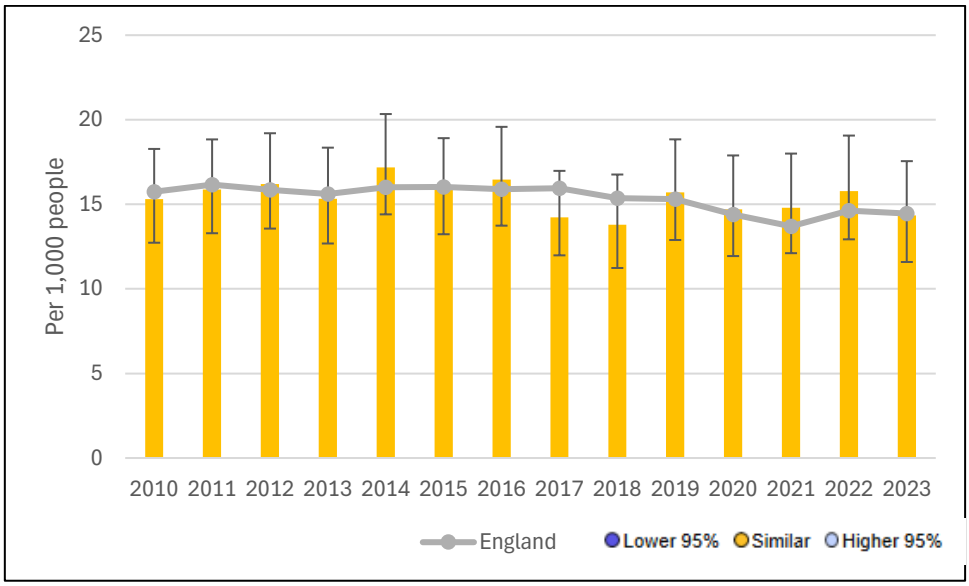
Twins or triplets occur in approximately 1 in 60 pregnancies, and 3% of live-born babies are from multiple gestations. In England and Wales, the incidence of multiple births has risen in the past 30 years[121]. This is due mainly to increasing use of assisted reproduction techniques, including in vitro fertilisation (IVF), and also to changing demographics as women defer pregnancy and twins are more common at later ages[122].

Women with a twin or triplet pregnancy are at higher risk compared with women with a singleton pregnancy. Adverse outcomes are more likely, both for the woman and her babies, during the prenatal and intrapartum periods. Because of this, women need increased monitoring and more contact with healthcare professionals during their pregnancy[122].

Figure 16 shows the number of maternities per 1,000 where the outcome is a multiple birth for Suffolk between 2010 and 2023, compared to England. Results show that:

- In 2023 there were 14.3 per 1,000 multiple births (94 births) in Suffolk, statistically similar to the England estimate of14.5 per 1,000.
- Recent trends show no statistically significant change in the rate of multiple births in Suffolk overtime.

Figure 16: Number of maternities where the outcome is a multiple birth expressed as a rate per 1,000 total maternities, for Suffolk, between 2010 and 2023, compared to England.



Source: Fingertips

More information and recommendations for healthcare professionals regarding multiple births can be found on the NICE Guidance: Twin and triplet pregnancy online page.

Immediate birth outcomes

Immediate birth outcomes describe the health and condition of babies at birth and during the first two weeks of life. This section examines immediate birth outcomes for babies born to Suffolk residents, reflecting the health of newborns and identifying those requiring additional medical support.

Premature births

Preterm birth refers to when a baby is born before 37 weeks of pregnancy. It can have a significant, and sometimes lifelong, impact on children and their families[123].

Being born early increases a child's likelihood of having long-term health conditions, as well as communication difficulties, autism and special educational needs[123].

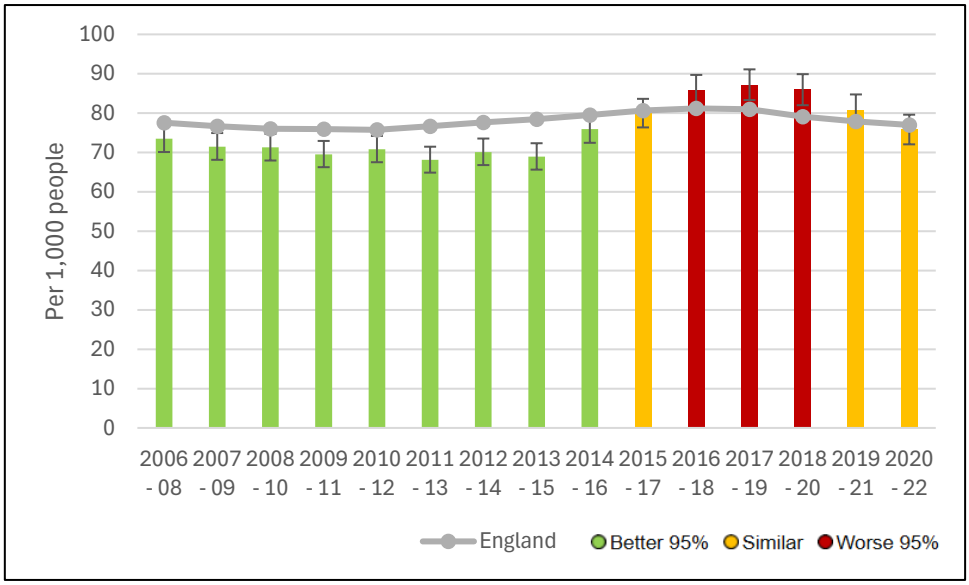
Preterm birth is the leading cause of neonatal mortality, and nearly 50% of all childhood deaths below 10 years of age are caused by preterm birth[123].

Following a preterm birth, some parents spend weeks or months caring for their baby in a specialist neonatal unit. This experience can have a profound psychological impact, which may not be fully evident until long after discharge home. Parents also often face practical and financial challenges at this time, which can persist as children grow up and prepare to start school[123].

Figure 17 shows the rate of premature live births and all stillbirths in Suffolk between 2006-08 and 2020-22 compared to England. Results show that:

- In 2020-22 75.8 per 1,000 live births or stillbirths were premature in Suffolk (1,572 births), statistically similar to England estimates 77.0 per 1,000.
- There has been a statistically significant decrease in Suffolk's premature birth rate from 2018-20 (85.9 per 1,000 [1,842 births]) to 2020-22. Although in most recent years 2019-21 (80.8 per 1,000 [1,707 births]) no significant change was shown.

Figure 17: Rate of premature live births and stillbirths (gestational age between 24-36 weeks) per 1,000 live births and stillbirths in Suffolk, between 2006-08 and 2020-22, compared to England



Source: Fingertips

The prediction and prevention of preterm birth is made more challenging due to the wide range of factors that contribute to a woman's individual level of risk. In many cases, women who go on to give birth preterm have no apparent risk factors. Although there are some identified risk factors of preterm birth, including[124]:

- Infection
- Being pregnant with more than one baby
- A weak cervix
- Having had surgery to your cervix, such as removing abnormal cells after cervical screening
- Previous premature birth
- Previous emergency c-section
- Living with overweight or underweight
- Smoking
- Drinking alcohol

- Recreational drug use

Overall, research does show that optimising women's health prior to pregnancy is an important part of preterm birth prevention[123].

The Saving Babies' Lives Care Bundle, produced by NHS England, outlines a range of interventions aimed at identifying mothers at risk of preterm birth and improving outcomes for preterm babies. While this guidance was generally welcomed, it has been shown that recommended interventions are delivered inconsistently; care may differ depending on where a preterm baby is born[123].

Birth weight

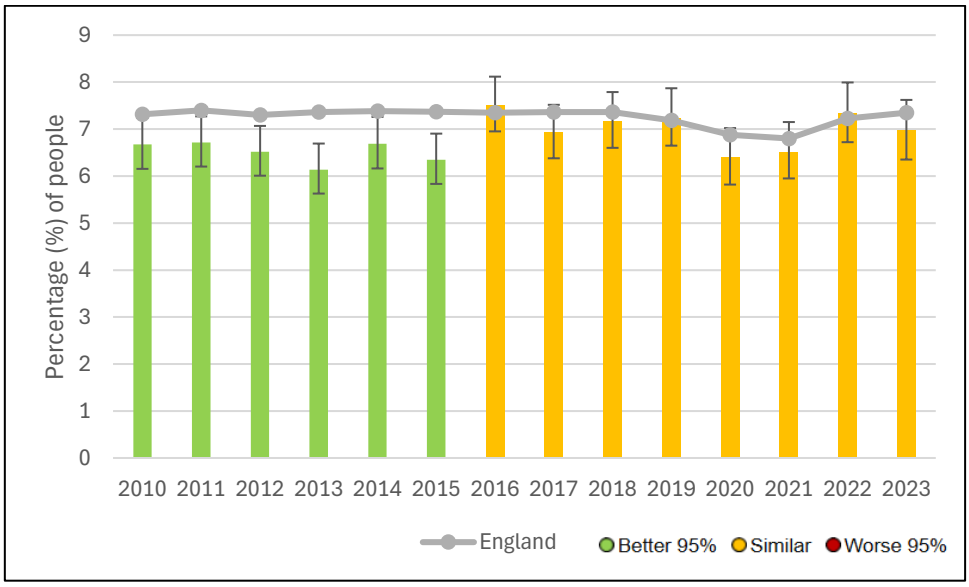
Low birth weight (LBW, under 2,500 grams) is associated with an increased risk of infant mortality, developmental problems in childhood and poorer health in later life[125].
At a population level, a high proportion of LBW babies is primarily related to poorer antenatal maternal health. Prioritising policies which target maternal health, both socioeconomic and those relating to antenatal health care quality and access, will contribute to a reduction in the number of LBW babies[125].

Reducing the number of babies born under 2,500 grams is an international priority, and the World Health Organisation has set a target to achieve a 30% reduction in the number of LBW babies (based on the 2012 baseline) by 2030[126].

Figure 18 shows all births with a recorded birthweight under 2500g as a percentage for Suffolk between 2010 and 2023, compared to England. Results show that:

- In 2023 7.0% of all births in Suffolk (430 births) had a recorded birthweight under 2500g, statistically similar to England estimates of 7.4%.
- Recent trends show no statistically significant change overtime.

Figure 18: All births with a recorded birth weight under 2500g as a percentage for Suffolk, between 2010 and 2023, compared to England



Source: Fingertips

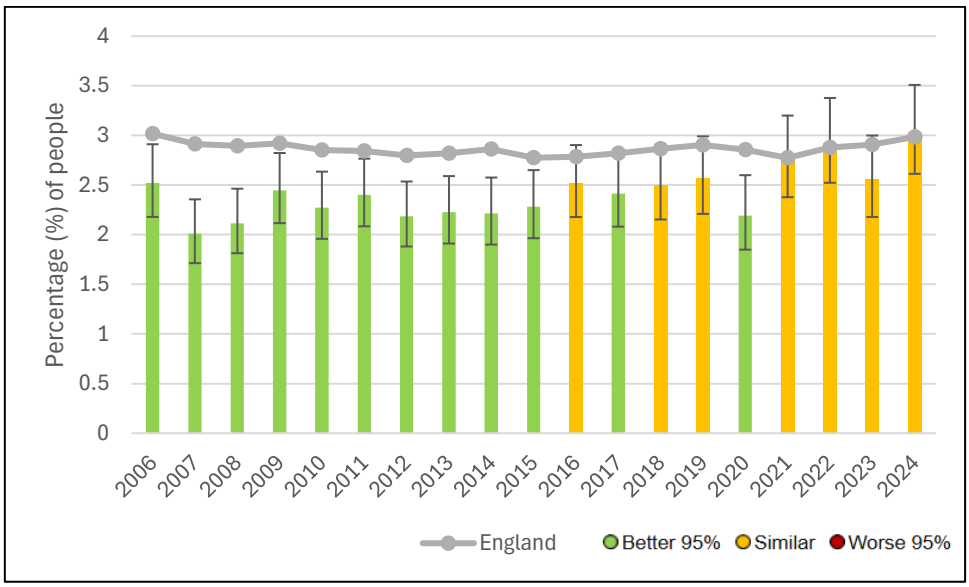
A large proportion of babies will be born under 2,500 grams because they are preterm births (born before 37 weeks of pregnancy). Whether they are born prematurely or at full term, the risk of low birth weight is related to[125]:

- smoking while pregnant
- substance and alcohol misuse
- pregnancy health and nutrition
- pregnancy-related complications
- a mother's or birthing person's young age

Figure 19 shows live births with a recorded birth weight under 2500g and who were born to term (gestational age of at least 37 completed weeks) as a percentage for Suffolk between 2006 and 2024, compared to England. Results show that:

- In 2024 3.0% of live term births in Suffolk (171 births) had a recorded birthweight under 2500g, statistically similar to England estimates of 3.0%.
- Recent trends show no statistically significant change over time

Figure 19: Live births with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks as a percentage for Suffolk, between 2006 and 2024, compared to England



Source: Fingertips

Low birth weight is further categorised into very low birth weight (VLBW, <1500g). The main cause of a baby having VLBW is being born prematurely, with VLBW children often born before 30 weeks of pregnancy. Another cause of very low birth weight is when a baby does not grow well during pregnancy. This is called intrauterine growth restriction (IUGR). It may happen because of problems with the placenta, the mother's health, or birth defects. Most very low birth weight babies who have IUGR are also born early. They are usually very small and physically immature[127].

Other risk factors for VLBW include[127]:

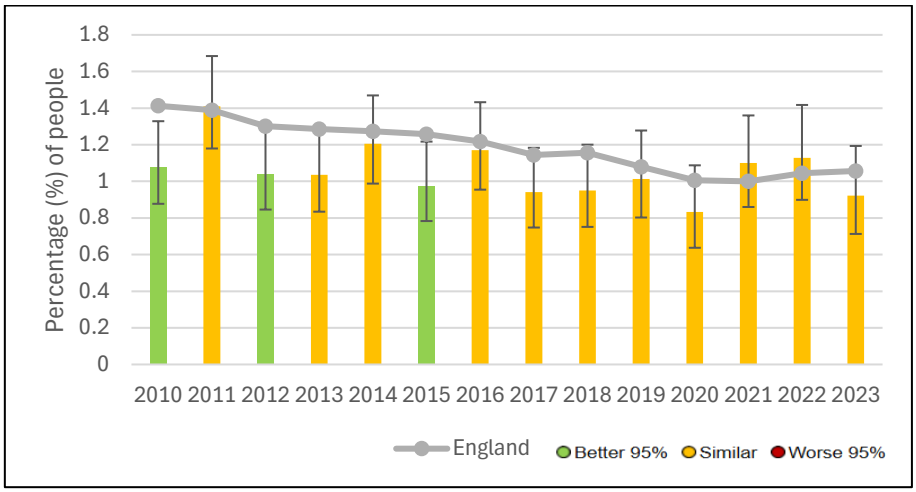
- Having an infection during pregnancy
- Not gaining enough weight during pregnancy
- Having a previous pregnancy with a low-birth-weight baby
- Smoking

- Using Alcohol or drugs
- Mother's or birthing people younger than age 17 or older than age 35

Figure 20 shows all births with a recorded birth weight under 1500g as a percentage for Suffolk between 2010 and 2023, compared to England. Results show that:

- In 2023 0.9% of all births in Suffolk (57 births) were recorded with a birth weight under 1500g, statistically similar to the England estimate of 1.1%
- Recent trends show no significant change overtime

Figure 20: All births with a recorded birth weight under 1500g as a percentage for Suffolk, between 2010 and 2023, compared to England



Source: Fingertips

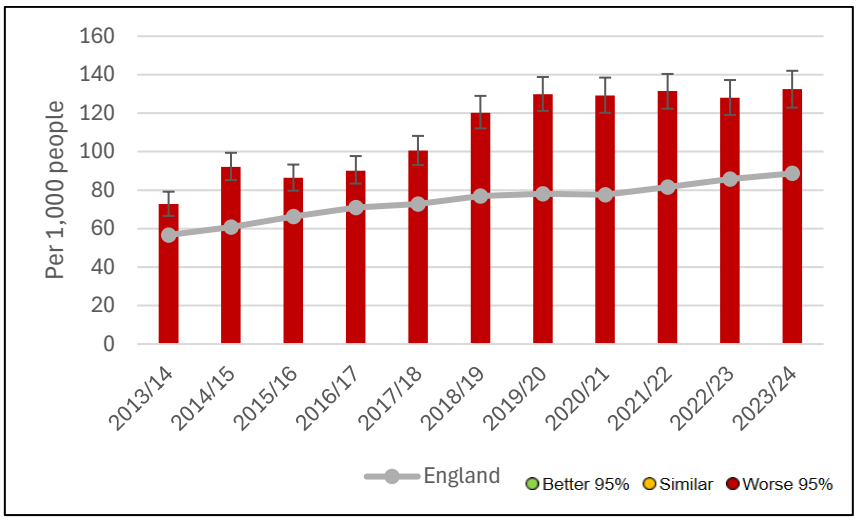
Admissions of babies under 14 days

Babies aged <14 days may be admitted to neonatal hospital care for many reasons, and while not all admissions are avoidable, high levels of emergency admissions soon after birth may be related to issues in the health assessments of babies or mothers before transfer or the result of poor postnatal care after the mother or birthing person is discharged[128]. Evidence has shown that dehydration and jaundice are two common reasons for re-admission of babies and are often linked to problems with feeding[129].

Figure 21 shows the number of emergency admissions of babies aged 0-13 days for Suffolk between 2013/14 and 2023/24 compared to England. Results show that:

- In 2023/24 132.5 per 1,000 babies aged 0-13 days in Suffolk were admitted to hospital, statistically significantly higher than the England estimate of 88.7 per 1,000.
- Rates statistically significantly increased from 2017/18 (100.7 per 1,000) to 2023/24. Although, in recent years no statistically significant difference has been shown.

Figure 21: Rate of emergency admissions of babies aged 0-13 days for Suffolk, between 2013/14 and 2023/24, compared to England



Source: Fingertips

Pregnancy loss

Please be aware that some of the definitions and explanations below use clinical language which may be upsetting for some readers. It is important to recognise that pregnancy loss (including miscarriage, stillbirth, and ectopic pregnancy) can be a deeply distressing experience for all those affected.

Pregnancy loss is a common experience that affects individuals and families across the county. Pregnancy loss can have wide-ranging impacts, affecting not only those who experience it directly but also partners, families, and wider support networks. An estimated 254,000 babies die in pregnancy or at birth each year in the UK, with most occurring before 24 weeks' gestation. The term baby/pregnancy loss losses can include miscarriage, ectopic, molar pregnancy, or because parents have decided to terminate a pregnancy following a diagnosis of a serious foetal abnormality[130].

Pregnancy loss, and especially recurrent pregnancy loss, is also a risk marker for obstetric complications, including preterm birth, foetal growth restriction, placental abruption, and stillbirth in future pregnancies, and a predictor of longer-term health problems, such as cardiovascular disease and venous thromboembolism[131].

Recent policy developments demonstrate commitment to improving pregnancy loss care. As of June 2025, Maternal Mental Health Services are available in all areas of England, providing specialist psychological support for women with moderate to severe mental health difficulties arising from birth trauma or baby loss. Additionally, all trusts in England are signed up to the National Bereavement Care Pathway, designed to improve quality and consistency of bereavement care and seven day a week bereavement services are being established in every area to support women and families experiencing pregnancy loss or neonatal death[132].

Miscarriage

Miscarriage is the spontaneous loss of pregnancy before the foetus reaches viability. The term includes all pregnancy losses from the time of conception until 24 weeks of gestation (loss of a pregnancy during the first 23 weeks)[133]. A miscarriage is described as “early” if it occurs before

13 weeks of gestation and "late" if it occurs between 13 and 24 weeks of gestation. The stages of miscarriage may include[134]:

- **Threatened miscarriage:** when vaginal bleeding, with or without lower abdominal pain, occurs in the first 23 weeks of gestation. Pregnancy may continue.
- **Inevitable miscarriage:** when specific clinical features indicate that a pregnancy is in the process of physiological expulsion from within the uterine cavity. Pregnancy will not continue and will proceed to incomplete or complete miscarriage.
- **Missed miscarriage** (also known as delayed or silent miscarriage): when a non-viable pregnancy is identified on an ultrasound scan without associated pain and bleeding.
- **Incomplete miscarriage:** when products of conception are partially expelled from the uterus. Many incomplete miscarriages may be missed miscarriages.
- **Complete miscarriage:** when all the products of conception have been expelled from the uterus, and bleeding has stopped.

Miscarriage is the most common cause of pregnancy loss and one of the most common complications in early pregnancy[135]. Early pregnancy loss accounts for over 50,000 hospital admissions in the UK each year[136]. It is estimated that miscarriage occurs in 8-24% of clinically recognised pregnancies[135–139]. However, the true rate is probably higher because many losses occur preclinically before the woman or birthing person realises that they are pregnant[137]. About 25% of women will experience a miscarriage in their lifetime. Most miscarriages (about 80%) occur in the first trimester[135]. Recurrent miscarriage affects about 1% of couples trying to conceive[140–142].

The most common cause of spontaneous pregnancy loss in the first trimester is foetal chromosomal abnormalities (detected in 50–85% of pregnancy tissue specimens after spontaneous miscarriage)[137,139,142–144]. No causes or associations are found in about 50% of couples with recurrent miscarriage (unexplained or idiopathic recurrent miscarriage). Up to 70% with no cause found achieve a successful live birth in future pregnancies depending on the age of the women or birthing person and the number of previous miscarriages[143].

Women may also experience infections or sepsis (which may occur before or after the miscarriage), and treatment complications such as[140]:

- Bleeding - retained early pregnancy tissue within the uterine cavity could result in persistent vaginal bleeding and suprapubic pain. Brisk bleeding may occur after complete evacuation of the uterus
- Uterine or cervical perforation- may occur during surgical evacuation of the uterus and can result in severe blood loss and shock
- Asherman's syndrome (rare)- may occur as a result of trauma to the endometrial lining during a curettage procedure. Scar tissue forms inside the uterus and/or the cervix and can result in infertility, recurrent miscarriage, and high-risk pregnancies

Furthermore, the risk of a future miscarriage increases with increasing number of previous miscarriages. A systematic review reported miscarriage rates of 11.3%, 17.0%, 28.0%, 39.6%, 47.2%, and 63.9% for women with no, one, two or three, four, five, and six previous miscarriages respectively[145].

Risk factors for miscarriage include:

- Advanced maternal age (usually defined as age 35 years or older)[142,143,146,147]
- Advanced paternal age[147]

  - Congenital uterine anomalies[142]
- Maternal endocrine disorders- such as Polyendocrine Metabolic Ovarian Syndrome (PMOS), diabetes mellitus, and thyroid disease[140,142,148]
  - Vitamin D deficiency[149]
  - Previous miscarriage[145]
  - Black ethnic background[150]
  - Smoking[151]
  - Alcohol consumption (approximately 10 units per week)[151]
  - Increased caffeine intake[142]
  - Obesity[142]
  - Exposure to environmental risk factors (such as air pollution and household chemicals)[142]

Risk factors for recurrent miscarriage may include:

- Chromosomal abnormalities[142,143]
- Blood clotting factors[142,143]
- Parental chromosomal anomaly[140,143]
- PMOS[143]
- Subclinical hypothyroidism and thyroid autoantibodies[143]
- Prolactin imbalances [142]
- Unhealthy BMI classification (underweight, overweight or obese)[152]

Stillbirth

A stillbirth is when a baby is born dead after 24 completed weeks of pregnancy. It happens in around 1 in every 250 births in England. If the baby dies before 24 completed weeks, it's known as a miscarriage or late foetal loss[153].

Research shows that stillbirths are associated with a significant and lasting decline in women's physical health, even after controlling for sociodemographic factors. Women who experience losses often report worse health than those transitioning to motherhood, with symptoms potentially including fatigue, pain, and cardiovascular diseases[154,155].

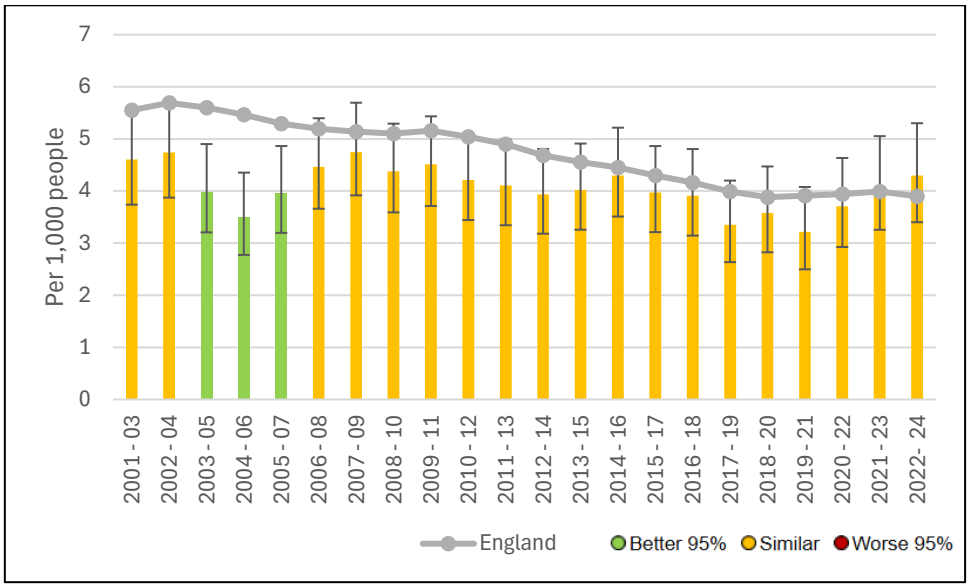
It should also be acknowledged that, following a stillbirth, an individual's body will typically experience many of the same physiological changes as if the baby had survived, including the onset of lactation. These bodily responses can be unexpected and may further contribute to the emotional distress encountered during the recovery process[156]. Tommy's charity online page Physical effects and recovery after stillbirth provides further information.

In 2015, the Government announced the National Maternity Safety Ambition to reduce the rate of stillbirths, neonatal deaths and maternal deaths in England by 50% by 2030. The ambition was subsequently revised in 2017 and the deadline for meeting the target was brought forward to 2025[157].

Figure 22 shows the rate of stillbirths for all maternal ages occurring per 1,000 births for Suffolk between 2001-03 to 2022-24 compared to England. Results show that:

- From 2022-24 the rate of stillbirths from all maternal ages in Suffolk was 4.3 per 1,000, statistically similar to England estimates.
- Recent trends show no significant change.

Figure 22: Rate of stillbirths (foetal deaths occurring after 24 weeks of gestation) for all maternal ages occurring per 1,000 births for Suffolk, between 2001-03 and 2022-24, compared to England.



Source: Fingertips

A large number of stillbirths occur in babies who have previously shown no signs of health problems, and in many cases, the cause remains unknown. However, there are certain factors that are understood to contribute to stillbirths. Numerous cases are associated with issues affecting the placenta, the organ responsible for connecting the baby's blood supply to the mother's or birthing people and providing essential nourishment throughout pregnancy. Other conditions that cause or may be associated with stillbirth include[153]:

- Bleeding (haemorrhage) before or during labour
- Placental abruption- where the placenta separates from the womb before the baby is born (there may be bleeding or abdominal pain)
- Pre-eclampsia- a condition that causes high blood pressure in the mother
- A problem with the umbilical cord, which attaches the placenta to the baby's tummy button – the cord can slip down through the entrance of the womb before the baby is born (cord prolapse) or can be wrapped around the baby and become knotted
- intrahepatic cholestasis of pregnancy (ICP) or obstetric cholestasis – a liver disorder associated with severe itching during pregnancy
- a genetic physical defect in the baby
- pre-existing diabetes
- an infection in the mother that also affects the baby

Further identified risk factors of having a stillborn baby include[153]:

- having twins or a multiple pregnancy
- having a baby who doesn't grow as they should in the womb
- being under 20 or over 35 years old
- smoking, drinking alcohol or misusing drugs while pregnant
- living with obesity- having a body mass index of 30 or above
- having a pre-existing physical health condition, such as diabetes

Ectopic pregnancy

An ectopic pregnancy is when a fertilised egg implants outside the womb, most commonly in a fallopian tube. Symptoms include abdominal pain, vaginal bleeding, and missed periods, but can also involve dizziness or shoulder tip pain.

In some cases, ectopic pregnancies can be a medical emergency that requires prompt surgical intervention [158].

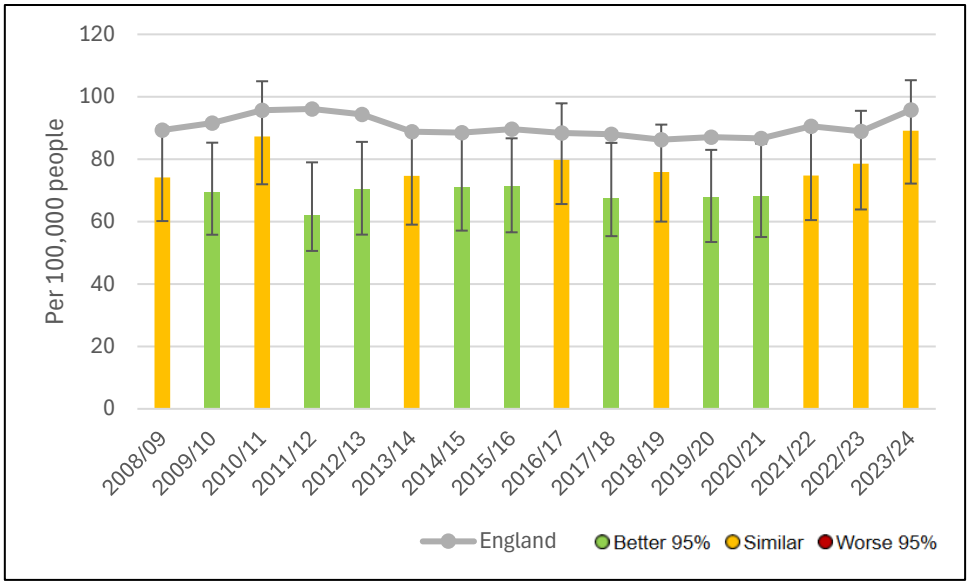
Ectopic pregnancy remains the most frequent cause of maternal death in early pregnancy. The MBRRACE-UK 2024 Report found that from 2020 to 2022, 12 women died from ectopic pregnancy across the UK and Ireland- almost twice the 2018-20 recorded rate. Additionally, the report states that all 12 women who died from an ectopic pregnancy could have had better care, and improvements to care may have made a difference to the outcome for nine women (75%). The report highlights the need for women and clinicians to be aware of the symptoms of ectopic pregnancy and to "Think Ectopic"[159].

Evidence shows that, in the UK, the incidence of ectopic pregnancy is approximately 11 in 1,000 pregnancies[160], with an estimated 12,000 ectopic pregnancies diagnosed each year[161]. The incidence of ectopic pregnancy reported in women attending early pregnancy units is 2–3%[162]. The reported rates of ectopic pregnancy after assisted reproduction vary from 0.8–8.6%[163–166], although the incidence has decreased over time due to factors such as extended embryo culture and fewer embryos being transferred[163,164].

Figure 23 shows ectopic pregnancy admissions to hospital in women aged 15-44 years per 100,000 population for Suffolk between 2008/09 to 2023/24, compared to England. Results show that:

- In 2023/24 the ectopic pregnancy admissions rate in Suffolk was 89.1 per 100,000, statistically similar to the England estimate of 95.8 per 100,000
- Recent trends for ectopic pregnancy admissions rate in Suffolk show no significant change

Figure 23: ectopic pregnancy admissions to hospital in women aged 15-44 years per 100,000 population for Suffolk between 2008/09 to 2023/24, compared to England



Source: Fingertips

About a third of women diagnosed with an ectopic pregnancy have no identifiable risk factor. However, the following factors have been associated with an increased risk of ectopic pregnancy:

- Previous ectopic pregnancy[158]
- History of sexually transmitted infections[167]
- History of pelvic inflammatory disease[158]
- Previous pelvic surgery[158]
- Black ethnicity[158]
- History of infertility
- Assisted reproduction techniques (especially in vitro fertilisation)[158,167]
- Cigarette smoking[158,167]
- Maternal age over 35 years[158]
- Having multiple sexual partners[158,168]
- Intrauterine contraception[158,169]

Mental health after a pregnancy loss

Women or birthing person

The consequences of pregnancy loss can be both physical and psychological[131]. Evidence shows that grief following pregnancy loss (the involuntary loss of a foetus 24 weeks of gestation- including therapeutic abortion) is comparable in nature, intensity, and duration to grief reactions in people suffering other types of major loss[140,170].

Research indicates that women or birthing people who experience pregnancy loss have a higher risk of developing PTSD, anxiety, and depression, with these conditions often persisting at clinically significant levels for several months following the loss[130,131]. For example, about 1 in 5 women who experience a miscarriage (20%) develop symptoms of depression and/or anxiety. Symptoms may persist for up to 3 years, impacting quality of life and subsequent pregnancies[171]. Additionally, a systematic review and meta-analysis found that women or birthing people who experience stillbirth are at higher risk of experiencing depressive and anxiety disorders[172].

Similarly, a large, multi-centre cohort study in three London hospitals found that[173]:

- 29% of women met the criteria for PTSD one month after early pregnancy loss, decreasing to 18% nine months after the loss.
- Moderate/severe anxiety was diagnosed in 24% of women one month following loss, decreasing to 17% after nine months.
- Moderate/severe depression was diagnosed in 11% of women following a loss, decreasing to 6% after nine months.

As a survey sample, the following findings may not be representative of all people experiencing pregnancy loss, but they highlight the potential scale and severity of distress among those affected. A Mariposa Trust Survey conducted with 340 people who had experienced a pregnancy loss found that[174]:

- 49.4% of responders reported they had considered ending their life following baby loss
- 47% of responders were diagnosed with depression
- 63.8% of responders reported undiagnosed depression
- 69.1% of responders reported long-term mental health issues

- 16.5% of responders reported their partners suffered suicidal thoughts following baby loss
- 41.4% of responders reported their partners have suffered mental health issues following baby loss

Several aspects of a woman's or birthing person's life have been shown to potentially influence the risk of developing PTSD, anxiety, and depression after losing a baby. These include whether the pregnancy was planned or unplanned, previous struggles with infertility or long attempts to conceive, lack of warning signs before the loss, previous miscarriages or losses at later stages, physical or mental health conditions, absence of living children, feelings of social isolation, relationship difficulties with a partner, younger age, and lower socioeconomic status[173,175,176].

Partner or non-birthing person

Partners have also been shown to display depression and anxiety after pregnancy loss[173,177]. Research has shown that feelings associated with baby loss are similar for both men and women, but men often feel the need to take on the 'supporter' role, potentially at the expense of their own mental wellbeing[178]. Evidence has also highlighted a lack of social recognition of the loss, often leading to 'disenfranchised grief' for men as well as challenges in accessing support, with reports suggesting that in some cases only the mother or birthing person was offered emotional support[130].

It is recommended that a mental health check-up should be available to all women or birthing people **and their partners** following a baby loss and either a clinical referral made or a self-referral encouraged. Any woman or birthing person, or partners with deteriorating mental health or displaying risk factors for suicide or self-harm should be prioritised for immediate assessment. Sufficient time must be available in follow-up appointments with bereaved parents to enquire about their emotional well-being and to offer information on self-referral support or other forms of psychological therapies should it be required[130]. Further detail can be found in The Independent Pregnancy Loss Review and NICE antenatal and postnatal mental health: clinical management and service guidance.

Termination of pregnancy

While the definitions below use clinical language, it is important to recognise that termination of pregnancy can be a deeply distressing experience for those affected.

A termination of pregnancy (or induced abortion) is a procedure to end a pregnancy. There are two methods of abortion: medical and surgical. Medical abortion is the use of medications (mifepristone followed by misoprostol) to end a pregnancy. Surgical abortion is the use of transcervical procedures (manual vacuum aspiration, electric vacuum aspiration, or dilatation and evacuation) to end a pregnancy[179].

In England, abortion is lawful only where the conditions set out in the Abortion Act 1967 are satisfied; outside of these conditions, performing or procuring an abortion remains a criminal offence. Broadly, a pregnancy may lawfully be ended by a registered medical practitioner in an NHS hospital or other approved premises where two medical practitioners agree, in good faith, that one of the following applies[179]:

- The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant person or any existing children of their family.

- The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant person.
- Continuing the pregnancy would involve risk to the life of the pregnant person, greater than if the pregnancy were terminated.
- There is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

The legal landscape has recently shifted. Following a 2025 parliamentary vote, MPs supported amendments to decriminalise abortion in respect of women ending their own pregnancies. These provisions were included in the Crime and Policing Bill, which has now completed its parliamentary passage and received Royal Assent, becoming the Crime and Policing Act 2026.

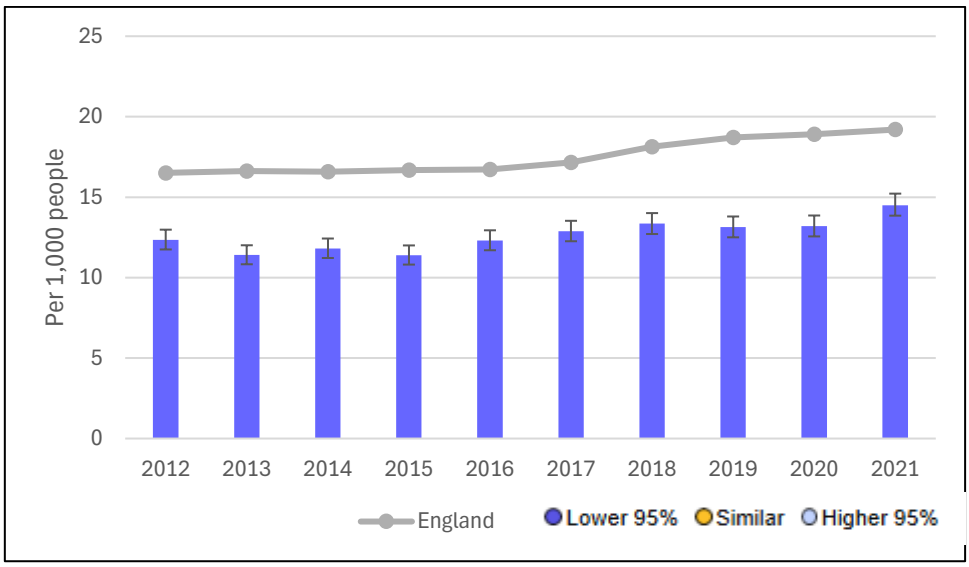
The new law removes women from the criminal code when they end their own pregnancies. It doesn't change the wider abortion law, the 24-week limit, or how and when abortions are available. In practice, women can no longer be investigated or prosecuted for ending their own pregnancy, and the threat of life imprisonment under the Offences Against the Person Act 1861 has been lifted. The Act also pardons women already convicted or investigated under the old laws (an amendment introduced by Baroness Thornton). The Abortion Act 1967 still governs how abortion services are regulated and delivered - what's changed is that pregnant people themselves are no longer criminalised in England and Wales.

Abortion is a safe healthcare intervention when carried out in line with clinical best practice (that is with a method appropriate to the pregnancy duration and by a person with the necessary skills). When an abortion is safe, the risk of major complications is rare at all pregnancy durations. Unsafe abortion is a leading cause of mortality and morbidity in pregnant people worldwide[179].

Figure 24 shows the total abortion rate per 1,000 females aged 15-44 years in Suffolk between 2012 and 2021 compared to England. Results show that:

- In 2021, the total abortion rate in Suffolk was 14.5 per 1,000, statistically significantly lower than England estimates (19.2 per 1,000).
- Recent trends in the total abortion rate in Suffolk show no significant change from rates in 2020 compared to 2021.

Figure 24: Total abortion rate per 1,000 female population aged 15-44 years for Suffolk, between 2012 and 2021, compared to England



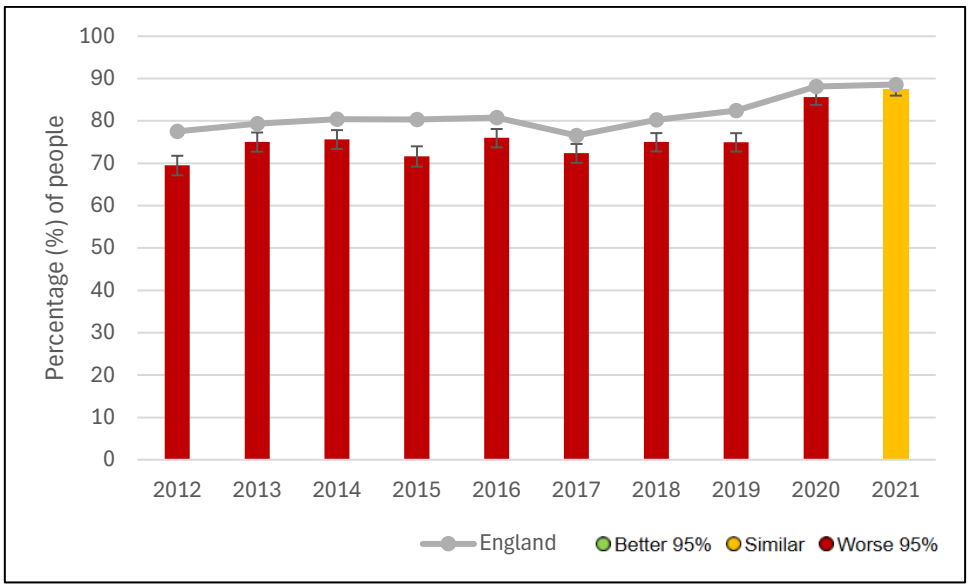
Source: Fingertips

Complication risks increase as gestation advances, so earlier access to abortion improves safety. Timely provision is also recognised as a marker of high-quality, accessible care and supports more efficient use of health resources.

Figure 25 presents the percentage of abortions completed under 10 weeks for Suffolk between 2012 and 2021 compared to England. Results show that:

- In 2021 the percentage of abortions completed under 10 weeks for Suffolk was 87.6%, statistically similar to the England estimate of 88.6%.
- The percentage of earlier abortions in Suffolk have statistically significantly increased from 2012 (69.5%) to 2021 (87.6%)- an 18-percentage point increase.

Figure 25: Percentage (%) of Abortions under 10 weeks for Suffolk, between 2012 and 2021, compared to England



Source: Fingertips

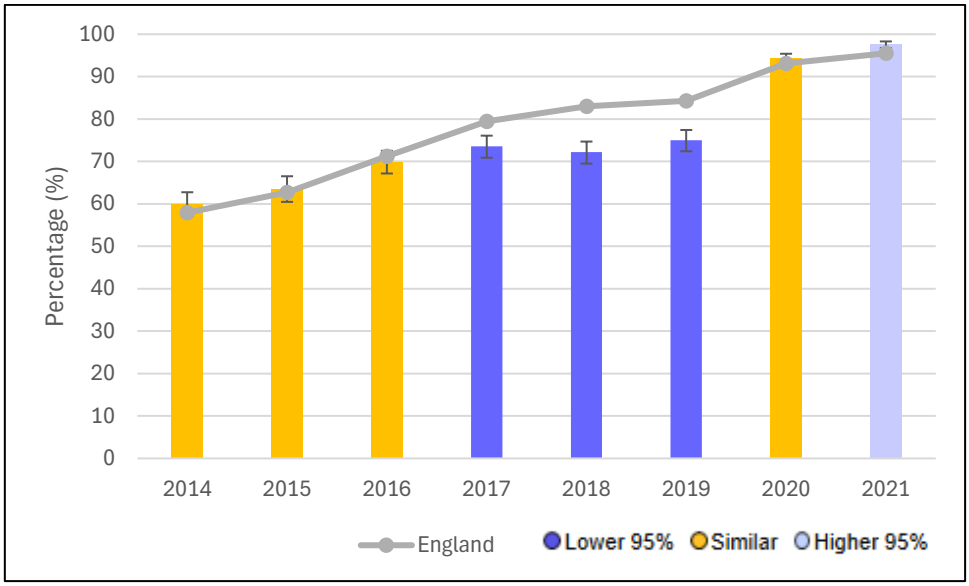
The level of transparency regarding the availability of medical and surgical abortion services at the local level is crucial for understanding patient choice. Monitoring this indicator enables local areas to assess the range and balance of abortion services accessible to women. Notably, an unusually low or high proportion of medical abortions may signal potential concerns that warrant further investigation.

Early medical abortions are generally preferred, as they are less invasive than surgical alternatives. They present a reduced risk profile, given that they do not require instrumentation or anaesthetics, further contributing to their safety. In addition to clinical advantages, medical abortions are typically more cost-effective than surgical procedures. This economic benefit, combined with increased safety and reduced invasiveness, underscores the importance of ensuring a balanced provision of both medical and surgical abortion services to support patient choice and service quality.

Figure 26 shows the percentage of abortions under 10 weeks that are medical, in Suffolk, between 2014 and 2021 compared to England. Results show that:

- In 2021 97.6% of abortions under 10 weeks in Suffolk were medical, statistically significantly higher than England estimates (95.5%).
- Recent trends show that in Suffolk the percentage of medical abortions under 10 weeks is statistically significantly increasing with a 3.3 percentage point increase shown from 2020 (94.3%) to 2021 (97.6%).

Figure 26: Percentage (%) of abortions under 10 weeks that were medical, in Suffolk, between 2014 and 2021, compared to England



Source: Fingertips

Mental health after termination of pregnancy

Understanding the evidence on mental health outcomes associated with induced abortion is critical for supporting informed decision-making and ensuring appropriate care for women or birthing people[180].

It's important to note that induced abortion includes both procedures performed for reasons related to unwanted pregnancy and therapeutic abortions performed for medical reasons, such as to preserve the mother's life or address severe foetal anomalies[180]. However, women or birthing people and their partners or non-birthing people facing therapeutic abortion may experience a different emotional context. With this in mind, the information provided above in the mental health after pregnancy loss section may also apply to those who have experienced a therapeutic abortion.

Research indicates that mental health outcomes following induced abortion are influenced more by the context and circumstances surrounding the pregnancy than by the abortion procedure itself. Women or birthing people experiencing an unwanted pregnancy show similar rates of mental health difficulties whether they continue the pregnancy or have an induced abortion[180].

Certain factors have been associated with poorer mental health outcomes following induced abortion. These include having a history of mental ill-health, having negative attitudes towards abortion, experiencing pressure from a partner to terminate the pregnancy, and having negative experiences during or after the abortion procedure. Additionally, some evidence suggests that experiencing an adverse psychological reaction immediately following abortion may indicate a need for additional support[180].

Overall, the evidence suggests that healthcare professionals should take into account the wellbeing of the whole person, including their mental health history, their feelings about their situation, and any life stressors they may be facing[180].

Section 3: Demographic differences

Pregnancy outcomes and experiences of maternity care vary across the population. Evidence indicates that certain demographic characteristics- including age, ethnicity, socioeconomic circumstances, and disability status- are associated with different patterns of risk, access to services, and health outcomes throughout the pregnancy journey. Women and birthing people from certain demographic groups may experience higher rates of pregnancy complications, adverse birth outcomes, and maternal mortality, as well as barriers to accessing timely, appropriate, and culturally competent care. These differences reflect a complex interplay of biological, social, structural, and service-related factors, with characteristics often intersecting to create varying patterns of experience and outcome.

This section examines demographic patterns across these four key dimensions and their implications for maternity care delivery.

Age

Teenage pregnancy

Teenage pregnancy is associated with a range of outcomes for young parents and their children. For adolescent mothers, there tends to be a higher risk of reduced educational attainment, with research suggesting that early childbearing may affect the likelihood of completing secondary education and subsequent earnings potential[181]. Young mothers may also experience social isolation, economic disadvantage, and poorer mental and physical health[181,182]. Research also indicates that adolescent mothers have higher probabilities of experiencing poverty and relying on welfare support in the years following their first birth[181].

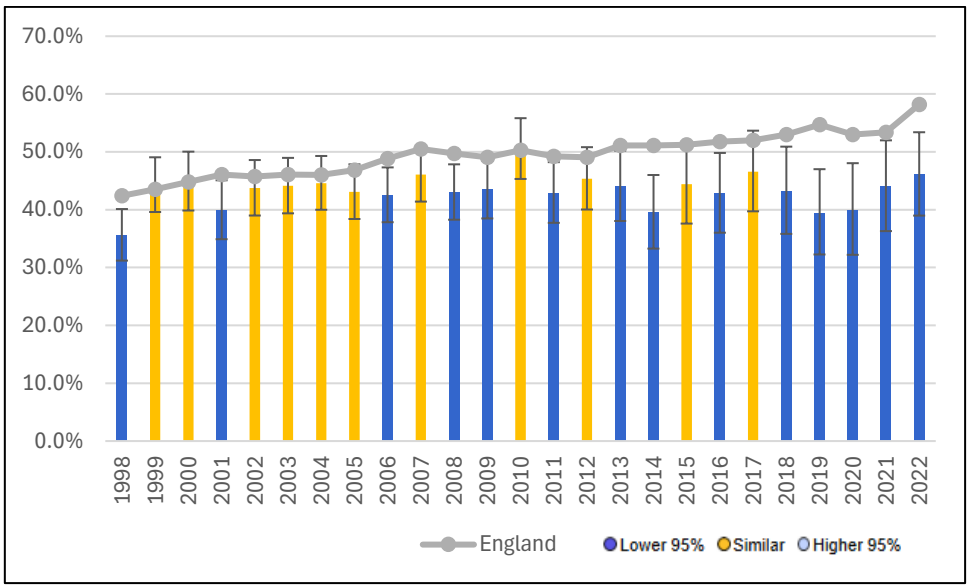
Children born to adolescent mothers may also face certain disadvantages. They are more likely to be born preterm or with low birthweight, and some studies suggest elevated risks of adverse developmental outcomes[181,182]. There is also some evidence of intergenerational patterns, with children of teenage mothers themselves facing increased likelihood of teenage parenthood[182].

While not all teenage conceptions are unplanned, teenagers remain at highest risk of unplanned pregnancy. One way to explore this- and an approach used by the Royal College of Paediatrics and Child Health (RCPCH)- is to look at the proportion of conceptions ending in abortion. However, it is important to note that this is a proxy measure rather than a direct measure: the decision to terminate is shaped by a range of factors beyond whether a pregnancy was planned, including access to services, social and family circumstances, and personal beliefs. Even so, the contrast across age groups is informative. In England and Wales in 2022, 61% of conceptions to under-16s and 58% of conceptions to under-18s ended in abortion, compared with around 18% among women aged 30 to 34. The markedly higher proportion among teenagers is consistent with a greater share of these conceptions likely being unintended.

Figure 27 shows the percentage of under 18s conceptions leading to abortion in Suffolk between 1998 and 2022, compared to England. Results show that:

- In 2022, 46.1% of conceptions to those aged under 18 years (15-17) led to an abortion in Suffolk, statistically significantly lower than the England estimate of 58.2%.
- Recent trends show no statistically significant change overtime.

Figure 27: The percentage of conceptions to those aged under 18 years (aged 15 to 17) that led to an abortion in Suffolk between 1998 and 2022, compared to England



Source: Fingertips

Longitudinal research has identified a range of individual, family, and social factors associated with teenage pregnancy. Risk factors commonly identified in the literature include adverse childhood experiences (ACEs); socioeconomic deprivation; attention, behaviour and conduct problems; poor educational attainment and disengagement from education; and family history of teenage pregnancy[181–183]. These findings appear consistent with a life course developmental model, suggesting that risk may accumulate across multiple domains over childhood and adolescence[182]. This understanding has implications for prevention efforts, indicating that interventions may benefit from addressing broader social factors alongside sexual behaviour.

Research suggests that reducing teenage pregnancy rates may require a comprehensive, multi-faceted approach. The UK Governments Teenage Pregnancy Prevention Framework offers evidence for potentially effective approaches, having contributed to a national reduction in under-18 conception rates. Key elements included comprehensive relationships and sex education (RSE) delivered in schools, alongside accessible and youth-friendly contraception and sexual health services[184].

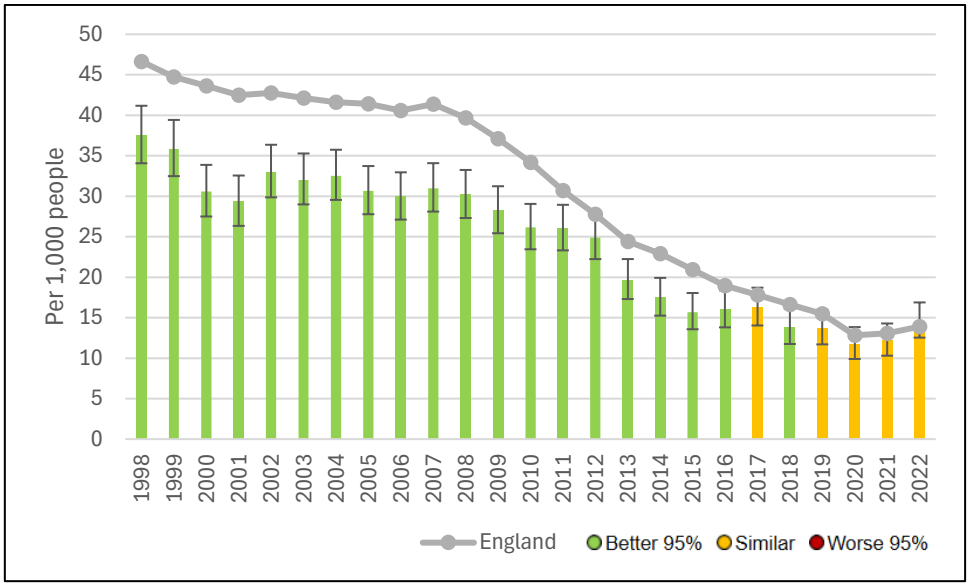
The evidence suggests that effective approaches may need to address the social factors that shape adolescent opportunities, particularly education and employment, as well as knowledge and access to contraception. Building trust in services, particularly among more vulnerable young people, appears to support earlier uptake of advice and support. For young people who become parents, dedicated coordinated support can help improve outcomes for both them and their children, including support for returning to education and training, access to maternity services, and engagement of young fathers[184].

Figure 28 shows the under 18s conception rate in Suffolk between 1998 to 2022, compared to England. Results show that:

- In 2022, the under 18s conception rate in Suffolk was 14.6 per 1,000, statistically similar to the England estimate at 13.9 per 1,000.

- Although the under-18 conception rate in Suffolk has fallen statistically significantly over the last 10 years (from 24.9 per 1,000 in 2012), the most recent data show a small uptick (12.2 per 1,000 in 2021). This increase is not statistically significant, but it is worth keeping under review as new data become available.

Figure 28:The under 18s conception rate in Suffolk between 1998 to 2022, compared to England



Source: Fingertips

Advanced maternal age

Advanced maternal age (AMA) is conventionally defined as pregnancy occurring at 35 years of age or older[185,186]. Women or birthing people of AMA are more likely to present with pre-existing medical conditions, including chronic hypertension, obesity, and diabetes mellitus, which compound baseline pregnancy risk[187,188]. Consequently, this demographic experiences elevated rates of pregnancy-related complications, including pre-eclampsia, gestational diabetes mellitus (GDM), placental abruption and postpartum haemorrhage[24,185,188]. Adverse perinatal outcomes are similarly increased, encompassing higher risks of low birthweight, preterm and post-term delivery, foetal macrosomia, chromosomal abnormalities, miscarriage, stillbirth and caesarean delivery[185,187,188]. These elevated complication rates translate to poorer maternal and perinatal outcomes overall.

Critically, even after adjustment for maternal comorbidities, multiple pregnancy, and use of assisted reproductive technologies (ART), advanced maternal age remains an independent predictor of adverse outcomes. A UK population-based cohort study found that women or birthing people aged 48 years and older retained significantly increased risks of gestational diabetes, caesarean delivery, and intensive care unit admissions after controlling for confounders[187]. Similarly systematic review and meta-analysis found that AMA independently increased the risk of stillbirth with this association not wholly explained by maternal comorbidities or ART use[185]. These findings demonstrate that maternal age itself carries distinct biological risk beyond its associated conditions.

The independent effect of maternal age intensifies progressively, with most complications rising particularly after age 40. Recent evidence shows significantly higher rates of caesarean section, preterm delivery, gestational diabetes, pre-eclampsia, and postpartum haemorrhage

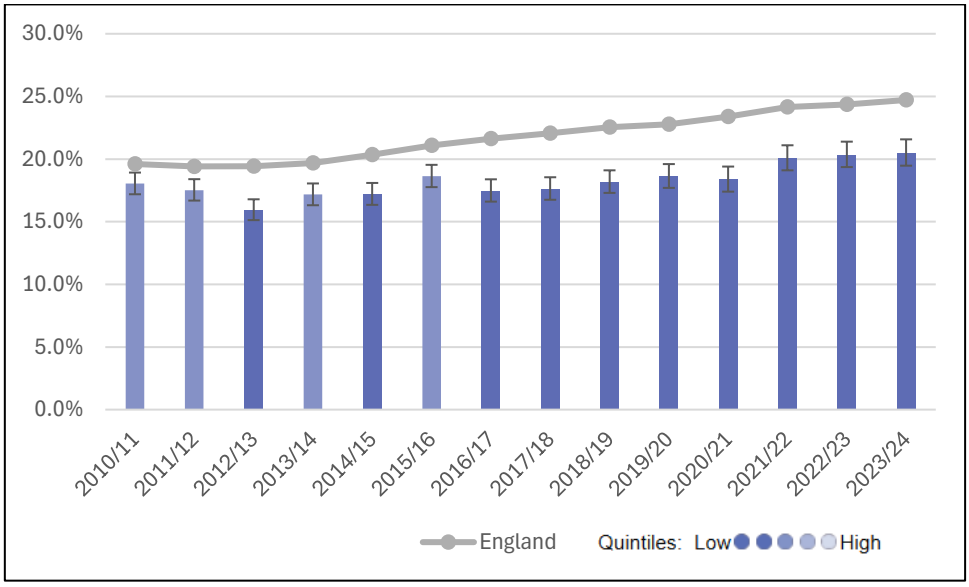
in women aged 40 and over compared with younger women or birthing people. Chromosomal abnormalities were also significantly more common in the older age group[188]. These findings highlight the need for tailored antenatal surveillance and clinical management strategies in this growing demographic.

The MBRRACE-UK report Saving Lives, Improving Mothers' Care also found that advanced maternal age is also independently associated with increased maternal mortality. Compared to women aged 25-29, those 35+ face nearly double the risk, driven primarily by women 40+ facing nearly 3-fold increased mortality risk compared to those 25-29. Women 35-39 showed elevated but non-significant risk. Overall, demonstrating that maternal mortality risk increases progressively with advancing maternal age[24].

The average age of childbirth has increased across the UK. In England, the percentage of deliveries to women or birthing people aged 35 years and above has increased by over a quarter (26.0%) from 2010/11 to 2023/24 rising from 19.6% to 24.7% of all deliveries. Figure 29 shows the percentage of deliveries to women or birthing people aged 35 years and above in Suffolk between 2010/11 to 2023/24 compared to England. Results show that:

- In 2023/24 just over 1 in 5 deliveries in Suffolk were to women or birthing people aged 35 years and above (20.5%).
- Compared to England overall, Suffolk has a younger maternal age profile at delivery, with the percentage of deliveries to women or birthing people aged 35 years and above ranking in the bottom 40% of England counties in recent years.
- Despite having a younger maternal age profile, the percentage of deliveries to women or birthing people aged 35 years and above is increasing in recent years and has increased by 13.9% from 2010/11 (18.0%) to 2023/24 (20.5%).

Figure 29: Percentage of deliveries to women or birthing people aged 35 years and above in Suffolk between 2010/11 and 2023/24, compared to England. Bar colour shows Suffolk's quintile against all upper-tier local authorities in England.



Source: Fingertips

Ethnicity

Pregnancy outcomes in the UK vary across ethnic groups, reflecting a complex interplay of biological, cultural, structural, and service-related factors. Understanding these patterns is important for delivering equitable, culturally competent maternity care.

Pre-existing medical conditions that affect fertility and pregnancy outcomes show ethnic variation. Tubal damage and uterine fibroids have been reported as being more common among the Black population, influencing both fertility and pregnancy outcomes. Obesity, which is associated with increased infertility risk and reduced IVF success through impaired ovarian response and lower implantation rates, also varies by ethnicity [189]. In Suffolk, a higher proportion of people who identify as Black or Black British are living with overweight or obesity across all age groups. These pre-existing conditions may influence fertility treatment needs and success rates.

For women or birthing people requiring assisted reproductive technologies (ARTs), ethnic differences emerge in both access and outcomes. The Human Fertilisation and Embryology Authority published the report Ethnic diversity in fertility treatment highlighting disparities in the use and outcomes of fertility treatment in the UK by ethnic group from 2017-21. Results showed that Black women or birthing people access fertility treatment later (average age 36.0 years) compared to White women (34-36 years), with Asian and Black single patients starting latest at 38-39 years. This variation in access has direct implications for success rates: IVF birth rates among women aged 18-37 are 23% for Black patients, 24% for Asian patients, and 32% for White patients per embryo transferred [189].

Access to NHS-funded treatment also shows ethnic variation: in 2021, 41% of Black patients, 49% of Asian patients, and 53% of White patients received NHS funding for fertility treatment. Ethnically matched donor availability differs too, with 60% of Black donor sperm and 74% of Mixed ethnicity donor sperm used in treatment is imported from abroad, compared to 50% of White donor sperm[189].

Patterns in antenatal care engagement also vary by ethnicity. NICE identified late booking after 16 weeks gestation as a particular concern for Black maternity service users. Late booking may result in missed national screening recommendations, delayed referrals to maternal medicine networks, and reduced early identification of foetal development concerns and associated risk factors, potentially increasing the risk of adverse outcomes[190].

Research has also highlighted that certain conditions, including neonatal jaundice and maternal pre-eclampsia may be more difficult to recognise on darker skin tones, potentially contributing to delayed diagnosis. It has been suggested that clinical training and standardised assessment tools may not adequately account for ethnic variation in presentation[191].

The National review of maternity services in England 2022 to 2024 highlighted that clinical assessment tools may not be adequately adapted for diverse populations. For example, the Apgar score used to evaluate newborn health was developed based on white European babies, with guidance referencing that a baby's skin should be "pink all over"; which may lead to inaccurate assessments and poorer outcomes for babies from ethnic minority backgrounds[192].

Specific pregnancy complications show differing prevalence across ethnic groups in the UK. The MBRRACE-UK report found that, between 2021-23, Black women or birthing people were

nearly three times more likely than White women or birthing people to experience thrombosis and thromboembolism, and more than twice as likely to suffer from cardiac disease during pregnancy. Asian women or birthing people showed notably elevated COVID-19-related complications at nearly 3 times the rate of White women or birthing people[24]. South Asian women or birthing people have also been shown to be at a higher risk of perinatal tears and major obstetric haemorrhage[192].

Birth outcomes reflect the accumulated effects of pre-existing conditions, pregnancy complications, and access to appropriate care throughout the pregnancy journey. Evidence indicates that South Asian or Black women or birthing people are more likely to have babies born early or small for gestational age (SGA)[192]. In the UK between 2017-2021, multiple birth rates from IVF, which carry additional maternal and neonatal risks, varied by ethnicity: 9% for Black patients, 7% for White patients, and 6% for those with mixed backgrounds. The higher multiple birth rate among Black patients may relate partly to multiple embryo transfer practices; among first-time IVF users under 37, this occurred in 20% of cases for Black patients compared to 13% for White patients[189].

Disparities also exist in mode of delivery and pain management. The National review of maternity services in England 2022 to 2024 found that Caribbean (Black or Black British) women or birthing people are more likely than British White women or birthing people to receive general anaesthesia for caesarean births (58% and 10% respectively for elective caesareans), though most trusts do not audit pain relief provision by ethnicity.

Perinatal mortality demonstrates significant ethnic variation. Research shows that stillbirth rates are higher for babies born to women or birthing people from South Asian and Black ethnic groups, with babies from Black ethnic groups experiencing the highest rates of stillbirths and infant deaths overall, and babies from Asian ethnic groups consistently the second highest[190,192].

Maternal mortality represents the most severe outcome along the pregnancy continuum, with persistent ethnic differences despite overall improvements. The 2025 MBRRACE-UK report found that compared to White women or birthing people, Asian women or birthing people experienced 1.35 times higher maternal mortality rates, while Black women faced 2.27 times higher rates. Notably, although the maternal mortality rate for Black women or birthing people has decreased to its lowest level since 2013-15, significant differences compared White women or birthing people persist[24].

These demographic patterns observed across the pregnancy continuum are shaped by multiple intersecting factors that influence both care-seeking behaviours and service delivery. The Office for Equality and Opportunity research and analysis: Confidence in maternity care services: engagement with ethnic minority women and maternity staff and the Care and Quality Commission's National review of maternity services in England 2022 to 2024 identified the following barriers to care access and quality [191,192]:

- **Language barriers**: When professional interpreters are unavailable, women often rely on family members for interpretation, which may affect their ability to make fully informed decisions. This was particularly prevalent for women from Asian and Somali backgrounds. Some services maintain hospital signage in English only despite diverse populations, and incidents have been recorded linking poor outcomes to lack of interpreting services.

- **Lack of support and adherence to religious and cultural practices:** Muslim women frequently prefer female clinicians in accordance with religious practices, while cultural attitudes toward pregnancy outcomes differ across communities. Women report more positive experiences when cultural needs are accommodated, such as having access to counsellors who share their religious background following pregnancy loss.
- **Experiences of racism and discrimination:** Women reported feeling consistently dismissed, with their concerns not taken seriously and their pain not believed. Staff from ethnic minority groups identified a lack of respect for ethnic minority women, using terms like "dismissive," "disrespectful," and "patronising" to describe interactions.
- **Stereotyping:** Black women in particular were acutely aware of being stereotyped and tailored their behaviour to avoid being perceived as "loud" or "difficult," while Muslim women reported assumptions being made about their English proficiency based on their attire.
- **Lack of continuity of care:** seeing different midwives at each appointment- forced women to repeatedly explain their circumstances, which was described as emotionally exhausting and led many to stop sharing concerns altogether.

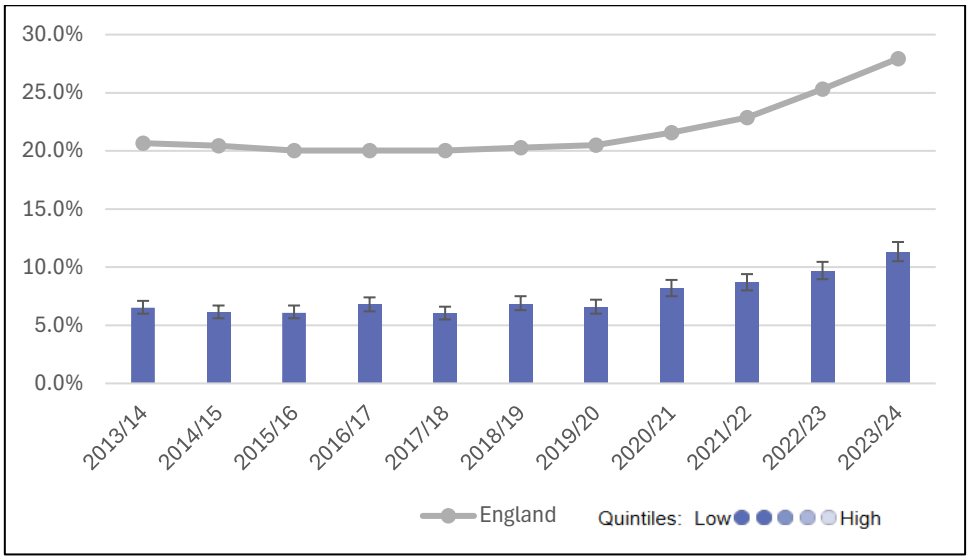
These reports emphasise that cumulative barriers may create an environment where ethnic minority women or birthing people may delay seeking care or disengage from services[191,192].

Addressing these disparities is further complicated by inconsistent data practices. The National review of maternity services in England 2022 to 2024 found considerable variation in how trusts collect and use ethnicity data, limiting the ability to identify disparities and evaluate progress.

Figure 30 shows the percentage of deliveries to women or birthing people from ethnic minority groups in Suffolk between 2013/14 and 2023/24, compared to England. Results show that:

- In 2023/24 over 1 in 10 deliveries in Suffolk (11.3%) were to women or birthing people from ethnic minority groups.
- Compared to England overall, Suffolk has a less ethnically diverse profile at delivery, with the percentage of deliveries to women or birthing people from ethnic minorities consistently ranking in the bottom 40% of England counties over time.
- Despite having a less ethnically diverse profile at delivery, the percentage of deliveries to women or birthing people from ethnic minority groups in Suffolk is increasing in recent years and has increased by almost three-quarters (73.9%) from 2010/11 (6.5%) to 2023/24 (11.3%).

Figure 30: The percentage of deliveries to women or birthing people from ethnic minority groups in Suffolk between 2013/14 and 2023/24, compared to England. Bar colour shows Suffolk's quintile against all upper-tier local authorities in England

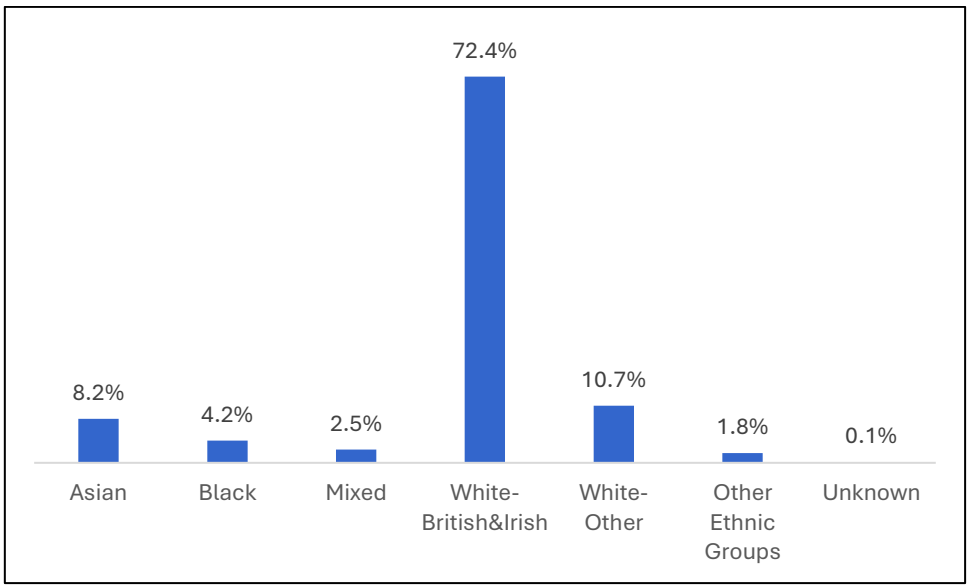


Source: Fingertips

Using population health management data, between November 2024 and October 2025 there were a total of 4,410 birth episodes (defined as an individual who has given birth) across Suffolk excluding Waveney. Of these birth episodes between November 2024 and October 2025, 16.8% were to women or birthing people from ethnic minority groups. Figure 31 shows the percentage of birth episodes between November 2024 and October 2025 in Suffolk, excluding Waveney, by ethnicity. Results show that:

- Over 2 in 3 birth episodes were to women or birthing people who identify as White-British and Irish (72.4%).
- Over 1 in 10 birth episodes were to women or birthing people who identify as White-Other (10.7%)
- Over 1 in 13 birth episodes were to women or birthing people who identify as Asian (8.2%)
- Just under 1 in 20 birth episodes were to women or birthing people who identify as Black (4.2%)
- 1 in 40 birth episodes were to women or birthing people who identify as Mixed ethnicity (2.5%)
- Just under 1 in 50 birth episodes were to women or birthing people who identify within an Other Ethnic Group (1.8%).

Figure 31:Percentage of birth episodes between November 2024 and October 2025 in Suffolk, excluding Waveney, by ethnicity



Source: Population Health Management Analytics

Deprivation

Socioeconomic deprivation remains a significant determinant of maternal health outcomes in England. A national cohort study exploring adverse pregnancy outcomes attributed to socioeconomic deprivation found statistically significantly higher risk of stillbirth, preterm birth and foetal growth restriction for women or birthing people in the most deprived areas compared to the least deprived areas[193].

The MBRRACE-UK Maternal Report 2025 provides evidence that women or birthing people living in the most deprived areas face substantially higher risks of maternal mortality. The report found that[24]:

- During 2021-23 in England, women or birthing people living in the most deprived areas had a maternal mortality rate nearly two times higher than women living in the least deprived areas.
- There was a disproportionate burden of maternal mortality among women or birthing people from the most disadvantaged backgrounds in England in 2021-23, with over a quarter (27%) of all deaths occurring in the most deprived quintile, despite this group representing only 20% of the population.
- While mortality rates have increased across all groups overtime, the absolute difference between the most and least deprived has grown, emphasising the cumulative disadvantage faced by women or birthing people in deprived areas.

This section examines disparities in risk factors, health-promoting behaviours and complex social factors throughout the pregnancy journey, across deprivation levels, that may contribute to these inequalities.

This section includes local population health management data for Suffolk (excluding Waveney) where possible to investigate disparities in a healthy pregnancy journey across deprivation deciles- where deprivation deciles are classified by the Index of Multiple Deprivation 2025.

However, national findings are also used to highlight key disparities- where deprivation deciles are classified by The English Indices of Deprivation 2019 (IoD2019).

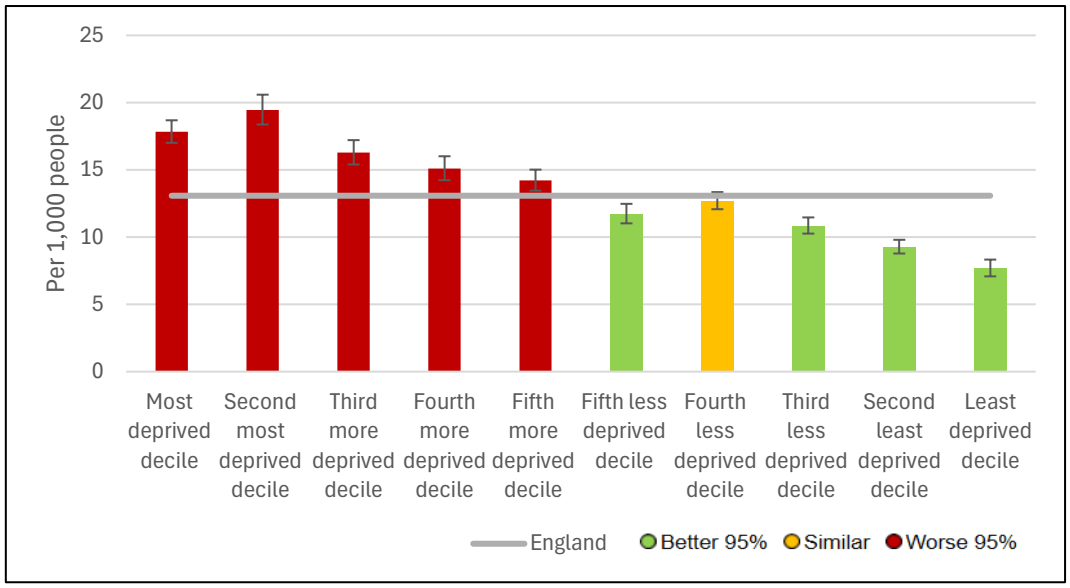
Preconception

Under-18 conception

National data shows that under-18 conception rates remain considerably higher amongst young women living in the most deprived areas. Figure 32 shows the 2022 under-18 conception rate in England, split by deprivation decile (IoD 2019). Results show that:

- In 2022, there was a deprivation gradient in under-18 conception rates, with all five most deprived deciles showing rates significantly above the England average.
- In 2022, the most deprived areas had 2.3 times higher under-18 conception rates compared to the least deprived areas.

Figure 32: Under-18 conception rate in England, 2022, split by deprivation decile (IoD 2019), compared to England average



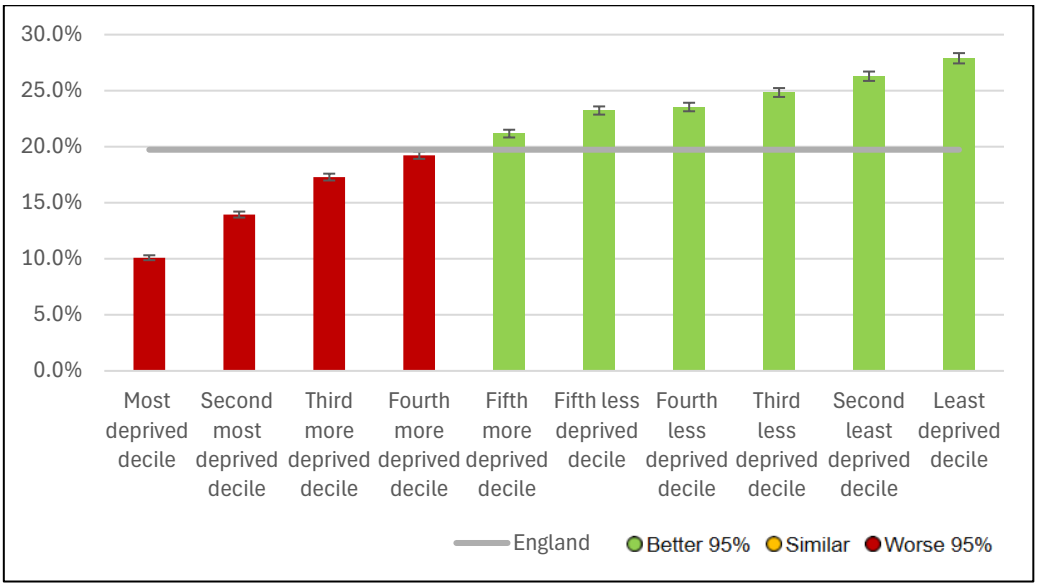
Source: Fingertips

Folic acid supplementation

National findings show that the uptake of folic acid supplementation is lowest in the most deprived areas. Figure 33 shows the percentage of pregnant women who started taking folic acid prior to pregnancy as reported at time of their first antenatal appointment in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average. Results show that:

- In 2023/24, there was a deprivation gradient in folic acid supplements taken before pregnancy, with the four most deprived deciles showing percentages statistically significantly below (worse) than the England average.
- In 2023/24, the least deprived areas (27.9%) had a 2.8 times higher percentage of women or birthing people taking folic acid supplements before pregnancy compared to the most deprived areas (10.1%).

Figure 33: The percentage of women or birthing people who take folic acid supplements before pregnancy in England, 2023/24, split by deprivation decile (IoD 2019) compared to England average



Source: Fingertips

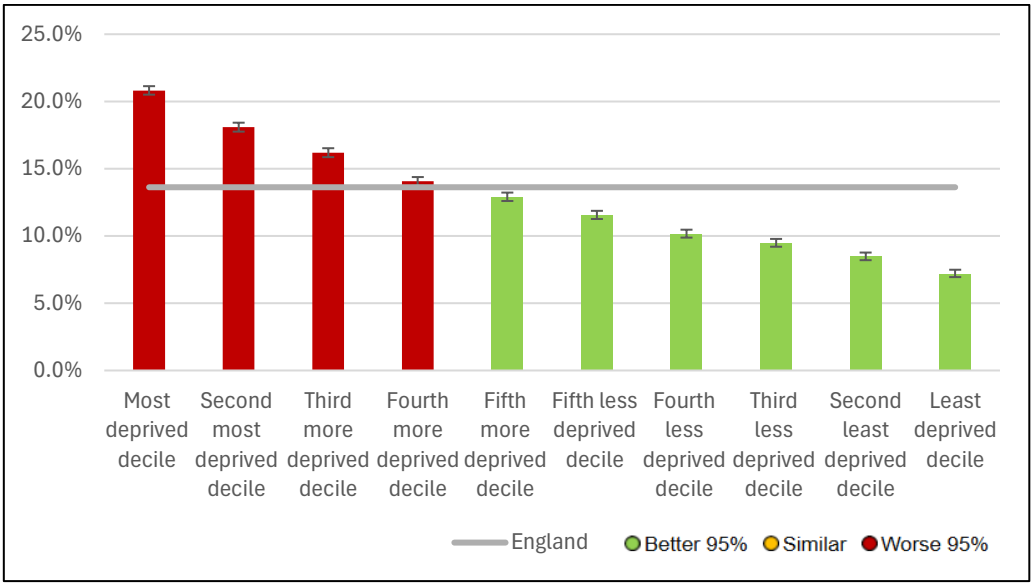
Maternal health behaviours

Smoking

During pregnancy, health behaviours that may affect maternal outcomes were also shown to vary across deprivation levels. Figure 34 shows the percentage of pregnant women who smoke in early pregnancy in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average. Results show that:

- In 2023/24, there was a deprivation gradient in the percentage of pregnant women who smoke in early pregnancy, with the four most deprived deciles showing percentages statistically significantly worse than the England average.
- In 2023/24, the most deprived areas (20.8%) had a 2.9 times higher percentage of pregnant women who smoke in early pregnancy compared to the least deprived areas (7.2%).

Figure 34: The percentage of pregnant women who smoke in early pregnancy in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average

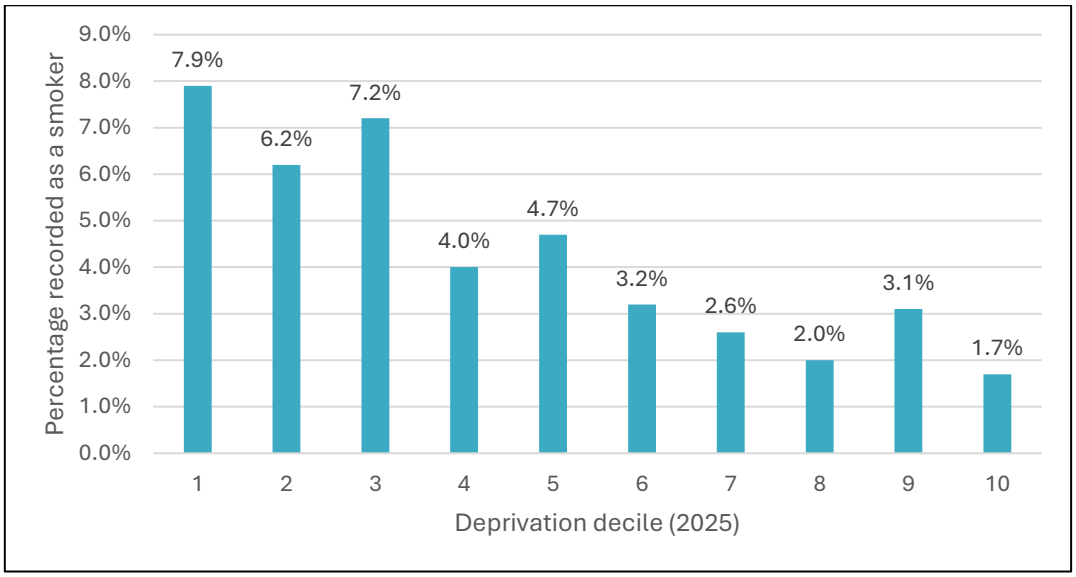


Source: Fingertips

These national disparities in smoking prevalence in early pregnancy are echoed in local data for smoking at birth. Figure 35 shows the percentage of women or birthing person who were recorded as a smoker at the time of birth where the birth episode took place between November 2024 and October 2025, across Suffolk (excluding Waveney), split by deprivation decile(IoD 2025). Results show that:

- In birthing episodes between November 2024 and October 2025 there was a deprivation gradient in the percentage of women or birthing people who smoked at time of birth, with smoking prevalence at birth at 7.9% in the most deprived areas (decile 1) and 1.7% in the least deprived areas (decile 10).
- The percentage of women and birthing people smoking in the most deprived decile was 4.6 times higher than in the least deprived decile.

Figure 35: Percentage of women or birthing person who were recorded as a smoker at the time of birth where the birth episode took place between November 2024 and October 2025, across Suffolk (excluding Waveney), split by deprivation decile-IoD 2025



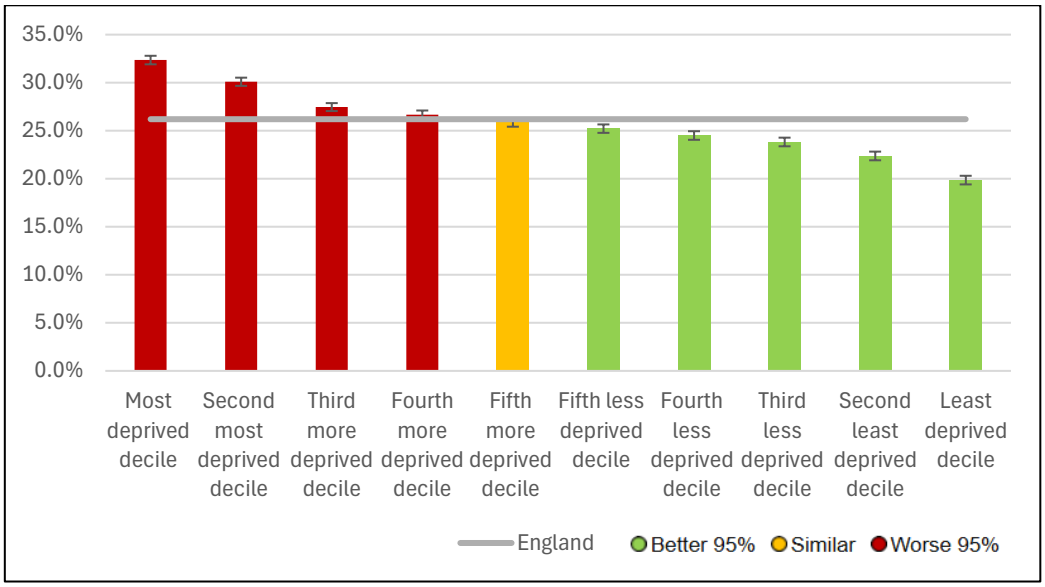
Source: Population Health Management Analytics

Living with obesity

Figure 36 shows the percentage of pregnant women or birthing people who are living with obesity as classified by BMI in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average. Results show that:

- In 2023/24, there was a deprivation gradient in the percentage of pregnant women who are living with obesity, with the four most deprived deciles showing percentages statistically significantly worse than the England average.
- In 2023/24, the most deprived areas (32.4%) had a 1.6 times higher percentage of pregnant women who are living with obesity compared to the least deprived areas (19.8%).

Figure 36: The percentage of pregnant women who are living with obesity as classified by BMI in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average.



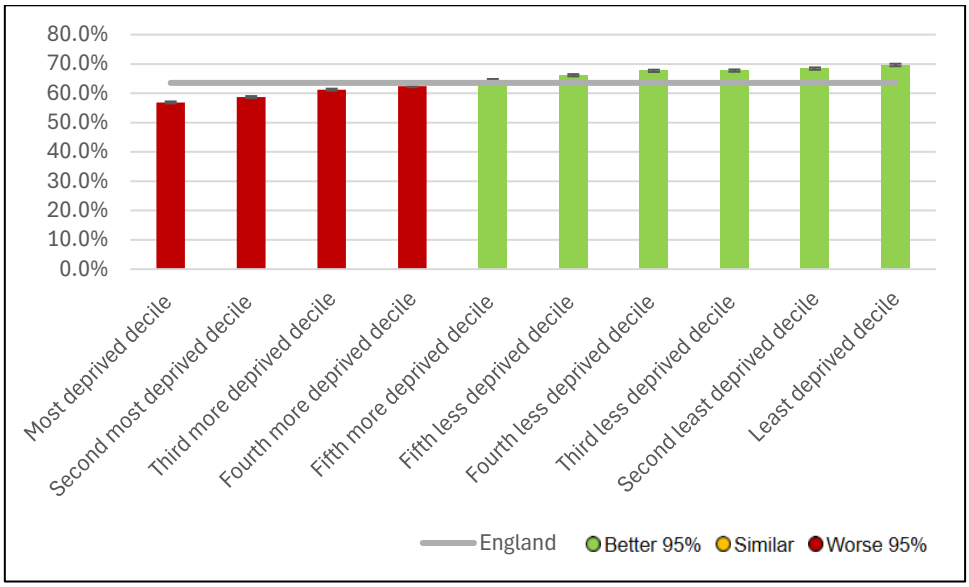
Source: Fingertips

Booking appointments

Figure 37 shows the percentage of pregnant women or birthing people who have their booking appointment with a midwife within 10 completed weeks of their pregnancy, in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average. Results show that:

- In 2023/24, there was a deprivation gradient in the percentage of pregnant women or birthing people who have their booking appointment with a midwife within 10 completed weeks of their pregnancy, with the four most deprived deciles showing percentages statistically significantly worse than the England average.
- In 2023/24, the least deprived areas (69.6%) had a 1.2 times higher percentage of pregnant women or birthing people who have their booking appointment with a midwife within 10 completed weeks of their pregnancy compared to the most deprived areas (56.9%).

Figure 37: The percentage of pregnant women who have their booking appointment with a midwife within 10 completed weeks of their pregnancy, in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average

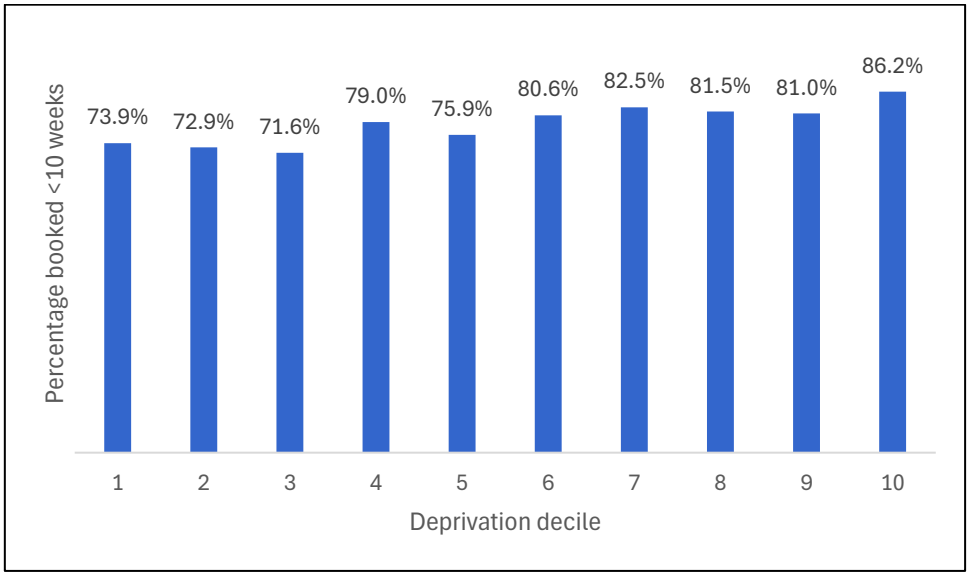


Source: Fingertips

Similar patterns are shown locally. Figure 38 shows the percentage of women or birthing people whose booking appointment with a midwife occurred before the 10th week of pregnancy, where birth episode took place between November 2024 and October 2025, across Suffolk (excluding Waveney), split by deprivation decile-IoD 2025. Results show that:

- In birthing episodes between November 2024 and October 2025 there was a deprivation gradient in the percentage of women or birthing people whose booking appointment with a midwife occurred before the 10th week of pregnancy, with 73.9% of women in the most deprived areas (decile 1) and 86.2% in the least deprived areas (decile 10).
- The percentage of women and birthing people whose booking appointment with a midwife occurred before the 10th week of pregnancy in the least deprived decile was 1.2 times higher than in the most deprived decile (a 12.3 percentage point difference).
- The lowest percentage of women or birthing people whose booking appointment with a midwife occurred before the 10th week of pregnancy was seen in decile 3 at 71.6%.

Figure 38: Percentage of women or birthing people whose booking appointment with a midwife occurred before the 10th week of pregnancy, where birth episode took place between November 2024 and October 2025, across Suffolk (excluding Waveney), split by deprivation decile- IoD 2025



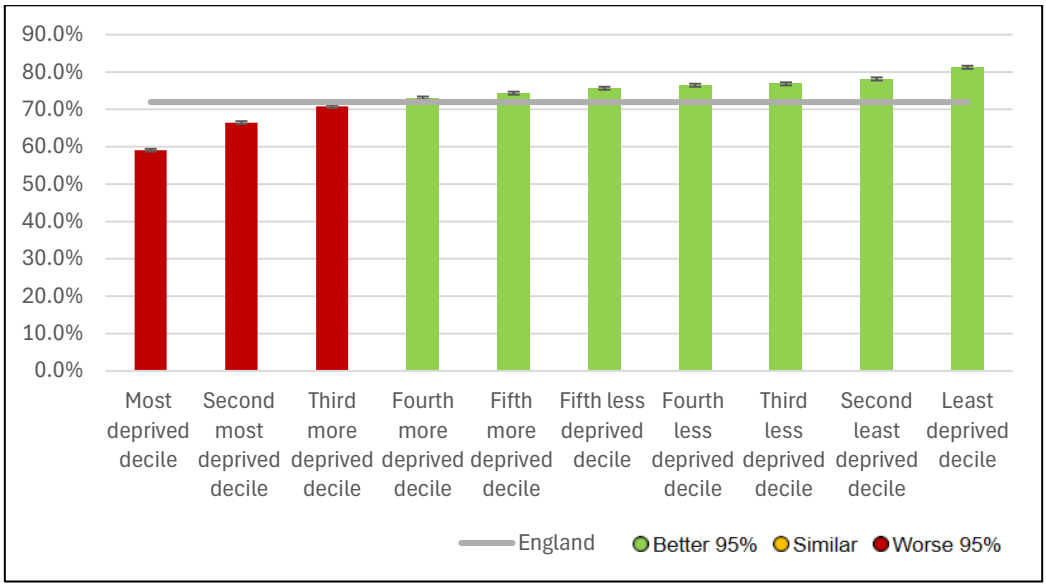
Source: Population Health Management Analytics

Breastfeeding

Figure 39 shows the percentage of pregnant women or birthing people whose baby's first feed was breastmilk in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average. Results show that:

- In 2023/24, there was a deprivation gradient in the percentage of pregnant women or birthing people whose baby's first feed was breastmilk in England, with the three most deprived deciles showing percentages statistically significantly worse than the England average.
- In 2023/24, the least deprived areas (81.3%) had a 1.4 times higher percentage of pregnant women or birthing people whose baby's first feed was breastmilk in England compared to the most deprived areas (59.1%).

Figure 39: The percentage of pregnant women or birthing people whose baby's first feed was breastmilk in England, in 2023/24, split by deprivation decile (IoD 2019), compared to the England average

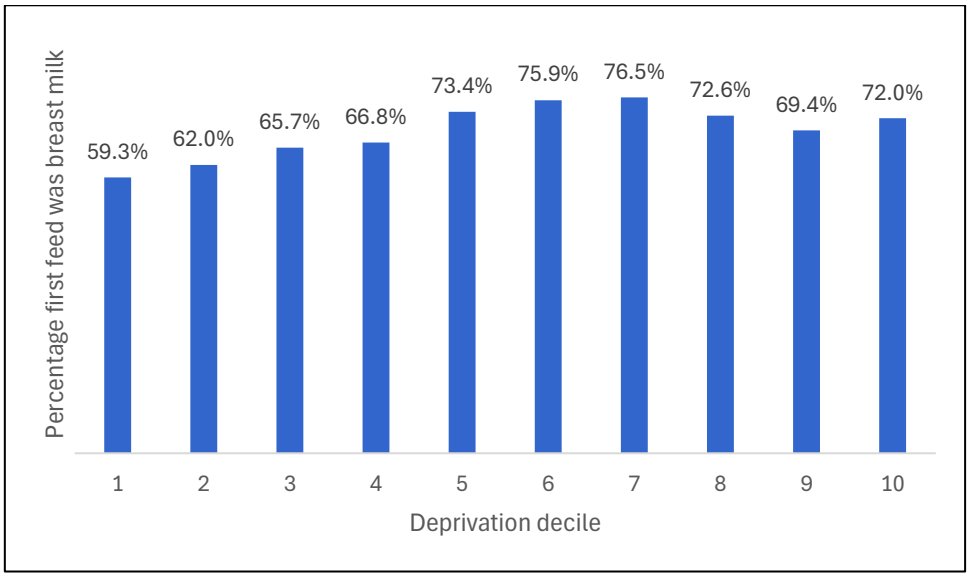


Source: Fingertips

This national pattern is mirrored locally. Figure 40 shows the percentage of women or birthing people whose first feed of their baby was breast milk, where birth episode took place between November 2024 and October 2025, across Suffolk (excluding Waveney), split by deprivation decile-IoD 2025. Results show that:

- In birthing episodes between November 2024 and October 2025 there was a deprivation gradient in the percentage of women or birthing people whose first feed of their baby was breast milk, with 59.3% of women in the most deprived areas (decile 1) and 72.0% in the least deprived areas (decile 10).
- The percentage of women and birthing people whose first feed of their baby was breastmilk in the most deprived decile was 1.2 times higher than in the least deprived decile (a 12.7 percentage point difference).
- The highest percentage of women or birthing people whose first feed of their baby was breast milk was seen in decile 7 at 76.5%.

Figure 40: Percentage of women or birthing people whose first feed of their baby was breast milk, where birth episode took place between November 2024 and October 2025, across Suffolk (excluding Waveney), split by deprivation decile-IoD 2025



Source: Population Health Management Analytics

Complex social factors

Maternal health outcomes are shaped not only by risk factors, promoting health behaviours and clinical factors but also by the broader social circumstances in which women and birthing people live. Deprivation, when combined with multiple complex social factors such as domestic abuse, substance use, or immigration status, can create significant barriers to accessing coordinated, effective care[24].

The 2025 MBRRACE report Saving Lives, Improving Mothers' Care included a Morbidity Confidential Enquiry specifically examining the care of women or birthing people living in the most deprived areas. A recurring theme in the confidential enquiries was the delivery of care through multiple, siloed services without adequate coordination[24].

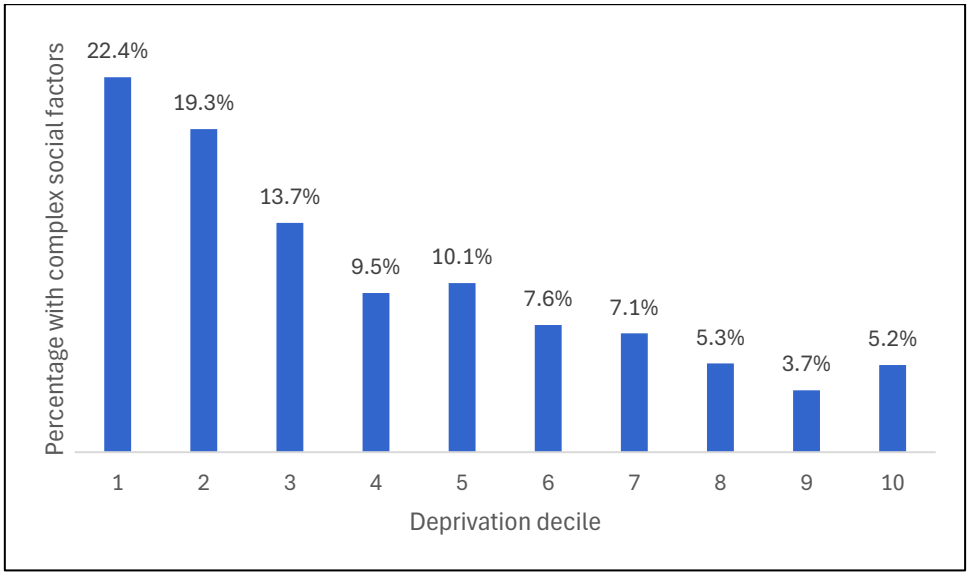
Among the women studied, 17 were identified as experiencing multiple disadvantages in addition to deprivation, including factors such as substance use, domestic abuse, childhood abuse, recent immigration, refugee or asylum seeker status, mental health diagnoses, female genital mutilation and learning difficulties. Women or birthing people with complex social circumstances often interact with numerous health and social care providers, but information sharing and coordinated care planning was shown to frequently fall short[24].

Figure 41 shows the percentage of women or birthing people who presented for antenatal care with any complex social factors (examples include but are not limited to poverty; homelessness; substance misuse; difficulty speaking or understanding English; age under 20; domestic abuse; recent migrants; asylum seekers or refugees) who had a birth episode between November 2024 and October 2025, in Suffolk (excluding Waveney), split by deprivation decile- IoD 2025. Results show that:

- In birthing episodes between November 2024 and October 2025 there was a deprivation gradient in the percentage of women or birthing people who presented for antenatal care with any complex social factors, with 22.4% of women in the most deprived areas (decile 1) and 5.2% in the least deprived areas (decile 10).

- The percentage of women or birthing people who presented for antenatal care with any complex social factors in the most deprived decile was 4.3 times higher than in the least deprived decile (a 17.2 percentage point difference).
- The lowest percentage of women or birthing people who presented for antenatal care with any complex social factors was seen in decile 9 at 3.7%.

Figure 41: Percentage of women or birthing people who presented for antenatal care with any complex social factors who had a birth episode between November 2024 and October 2025, in Suffolk (excluding Waveney), split by deprivation decile- IoD 2025.



Source: Population Health Management Analytics

Living with a disability

Disabled women make up 20% of women of reproductive age (15-49 years) in the UK, equating to around 2.9 million women. Emerging evidence shows that disabled women have worse maternity care access, experiences and outcomes[194].

The report, from The London School of Hygiene & Tropical Medicine (LSHTM) and the Missing Billion Initiative (MBI), Disparities in maternity care for disabled women in the UK reviewed existing evidence on maternity care access and the experiences and outcomes by disability status in the UK. Key findings of the report include that those women or birthing people who are classified as disabled (defined under the Equality Act 2010 as if an individual has a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities) in the UK have[194]:

- 44% higher odds of stillbirth or neonatal mortality for infants born to disabled mothers or birthing people
- 30-69% higher odds of caesarean birth
- 35%-70% lower odds of breastfeeding
- 51%-111% higher odds of longer postnatal hospital stays

Antenatal health behaviours showed disparities as well: Disabled women or birthing people had higher rates of smoking during pregnancy, and some evidence points to greater likelihood of illegal/recreational drug use, poor diet, low exercise, and lack of folic acid supplementation[194].

Qualitative studies highlighted several challenges women and birthing people with a disability status in the UK face when using maternity services. However, it is important to note that disability is diverse, and women and birthing people with a disability status may experience different barriers depending on their individual circumstances; however, the following common problems were consistently identified across the qualitative research. These included[194]:

- difficulty understanding written and verbal information
- physical accessibility issues with facilities
- staff who lacked knowledge about disability or held unhelpful attitudes.
- lack of continuity- having to explain needs repeatedly to different providers across antenatal, delivery, and postnatal care.
- Stigmatisation concerns about disclosing their disability and worries about how they might be perceived

The report also reviewed UK maternity guidance documents and found very limited attention to disability. Of 67 Royal College of Obstetricians and Gynaecologists reports reviewed, only 2 mentioned disability. Among 30 National Institute for Health and Care Excellence guidance documents on fertility, pregnancy and childbirth, just 6 made any reference to disability- and these mentions were typically brief with limited detail on maternity care for disabled women[194].

Despite these challenges, pregnant women and birthing people with a disability status have legal rights to additional support under human rights law and equality law, which require NHS Trusts to make reasonable adjustments to ensure equal access to maternity care. These adjustments should be personalised and may include longer appointments, accessible information formats, appropriate physical accommodations, and enhanced communication support[195].

Initiatives are underway to develop tools such as disability pregnancy passports to improve communication between women and multidisciplinary healthcare teams, support continuity of care, and document reasonable adjustments needed[196]. However, evidence suggests that addressing equity in pregnancy outcomes for disabled women or birthing people must further involve workforce training, policy development, facility accessibility, and integration of disability considerations throughout maternity care guidance and service delivery[194–196].

Section 4: Wider determinants

While individual health behaviours and medical conditions are important factors in a healthy pregnancy journey, they exist within a broader social, economic, and environmental context. Wider determinants of health shape people's ability to access care before, during, and after pregnancy, make healthy choices, and maintain wellbeing from conception through the early postnatal period[197].

Research from the UCL Centre for Longitudinal Studies suggests that financial pressures, career considerations, and partnership circumstances are among the main factors influencing whether people are trying to have children or expand their family. While parents will naturally have many reasons for deciding on the timing and spacing of their children, the study also noted that it is likely that the current cost-of-living pressures, with rising housing and childcare expenses, are also shaping the environment in which the population is making fertility decisions[198].

While the declining birth trends shown across Suffolk result from complex factors, they underscore the importance of considering the broader context in which reproductive decisions are made. Beyond the decision to conceive, these socioeconomic factors continue to have an impact throughout pregnancy, childbirth, and the postnatal period. Studies show that income, education, employment, and housing influence access to prenatal care, maternal health knowledge, and wellbeing during pregnancy[199].

This section examines how wider determinants influence a healthy pregnancy journey, supporting strong foundations for maternal and infant health.

Financial stability

Financial stability is crucial throughout the pregnancy journey because it reduces stress and provides consistent access to essential resources like medication, nutritious food, and stable housing. These factors directly influence physical and mental health before conception and continue to shape outcomes during pregnancy, childbirth, and the postnatal period[200,201]. Research demonstrates that income disparities significantly affect access to timely prenatal care, with women from lower-income backgrounds often experiencing delayed initiation of care and fewer prenatal visits, increasing the likelihood of adverse outcomes[199]. Understanding the financial pressures facing families provides important context for supporting a healthy pregnancy journey.

The cost of raising a child represents a significant financial commitment that can influence the pregnancy journey from the earliest stages. Recent analysis by the Child Poverty Action Group (CPAG) shows that the total cost of raising a child to age 18 is over £250,000 for a couple and nearly £290,000 for a lone parent. This includes essentials like food, clothing and heating, but no luxuries.

Table 7 shows the extent to which UK families have enough to cover the minimum cost of living in 2025- where families are defined as two children aged 3 and 7. Results show that:

- Non-working couples can cover just 37% of minimum family costs- a shortfall of 63%. This increases slightly for a non-working lone parent at 44%- a shortfall of 56%.
- Even when working full-time on median wage couples still fall 2% short of minimum needs. This deficit is larger for lone parents on median wage at 21%.

Table 7: The extent to which families have enough to cover the minimum cost of living in 2025. Net income* as a percentage of minimum family costs- family with two children aged 3 and 7

Type of work	Couple	Lone parent
Not working	37%	44%
Working full time on minimum wage	82%	69%
Working full time on median wage	98%	79%

*Net income refers to disposable income, after subtracting rent, childcare and council tax. These calculations assume eligibility for universal credit, with entitlements updated to April 2025.
Source: CPAG

Such economic pressure can directly impact physical and mental health throughout the pregnancy journey. Research using UK cohort data found that major economic shocks, job loss, and financial hardship experienced during the first 18 weeks of pregnancy may predict lower average birth weight and smaller head circumference[202].

Financial strain and associated stress during pregnancy has also been shown to impact maternal mental health. Financial stress has been associated with increased depressive symptoms and pregnancy-specific distress, which in turn are linked to lower birth weight[203]. A survey by Home-Start London of 300 families with babies and young children found that money worries are impacting perinatal health, with families reporting that financial stress affects their ability to care for themselves and their babies during the pregnancy and the postnatal period[204].

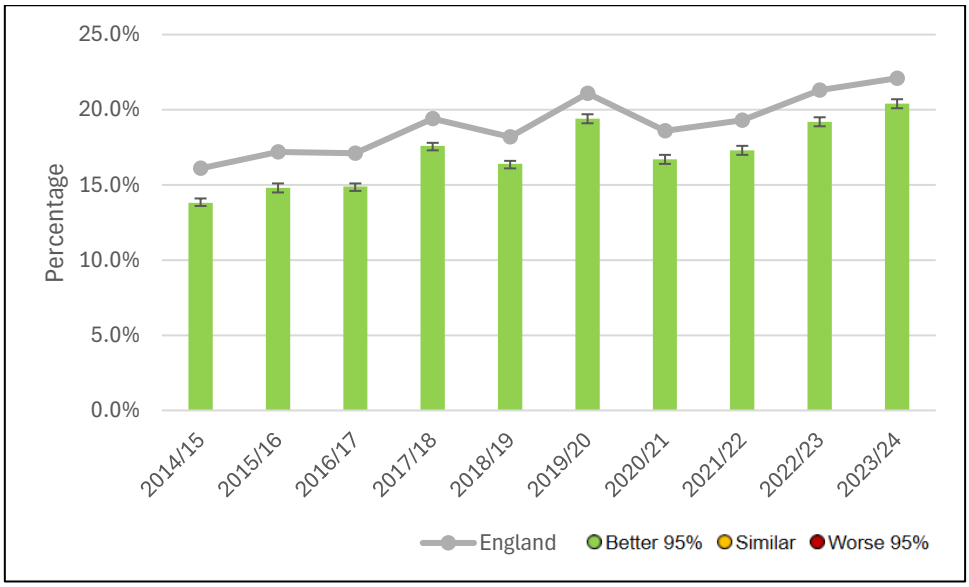
Local data reinforces these national challenges regarding financial hardship and worklessness. In Suffolk between January and December 2023, the Annual Population Survey found that over 1 in 10 households (that have at least one person aged 16 to 64) were workless households (13.0% [30,300]).

While minimum wage data for Suffolk is not available; the Office for National Statistics publish figures on employee jobs with hourly pay below the Living Wage Foundation's living wage threshold. The data shows that, in 2025, the living wage for the UK outside London was £12.60- £0.39 higher than the national minimum wage. Approximately 15.6% of Suffolk employees earn below this living wage, equating to around 50,000 jobs.

The financial pressures facing Suffolk families are reflected in child poverty statistics. Figure 42 shows the percentage of children aged under 16 years in relative low income families (defined as households with an equivalised net income below 60% of the contemporary median, frequently adjusted after housing costs), between 2014/15 and 2023/24, compared to England. Results show that:

- In 2023/24, 20.4% of children under 16 years of age were in relative low income families (27,143 people), statistically significantly better than England estimates (22.1%).
- Although statistically better than England estimates this still means that over 1 in 5 children under 16 years of age were in relative low income families in 2023/24.
- Recent trends also show that this Suffolk percentage is statistically significantly increasing and getting worse over time.

Figure 42: Percentage of children in relative low income families (under 16s) in Suffolk, between 2014/15 to 2023/24, compared to England

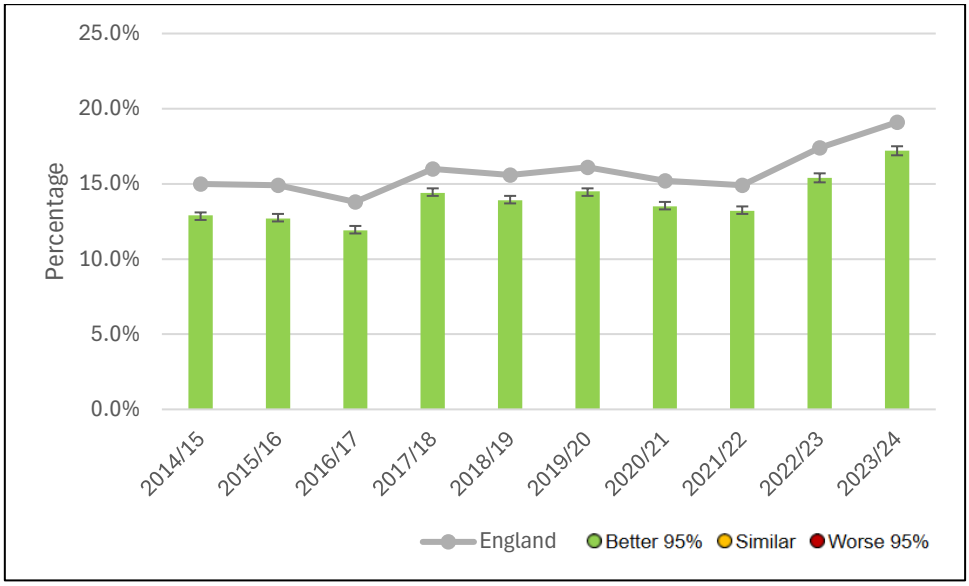


Source: Fingertips

Figure 43 shows the percentage of children under 16 years of age in absolute low income families (defined as children living in households with disposable income below 60% of the median income in a base year) in Suffolk, between 2014/15 and 2023/24, compared to England. Results show that:

- In 2023/24, 17.2% of children under 16 years of age were in absolute low income families (22,884 people), statistically significantly better than England estimates (19.1%).
- Although statistically better than England estimates this still means that over 1 in 6 children under 16 years of age were in absolute low income families in 2023/24.
- Recent trends also show that the Suffolk percentage is statistically significantly increasing and getting worse over time.

Figure 43: Percentage of children in absolute low income families (under 16s) in Suffolk, between 2014/15 to 2023/24, compared to England



Source: Fingertips

Employment

Employment and work conditions have influence throughout the pregnancy journey, impacting the wellbeing of women and birthing people in multifaceted ways. The nature of employment- including job security, workplace policies, and physical demands- plays a role in shaping health outcomes from before conception through to the postnatal period[199,201].

Research shows that employment status is associated with common risk factors of adverse pregnancy outcomes. In a 2017 study, analysing data from 8,343 mothers of healthy infants in the National Birth Defects Prevention Study (1997-2007), employed women were shown to be more likely to smoke and consume alcohol during early pregnancy, while non-employed women were more likely to use folic acid supplements and had different pre-pregnancy body mass index distributions[205].

In addition, a survey run by Fertility matters @work (142 women respondents) revealed how workplace conditions create barriers to healthy conception attempts. While acknowledging the small sample size and the likelihood of selection bias due to greater response rates from

women who have experienced issues, it remains important to highlight the key themes that have emerged, as these may go unrecognised in other workplace settings[206]:

- **Psychological stress from work situations:** Many felt "stuck" in unsuitable jobs when trying to conceive-due to fears of losing maternity benefits, creating chronic workplace stress. Work pressure itself was also shown to negatively impact conception attempts, creating a counterproductive cycle. IVF treatment was shown negatively influence mental and emotional wellbeing which also impacted individuals' ability to work.
- **Physical and practical challenges:** Frequent, unpredictable medical appointments were shown to require workplace flexibility that was often unavailable. Physical demands of treatment (medications, procedures, side effects) were also shown to affect work performance. A large proportion also reported taking sick leave when trying to conceive, impacting their career.
- **Workplace environment:** A large proportion of respondents felt unable to discuss treatment with their employers. Poor management response and discrimination fears were shown to create additional stress. Lack of flexibility was shown to force use of annual leave for medical appointments.

During pregnancy, workplace factors continue to influence maternal health and wellbeing. Research examining socioeconomic determinants demonstrates that supportive work environments that accommodate the needs of pregnant women-including access to maternity leave, flexible work schedules, and ergonomic adjustments- play a crucial role in promoting maternal wellbeing. However, factors such as limited access to paid maternity leave, strenuous work environments, and job insecurity can impose considerable stress and physical strain on expectant mothers or birthing people, potentially contributing to adverse maternal health outcomes and complications during pregnancy[199].

Additionally, pregnancy discrimination remains a notable concern. Research by the Equality and Human Rights Commission found that 3 in 4 mothers (77%) reported a negative or potentially discriminatory experience during pregnancy, maternity leave, and/or on return from maternity leave. Around 1 in 9 mothers (11%) reported they felt forced to leave their job- including those being dismissed, made compulsorily redundant where others were not, or feeling treated so poorly they had to leave. 1 in 5 mothers experienced harassment or negative comments related to pregnancy or flexible working, and 1 in 10 were discouraged from attending antenatal appointments- directly impacting their ability to access essential pregnancy care[207].

Inadequate employment benefits and support create financial strain that extends throughout and beyond pregnancy. Data from the Office for National Statistics (April 2014 to December 2022) demonstrates lasting impacts on women's wellbeing, with earnings significantly reduced for at least five years following adverse pregnancy events- suggesting that inadequate workplace support during and after pregnancy complications may compound financial stress during already vulnerable periods. Average earnings losses included £13,581 following stillbirth, £12,441 following neonatal death, and £3,511-£4,101 following miscarriage[208].

The Maternity Action cost of living survey found that 71% of women worried 'a lot' about money during pregnancy or maternity leave, with 58% returning to work earlier than planned for financial reasons- often before they felt physically or mentally ready. Half of respondents reported buying less healthy food due to cost, and a quarter had gone without food themselves

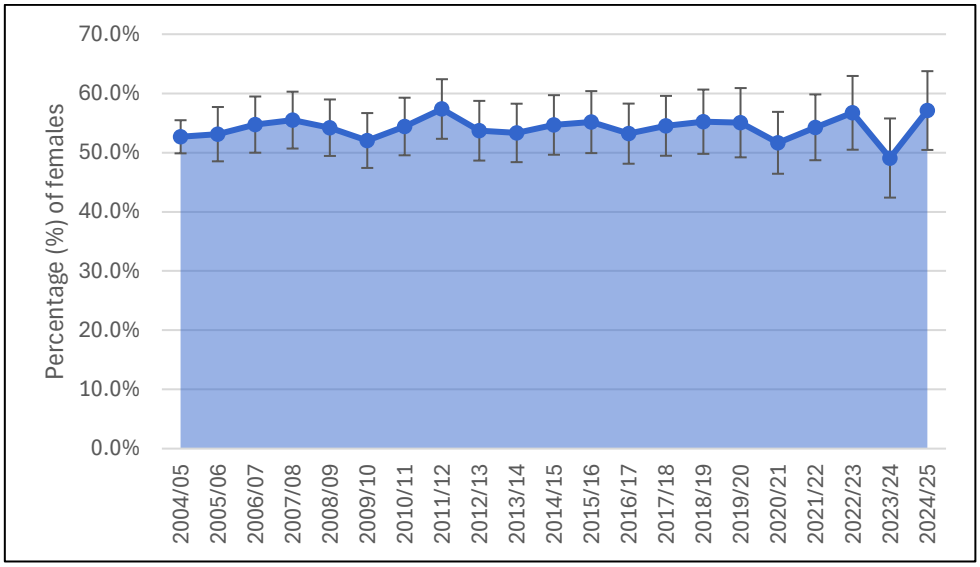
to feed their children. Statutory maternity pay equates to just 47% of the National Living Wage, creating significant financial strain for families during a critical period[209].

These financial pressures occur within a context where national maternal employment has reached historic highs. 2021 ONS data on families and the labour market found that in April to June 2021, 3 in 4 women or birthing people with dependent children (75.6%) were in work in the UK, reaching its highest level in the equivalent quarter over the last 20 years (66.5% in 2002). The employment rate was higher for mothers and birthing people than either women or men without dependent children and has been since 2017. From 2020, in families where both parents are employed, it has become more common for both parents to work full-time, rather than a man working full-time with a partner working part-time. A third (33.3%) of women or birthing people with dependent children reported to have agreed special working arrangements in their job.

Locally, figure 44 shows the percentage of females (ages 16 years and over) in Suffolk who are 'in employment' (defined as completing at least one hour of paid work in the reference week or were temporarily away from a job) between June 2005-July 2006 and June 2024-July 2025. Results show that:

- In 2024/25, over half (57.1%) of all females aged 16 years or over in Suffolk were in employment (182,000 people).
- Recent trends show no significant change

Figure 44: The percentages of females (ages 16 years and over) in employment in Suffolk between June 2005- July 2006 and June 2024-July 2025, as reported by the Annual Population Survey



Source: Annual Population Survey

Education

Educational attainment has measurable associations with maternal health outcomes throughout the pregnancy journey. Research demonstrates that education operates as a determinant of health, influencing knowledge, behaviours, healthcare access, and pregnancy outcomes from preconception through to the postnatal period.

An international meta-analysis of 2,356,402 pregnancies published in the International Journal of Gynaecology & Obstetrics (2025) examined the association between maternal education and

adverse maternal and perinatal outcomes, finding that women with lower levels of education were at significantly greater risk of stillbirth and having a "small vulnerable newborn" (a composite measure of preterm birth, low birth weight, and small-for-gestational-age). The associations followed a dose-response pattern, with risk increasing as educational level decreased. It is important to note that the analysis includes data from low-, middle- and high-income countries, so findings should be interpreted with this context in mind; however, the association between maternal education and stillbirth remained significant when analysis was restricted to high-income countries only[210].

Educational levels are typically categorised as: primary education (elementary/basic schooling up to age 11), secondary education (high school level including GCSEs and A-levels or equivalent, ages 11–18), and tertiary education (higher education including university degrees, further education colleges, and vocational qualifications beyond school level). In this research, these categories refer to the highest level of education achieved[210].

Compared to women with tertiary education, women with secondary education had a 27% higher risk of maternal death (RR 1.27, 95% CI 0.38–4.30) and women with informal or primary education had approximately double the risk (RR 2.51, 95% CI 0.23–26.95). However, both estimates were imprecise with very wide confidence intervals and were not statistically significant, with the authors noting that the low frequency of maternal death made findings unreliable. The authors did highlight that, despite women with informal or primary education comprising fewer than half the study population of those with secondary education, the absolute number of maternal deaths was similar across the two groups[210].

The strongest and most consistent associations were found for stillbirth, where the dose-response pattern was clear: a 25% increased risk in women with secondary education (RR 1.25, 95% CI 1.09–1.43) and a twofold increased risk in women with informal or primary education (RR 2.03, 95% CI 1.27–3.24) compared to those with tertiary education. Lower education was also significantly associated with an increased risk of having a small vulnerable newborn, with a 12% increased risk for secondary education (RR 1.12, 95% CI 1.03–1.22) and a 20% increased risk for informal or primary education (RR 1.20, 95% CI 1.01–1.44). No significant association was found between maternal education and preeclampsia[210].

Research examining socioeconomic factors suggests that lower educational attainment may create interconnected barriers that can compromise maternal health throughout the pregnancy journey[199]:

- **Reduced health literacy and knowledge**: Lower educational levels may limit women's or birthing people's ability to access, understand, and effectively use health information and services. This reduced health literacy can affect decision-making throughout pregnancy, from selecting appropriate antenatal care to recognising warning signs of complications. Difficulty navigating complex health information- whether from healthcare providers, online sources, or community resources- may delay necessary care and contribute to suboptimal health behaviours.
- **Limited access to quality healthcare**: Educational disadvantage is often associated with reduced access to timely, high-quality maternal and newborn care. Women or birthing people with lower educational attainment may face barriers in advocating for needed services during pregnancy and childbirth.
- **Impact on health behaviours and self-care**: Education can influence health behaviours during pregnancy, including nutrition choices, substance use, physical

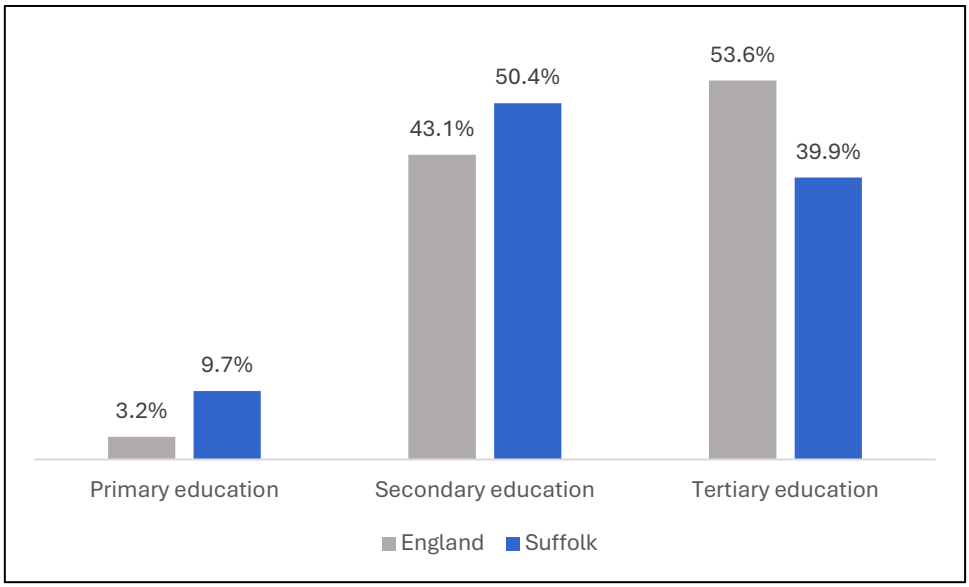
activity, and adherence to antenatal recommendations. Limited education may restrict understanding of how these behaviours affect pregnancy outcomes and capacity to implement recommended changes.

- **Intergenerational effects**: The impact of maternal educational disadvantage may extend beyond the current pregnancy, affecting child development. Research indicates that improving maternal educational attainment can produce intergenerational benefits for development and health outcomes.

Figure 45 shows the highest level of qualification of females ages 16 to 44 years in Suffolk as a percentage, as reported in the 2021 Census, compared to England. Categories are split into primary (no qualifications), secondary (level 1, 2 and 3 qualifications), and tertiary qualifications (level 4 and apprenticeships, vocational or work-related qualifications) as defined above. Results show that:

- Around 1 in 10 females (ages 16-44 years) in Suffolk (9.7%) highest level of qualification is at primary level- 6.5 percentage points higher than England estimates.
- Just over half (50.4%) highest level of qualification is at secondary level- 7.3 percentage points higher than England estimates
- Over 1 in 3 (39.9%) highest level of qualification is at tertiary level- 13.7 percentage points lower than England estimates

Figure 45: Highest level of qualification of females (ages 16-44 years) in Suffolk as a percentage, 2021 Census, compared to England



Source: ONS

Housing and environment

Housing, neighbourhood conditions, and environment exposures represent critical social determinants that can significantly influence maternal health outcomes throughout the pregnancy journey.

Research demonstrates multiple ways that housing conditions can affect maternal health:

- **Exposure to mould and dampness:** The presence of serious mould problems in housing is associated with approximately doubled risk of low birthweight and small-for-

gestational-age births, even after adjustment for maternal, sociodemographic, and other housing factors[211]

- **Crowding:** defined as more than one person per room, crowding shows associations with adverse birth outcomes, specifically increased risk of small-for-gestational-age births[211]
- **Psychological and mental health impacts**: Inadequate housing conditions, including overcrowding, lack of sanitation, and substandard living environments, pose considerable risks to the health of pregnant women. Stress associated with insecure housing and exposure to environmental hazards can contribute to adverse pregnancy outcomes and complications[199]

Suffolk's Housing and Health Needs Assessment found that it is estimated that 12,675 households in Suffolk may suffer from any form of damp. The actual proportion of damp and mould in Suffolk's homes may be higher- as dwellings built pre-1919 have the highest prevalence of some form of damp and mould at 11.0%, with almost 1 in 5 (18%) of Suffolk's housing stock is estimated to be built prior to 1914. Additionally, approximately 1,445 Suffolk residents are living in overcrowded, non-decent homes that do not meet the Decent Home Standard.

Ambient air pollution represents an emerging area of concern for pregnancy outcomes. A 2024 review by the Committee on the Medical Effects of Air Pollutants (COMEAP) examined whether outdoor air pollution during pregnancy affects birth outcomes. The review found some evidence suggesting links between air pollutants- specifically small particles (PM2.5 and PM10) and ozone (O3)- and adverse outcomes including preterm birth, low birthweight, and stillbirth. Some studies suggest air pollutants may interfere with placental function[212].

However, the committee noted important limitations: the evidence was not considered robust enough for government policy decisions, and no recent high-quality systematic review combining all available human population studies exists. The committee recommended new meta-analyses to properly assess available evidence and highlighted that further research is needed on how air pollution affects pregnancy outcomes. For context, established risk factors such as smoking during pregnancy likely pose higher risks than typical outdoor air pollution levels in the UK[212].

Conclusion

A healthy pregnancy journey begins long before conception and continues beyond birth, shaped at every stage by the health of both birthing and non-birthing people, the conditions in which they live, and the services available to support them. The evidence in this report paints a picture of where Suffolk is faring well, where it is keeping pace with England, and where targeted attention could most meaningfully improve outcomes for women, birthing people, partners, and babies.

There is genuine progress to recognise. Smoking at delivery is at its lowest recorded level, breastfeeding initiation and folic acid uptake outperform the national average, and cervical screening and abortion services are being accessed in ways that compare favourably with England. The Healthy Start Scheme has reached more families locally, and early signals on the maternal RSV vaccination programme are promising. These are meaningful wins that reflect sustained local effort and offer foundations to build on.

At the same time, the data points to areas where additional focus could make a difference. The majority of adults of reproductive age in Suffolk are living with overweight or obesity, mental health is the most prevalent pre-existing condition identified locally, and continued breastfeeding to 6–8 weeks remains below the national average. Emergency admissions of babies in the first two weeks of life and LRTI admissions in young children are significantly higher than England and worsening. For several important areas (including alcohol and drug use in pregnancy, physical activity, and the prevalence of conditions such as endometriosis, fibroids, and thyroid disorders) local data is limited, and national estimates suggest substantial unmet need that is not currently visible in local datasets.

The report also highlights how outcomes vary across the population. Women and birthing people in the most deprived areas of Suffolk, those from ethnic minority groups, those with disabilities, and those facing complex social factors consistently experience poorer outcomes and greater barriers to accessing timely, appropriate care. These patterns are shaped not only by clinical factors but by the wider social, economic, and environmental context (financial pressure, employment conditions, educational opportunity, and housing) all of which influence the pregnancy journey from preconception onwards.

Taken together, the findings suggest that supporting healthy pregnancy outcomes in Suffolk is most effective when framed around the whole journey, both parents, and the wider context in which families live. This means investing in early support and prevention before conception, providing accessible and joined-up care during pregnancy and the postnatal period, recognising and responding to inequalities, and continuing to strengthen local data so that future need can be identified and met.

A healthy pregnancy journey is a shared responsibility. With coordinated effort across health, local government, VCFSE partners and communities, Suffolk can continue to improve outcomes, reduce inequalities and support residents to start family life with the best possible foundation for long-term health and wellbeing.

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