You & your Baby 2024

A national survey of maternal health & wellbeing

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You & your Baby 2024

A national survey of maternal health & wellbeing:

Summary

This report presents findings from the latest national maternity survey which explored the experiences of women who gave birth in England during May 2024. A nationally representative sample was drawn from birth registration records, and 3,728 women responded to the survey. The report is organised into chapters covering the survey's background and aim, methodology, respondent characteristics, and detailed results on maternity care, maternal health and lifestyle, perinatal mental health, and infant feeding, followed by overall conclusions. A summary of the key findings is presented below:

Survey response

- A wide range of women with diverse characteristics, circumstances, and experiences responded (page 6).
- A higher proportion of women who took part were born outside the UK (around 3 in 10), from minority ethnic groups (around 3 in 10), and residing in the most disadvantaged areas (around 2 in 10), compared with previous surveys (Appendix H).

Perinatal mental health

- Prevalence of postnatal depression decreased marginally (2 in 10), compared with during the pandemic, but was higher than in pre-pandemic surveys (page 37).
- Prevalence of postnatal anxiety (2 in 10) and post-traumatic stress (1 in 10) increased marginally and was higher than in all previous surveys (page 37).
- Most women were asked about their mental health during pregnancy (8 in 10, page 8) and after giving birth (8 in 10, page 24).
- 2 in 10 women reported a pre-existing mental health diagnosis (page 36).
- 2 in 10 of women's partners had experienced mental health problems (page 41).

Maternity care

- 8 in 10 women were satisfied with care during pregnancy and birth, whereas 7 in 10 were satisfied with postnatal care (page 27).
- Perceptions of healthcare professionals were generally positive but a significant minority of women did not always feel they were listened to, treated as an individual, or with kindness and respect (page 25).
- 9 in 10 women attended a six-week postnatal check, which was higher than in all previous surveys (page 24).

Infant feeding

- 4 in 10 women wanted more help with breastfeeding (page 45).
- Breastfeeding initiation remained stable and continuation at six weeks and six months increased, compared with all previous surveys (page 43).

Maternal health and lifestyle

- Fewer women smoked tobacco cigarettes but more women vaped during their pregnancy, compared with all previous surveys (page 31).

You & your Baby 2024
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Tables in appendices

1. Background

We use the words "women" and "woman" throughout this report, reflecting biological sex, and recognising that this also reflects the identity of the great majority of those who are childbearing. These terms should be taken as including girls, and people whose gender identity does not correspond with their birth sex or who have a non-binary identity unless stated otherwise. All those using maternal and reproductive health care and services should receive individualised, respectful care including use of the gender nouns and pronouns they prefer.

The National Perinatal Epidemiology Unit (NPEU) has conducted national maternity surveys across England in 1995 (in collaboration with the Audit Commission),[1] 2006,[2] 2010,[3] 2014,[4] 2018,[5] and 2020.[6] The maternity surveys provide robust, population-level data on the health and maternity care experiences of women who have recently given birth, contributing to the broader evidence base in maternal health research. By documenting women's experiences throughout their maternity journey, the surveys serve as an important source of information for policymakers, healthcare professionals, and researchers as well as for women and their families.

The longitudinal approach of the national maternity surveys allows us to monitor trends and shifts in maternal health and maternity experiences over time, highlighting areas of progress as well as persistent challenges. Previous surveys have shown changes in the frequency of antenatal checks and postnatal visits,[7] breastfeeding rates and support,[8] [9] prevalence of perinatal mental health problems,[10] [11] access to mental health services,[12] and overall satisfaction with maternity care.[13]

[1] Audit Commission. First Class Delivery: Improving Maternity Services in England and Wales. London: Audit Commission, 1997.
[2] Redshaw M, Rowe R, Hockley C, Brocklehurst P. Recorded Delivery: A national survey of women's experience of maternity care 2006. Oxford: National Perinatal Epidemiology Unit, 2007.
[3] Redshaw M, Heikkila K. Delivered with Care: A national survey of women's experience of maternity care 2010. Oxford: National Perinatal Epidemiology Unit, 2010.
[4] Redshaw M, Henderson J. Safely Delivered: A national survey of women's experience of maternity care 2014. Oxford: National Perinatal Epidemiology Unit, 2014.
[5] Harrison S, Alderdice F, Henderson J, Quigley MA. You and Your Baby: A national survey of health and care. Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2020.
[6] Harrison S, Alderdice F, McLeish J, Quigley MA. You and Your Baby: A national survey of health and care during the 2020 Covid-19 pandemic. Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2021.
[7] Henderson J, Redshaw M. Change over time in women's views and experiences of maternity care in England, 1995-2014: A comparison using survey data. Midwifery. 2017 Jan;44:35-40. doi: 10.1016/j.midw.2016.11.003.
[8] Quigley MA, Harrison S, Levene I, McLeish J, Buchanan P, Alderdice F. Breastfeeding rates in England during the Covid-19 pandemic and the previous decade: Analysis of national surveys and routine data. PLoS ONE. 2023;18(10):e0291907. doi: 10.1371/journal.pone.0291907.
[9] Quigley MA, Harrison S, Levene I, et al. Breastfeeding support during the Covid-19 pandemic in England: Analysis of a national survey. BMC Public Health. 2024;24:3284. doi: 10.1186/s12889-024-20618-2.
[10] Harrison S, Quigley MA, Fellmeth G, Stein A, Ayers S, Alderdice F. The impact of the Covid-19 pandemic on postnatal anxiety and posttraumatic stress: Analysis of two population-based national maternity surveys in England. J Affect Disord. 2024 Jul 1;356:122-136. doi: 10.1016/j.jad.2024.04.003.
[11] Harrison S, Quigley MA, Fellmeth G, Stein A, Alderdice F. The impact of the Covid-19 pandemic on postnatal depression: Analysis of three population-based national maternity surveys in England (2014-2020). Lancet Reg Health Eur. 2023 May 15;30:100654. doi: 10.1016/j.lanepe.2023.100654.
[12] Harrison S, Pilkington V, Li Y, Quigley MA, Alderdice F. Disparities in who is asked about their perinatal mental health: An analysis of cross-sectional data from consecutive national maternity surveys. BMC Pregnancy Childbirth. 2023 Apr 27;23:263. doi: 10.1186/s12884-023-05518-4.
[13] Harrison S, Alderdice F, Fellmeth G and Quigley MA. Inequalities in childbirth experiences: A population-based cross-sectional survey in England during the Covid-19 pandemic [version 1; peer review: 1 approved with reservations]. NIHR Open Res 2025, 5:31. doi: 10.3310/nihropenres.13835.1.

The 2020 survey was particularly significant, offering valuable insights into the unique challenges surrounding pregnancy and childbirth during the Covid-19 pandemic.[6] [14]

In 2024, a new national maternity survey "You & Your Baby 2024" was commissioned by the Department of Health and Social Care (DHSC), funded through the National Institute for Health and Care Research (NIHR) Policy Research Unit in Maternal and Neonatal Health and Care (PRU-MNHC). Carrying out a maternity survey in 2024 was important to capture the experiences of women giving birth in England during the post-pandemic period and to assess whether these experiences aligned with those of women in pre-pandemic years or reflected enduring changes shaped by the impact of Covid-19.

The importance of the 2024 survey was further underlined by the need for up-to-date and comprehensive data on perinatal mental health – a key focus of recent health policy, which has been emphasised by the Health and Social Care Secretary, the Women's Health Strategy,[15] the NHS Mental Health Implementation Plan 2019/20–2023/24,[16] and the NHS Long Term Plan.[17] Historically, routine data collection on perinatal mental health in England has been limited, which makes the insights from the maternity surveys particularly valuable.

Finally, the stark evidence of inequalities in maternal health outcomes and maternity care experiences calls for urgent and focused attention.[18] The maternity surveys play a crucial role in capturing the maternity journey from women's perspectives and examining how experiences and outcomes vary for different groups of women. Understanding these differences is essential for informing effective policy decisions and ensuring that all women receive equitable, high-quality care throughout pregnancy, childbirth, and beyond.

2. Aim

The primary aim of the 2024 survey was to collect up-to-date, population-level data on the health and maternity care experiences of women who gave birth in England during 2024 and to compare the findings with those from previous surveys, including the 2020 pandemic survey. An additional aim of the 2024 survey was to collect detailed data on women's perinatal mental health to: assess the prevalence of common mental health problems; explore changes in prevalence over time; and

[14] McLeish J, Harrison S, Quigley M, Alderdice F. Learning from a crisis: A qualitative study of the impact on mothers' emotional wellbeing of changes to maternity care during the COVID-19 pandemic in England, using the National Maternity Survey 2020. BMC Pregnancy Childbirth. 2022;22:868. doi: 10.1186/s12884-022-05208-7.
[15] Department of Health and Social Care. Women's health strategy for England. 2022. Available at: https://www.gov.uk/government/publications/womens-health-strategy-for-england. Accessed 16 October 2025.
[16] NHS England. NHS Mental Health Implementation Plan 2019/20–2023/24. 2019. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf. Accessed 16 October 2025.
[17] NHS England. The NHS Long Term Plan. 2019. Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/. Accessed 16 October 2025.
[18] MBRRACE-UK. Saving lives, improving mothers' care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020–22. Oxford: National Perinatal Epidemiology Unit; 2024.

identify the perinatal mental health support and treatment women receive. The 2024 survey also aimed to explore how mental health outcomes and maternity care experiences vary for different groups of women.

In this report, we describe the health and maternity care experiences of women who took part in the 2024 survey and, where possible, compare these findings with those from previous maternity surveys. We also present our findings on prevalence, support and treatment of perinatal mental health problems. Additional questions, including more detailed analysis of women's perinatal mental health and disparities in health outcomes and maternity care experiences, will be addressed through publications in academic journals.

3. Methods

This section provides a brief overview of the methods used in the 2024 survey; further details are available in **Appendix A**. The 2024 survey was a large-scale national maternity survey of women who had recently given birth in England. A random, population-based sample of 16,000 women was identified by the Office for National Statistics (ONS) using birth registration records. Women were eligible if they were aged 16 years or older, were living in England at the time the birth of their baby was registered, and they had given birth to their baby in England during a two-week period in May 2024. All women were first contacted via mail when their baby was six months old. Prior to each mailing, ONS completed checks for maternal and infant deaths and any women who had died or whose baby had died were excluded from the sample.

To safeguard anonymity and protect personal data, the survey mailings were managed by ONS. All women received a letter of invitation, a participant information leaflet, and a multi-language information sheet – with a brief description of the survey in the ten most commonly spoken languages in the UK (excluding English). Women were invited to complete the survey online but paper or telephone completion was available upon request.

The initial mailing took place in November 2024 and a first reminder was sent approximately two weeks later. A second reminder followed in December 2024, two weeks after the first, and a final reminder was sent in January 2025, after a further six weeks. **Figure 1** shows the recruitment timeline.

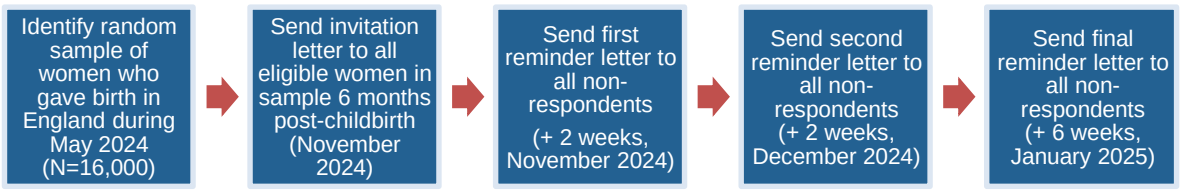

Figure 1: Recruitment timeline

In the questionnaire, women were guided through questions about their pregnancy, childbirth, and the postnatal period, and were asked to share their views and experiences of maternity care. Women were also asked about specific topics, particularly their mental health which was a key focus of the 2024 survey, but also about their health more generally and their experiences of infant feeding. Women who had a multiple birth were asked to respond based on their first-born baby only. A full breakdown of the questionnaire content is provided in **Table A1** in **Appendix B**.

4. The women who took part in the 2024 survey

4.1 Response to the survey

The survey was open from early November 2024 until the end of March 2025. The flow of recruitment and the number of questionnaires returned in the 2024 survey is shown in **Appendix C**. In total, 15,991 women were sent the initial invitation letter following eligibility checks. A small number of letters (n=206) were returned undelivered; 12,057 women either did not respond to the survey or declined via telephone or email; and 3,728 women returned questionnaires, a response rate of 23.6% (3,728 out of 15,785). **Figure 2** shows the overall response rates across the maternity surveys from 2006 to 2024. In 2006, the response rate was 62.6% and this has fallen with each successive survey – 54.1% in 2010, 46.7% in 2014, 29.0% in 2018, 28.9% in 2020, and 23.6% in 2024. The response rate therefore declined by 5.3% (-5.3%, 95% Confidence Interval (CI): -7.2– -3.4, p<0.001) between 2020 and 2024.

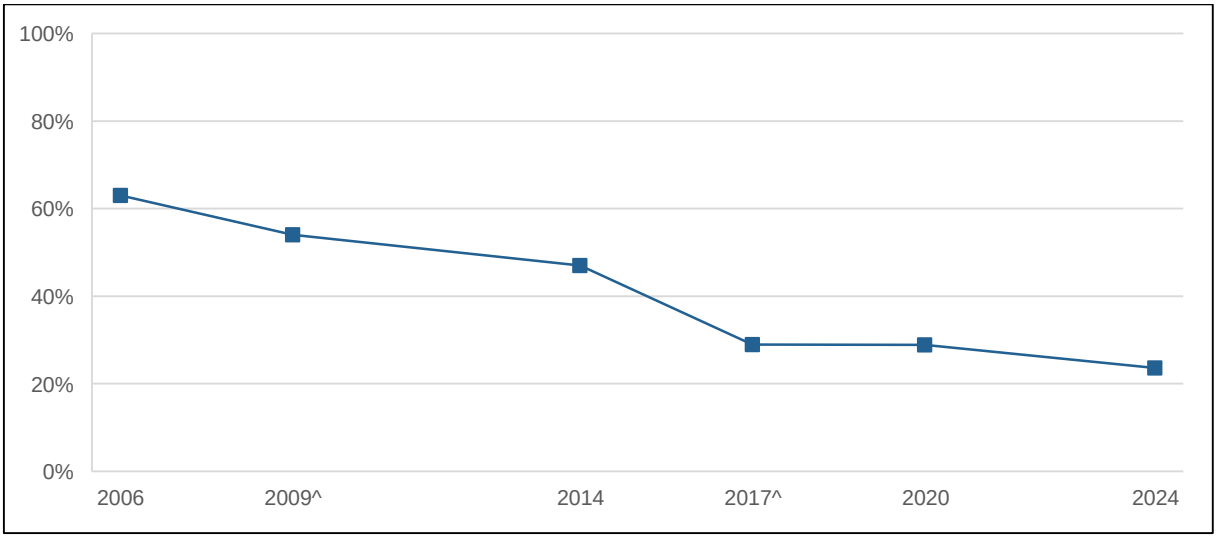

Figure 2: Response rates to the maternity surveys from 2006 to 2024

^ Women gave birth in 2009 and the survey was conducted in 2010; women gave birth in 2017 and the survey was conducted in 2018.

Note: The 2018, 2020 and 2024 surveys were distributed to women when their baby was six months old whereas the earlier surveys were distributed to women when their baby was three months old.

Although the overall response rate declined by 5.3% in 2024 compared with in 2020, the decrease was not equal across all groups of women (**Appendix D**). For example, the decline was smaller among the youngest women compared with those aged 35 and over (-2.1% vs -6.4%). The decline

was also smaller among women born outside the UK compared with those born in the UK (-0.4% vs -6.9%), among women living in the least advantaged areas compared with those in the most advantaged areas (-0.6% vs -8.1%), and among women who registered the birth in their sole name or in joint names but living separately, compared with those who registered the birth in married names (-2.0% vs -7.1%). These patterns indicate that the decline in response rates was less pronounced among some groups of women who are typically less likely to respond, resulting in a more demographically diverse sample of respondents in 2024 compared with in 2020, with greater representation of women whose views are sometimes less well captured.

4.2 Respondent characteristics

Appendix E shows the sociodemographic characteristics of the women who took part in the 2024 survey. Almost two-thirds (64.8%) of respondents were aged between 30 and 39 years and 72.3% of respondents were born in the UK. The three largest ethnic groups among the respondents were White British (67.8%), White Other (9.5%), and Black African (5.7%), and most respondents indicated that English was their main language (85.2%). The majority of respondents registered their baby's birth in married names or in joint (unmarried) names but living at the same address (92.5%) and 88.8% of respondents were living with a partner when they completed the survey. The highest proportions of respondents were living in London (15.1%) or the South East (17.1%). More respondents were living in the two most advantaged quintiles of the Index for Multiple Deprivation (IMD) (42.1%) than in the two least advantaged quintiles (36.9%), most (96.1%) had not made use of food banks within the last 12 months, and 85.7% had access to private transport. Over half (59.4%) of respondents had been educated to degree level (or equivalent), 22.6% to A-level (or equivalent), and 11.5% to GCSE level (or equivalent). Almost half (47.5%) of respondents indicated that they did not have a religion, over a third (36.3%) reported they were Christian, and 8.6% reported they were Muslim. The large majority of respondents described themselves as heterosexual (93.6%) and identified as a woman (99.4%), but some of those who took part reported different sexual orientations (3.5% identified as gay/lesbian or bisexual) or gender identities (a small minority identified as a man or non-binary), or indicated that they would prefer not to say. The median age of the babies when respondents completed the survey was 29 weeks (interquartile range=28–32 weeks).

4.3 Respondent representativeness

Summary data describing the key demographic characteristics of the respondents (N=3,728) alongside the non-respondents (N=12,057) in the 2024 survey are shown in **Appendix F**. The respondents and non-respondents were compared using chi-square tests and the p-values are shown. The 3,728 women who responded to the 2024 survey were more likely to be older, born in the UK, living in more advantaged areas of England, primiparous, and to have registered the birth of their baby in married names, compared with the 12,057 women who were invited to take part in the survey but who did not respond ($p<0.001$). The women who responded were also less likely to

have had a baby with low birth weight (p=0.008). Due to the differences between respondents and non-respondents on these key demographic characteristics, survey weights were applied to all survey results to reduce the effect of non-response bias (see **Appendix G** for further details on the calculation and application of survey weights). Summary data describing the characteristics of respondents across the maternity surveys are presented in **Appendix H**.

5. Results

The results are presented under the following six headings to help make the report easier to navigate and to facilitate access to specific data: 1) pregnancy; 2) childbirth; 3) maternity care during pregnancy, childbirth and the postnatal period; 4) maternal health and lifestyle; 5) perinatal mental health; and 6) infant feeding.

5.1 Pregnancy

Summary pregnancy data for the respondents to the 2024 survey are presented in **Table 1** in section 5.1.7 on pages 13–14.

5.1.1 Pregnancy planning

Effective pregnancy planning and optimal preconception health are associated with improved maternal and neonatal health outcomes.[19] Three-quarters (74.5%, 95%CI: 72.7–76.1) of women in the 2024 survey reported that their pregnancy was planned, which was consistent with previous maternity surveys (71% to 76% in the surveys from 2010–2020). One in twenty (5.0%) women indicated that their pregnancy was a result of fertility treatment, and 3.9% (95%CI: 3.3–4.5) indicated that they had used in vitro fertilisation (IVF) or IVF with intracytoplasmic sperm injection (ICSI). This estimate is slightly higher than the most recent data published by the Human Fertilisation and Embryology Authorisation, which reported that IVF accounted for approximately 3.1% of all births across the UK in 2023.[20] Women were asked to describe their reaction when they found out they were pregnant and 73.0% felt pleased or overjoyed, 21.5% had mixed feelings, and 1.7% felt unhappy.

5.1.2 Pregnancy booking

The pregnancy booking appointment at which women have their history taken and are given their pregnancy notes, usually by a midwife, is an important marker in planning care. According to the National Institute for Health and Care Excellence (NICE), pregnancy booking should ideally be

[19] Stephenson J, Heslehurst N, Hall J, Schoenaker DAJM, Hutchinson J, Cade JE, et al. Before the beginning: nutrition and lifestyle in the preconception period and its importance for future health. Lancet. 2018;391:1830-1841. doi: 10.1016/S0140-6736(18)30311-8.
[20] Human Fertilisation & Embryology Authority. Fertility treatment 2023: trends and figures. Available at: https://www.hfea.gov.uk/about-us/publications/research-and-data/fertility-treatment-2023-trends-and-figures/. Accessed 16 October 2025.

carried out by ten weeks' gestation.[21] In the 2024 survey, 68.8% (95%CI: 67.1–70.5) of women had attended their booking appointment by ten weeks' gestation. **Figure 3** shows the proportion of women who attended their booking appointment by ten weeks' gestation across the maternity surveys. The proportion increased between 2006 and 2014 and then remained relatively stable until 2020, before declining slightly by 2.4% (-2.4%; 95%CI -4.8– -0.01, p<0.05) between 2020 and 2024. The figure in the 2024 survey is higher than the routine data for England in 2023–2024 which shows that 63.5% of women had their booking appointment within the first ten weeks of pregnancy (Maternity Services Dataset (MSDS)).[22] **Figure 3** also shows the MSDS figures from 2017–18 through to 2023–24. During this period, the proportion of booking appointments held by ten weeks of pregnancy varied between 58% and 68%.[23] It is important to note that the MSDS is a maturing dataset and while completeness is improving over time, gaps remain in some areas. For gestation at booking, MSDS has a high proportion of missing data (approximately 42% compared with 2% in the 2024 survey).

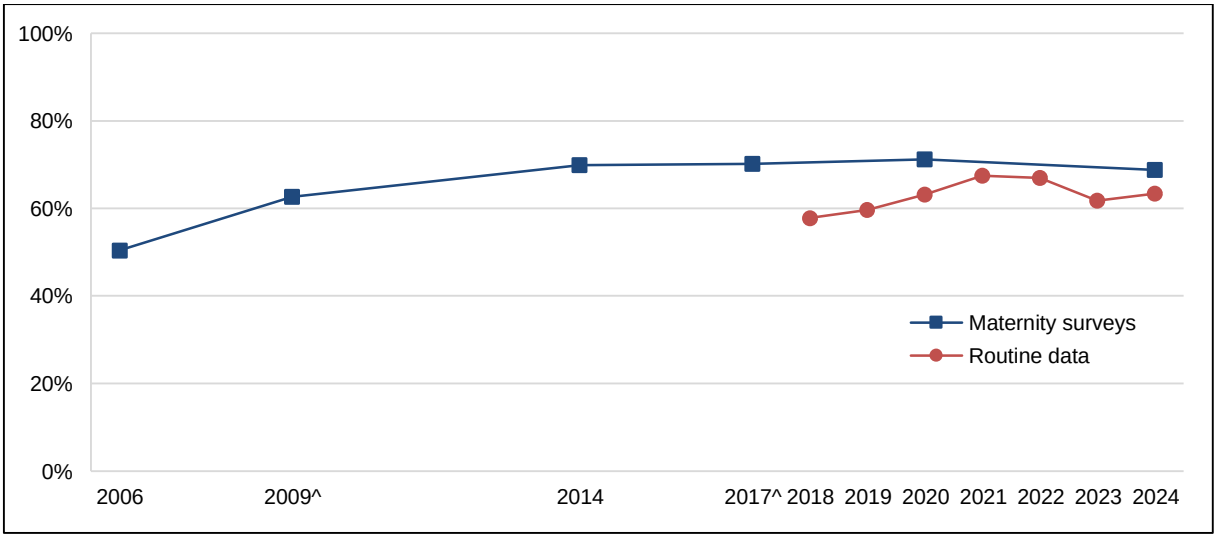

Figure 3: Proportion of women attending booking appointments by ten weeks' gestation across the maternity surveys and from routine data

^ Women gave birth in 2009 and the survey was conducted in 2010; women gave birth in 2017 and the survey was conducted in 2018

Routine antenatal and postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health problems. NICE recommends that all women should be asked about their mental health at their pregnancy booking appointment and at regular contacts in pregnancy.[24] In the 2024 survey, 80.6% (95%CI: 79.1–82.0) of women

[21] National Institute for Health and Care Excellence. QS22: quality statement 1—access to antenatal care. Available at: https://www.nice.org.uk/guidance/qs22/chapter/quality-statement-1-access-to-antenatal-care#quality-statement-1-access-to-antenatal-care. Accessed 16 October 2025.
[22] NHS Digital. NHS maternity statistics 2023-24. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2023-24. Accessed 16 October 2025.
[23] National Institute for Health and Care Excellence. NG201 implementation support toolkit. Available at: https://www.nice.org.uk/guidance/ng201/resources/implementation-support-toolkit-pdf-19754677567429. Accessed 16 October 2025
[24] National Institute for Health and Care Excellence. QS115: quality statement 4—asking about mental health and wellbeing. Available at: https://www.nice.org.uk/guidance/QS115/chapter/Quality-statement-4-Asking-about-mental-health-and-wellbeing. Accessed 16 October 2025.

were asked about their mental health around the time of their booking appointment and 78.9% (95%CI: 77.4–80.4) were asked about their mental health history. **Figure 4** shows the proportion of women who were asked about their mental health and their mental health history across the maternity surveys. There has been some fluctuation over time with between 75% and 84% of women having their mental health and mental health history assessed. These figures are considerably higher than the routine data for England which show that between 48% and 58% of booking appointments between 2019 and 2024 had a record of a risk assessment for mental health issues (58% in 2024).[21] However, as aforementioned, there are issues with completeness in the MSDS. Furthermore, the 2024 survey findings are more consistent with the 2024 maternity survey carried out by the Care Quality Commission (CQC) which found that 76% of women were asked about the mental health at their booking appointment. [25]

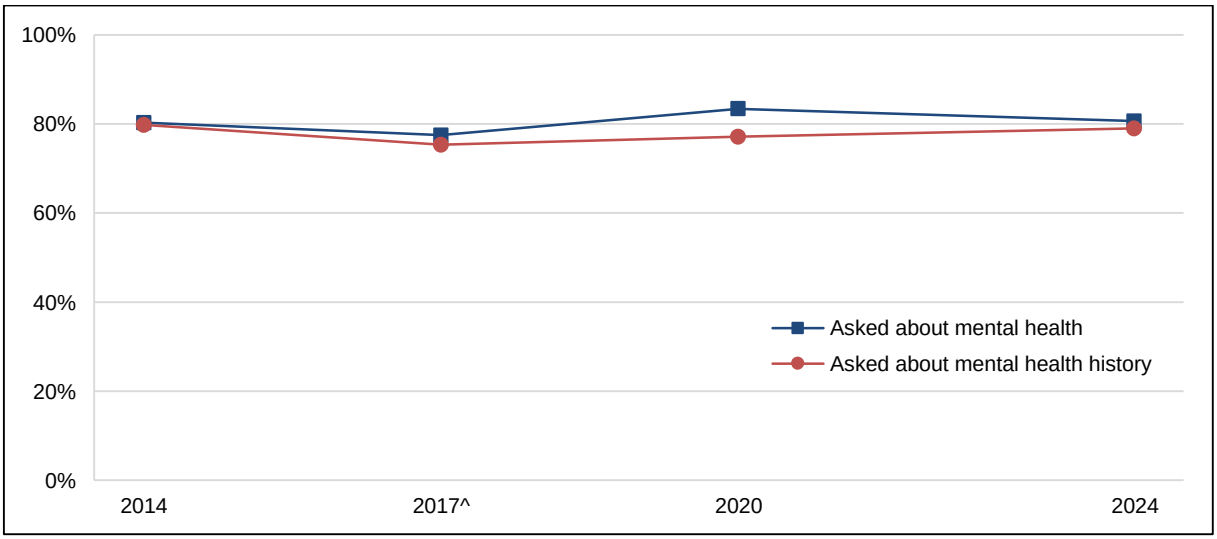

Figure 4: Proportion of women who were asked about their mental health around the time of their booking appointment across the maternity surveys

^ Women gave birth in 2017 and the survey was conducted in 2018

5.1.3 Access to information and preparedness for childbirth

Early, accessible, and evidence-based information is key to high-quality maternity care, as emphasised in the Better Births report.[26] NICE recommends that all pregnant women should have access to tailored, evidence-based information in formats they can understand – including digital.[27] Women in the 2024 survey were asked about access to online information during their pregnancy. The majority of women reported that they could go online as often as they needed to (85.1%), whereas 11.7% of women had more restricted access, and 3.2% did not have access to online

[25] Care Quality Commission. Maternity survey 2024. Available at: https://www.cqc.org.uk/publications/surveys/maternity-survey. Accessed 16 October 2025.
[26] National Maternity Review. Better births: improving outcomes of maternity services in England—A five-year forward view. NHS England; 2016. Available at: https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england/. Accessed 16 October 2025.
[27] National Institute for Health and Care Excellence. Antenatal care (NG201). 2021. Available at: https://www.nice.org.uk/guidance/ng201. Accessed 16 October 2025.

information at all. The proportion of women who did not have access to online information decreased by 4.6% compared with in 2020 (-4.6%, 95%CI: -5.5– -3.6, p<0.05).

Women were asked how prepared they felt for childbirth. Almost half of women reported that they felt very prepared (48.7%), 46.4% of women felt they were somewhat prepared, and 4.9% of women did not feel at all prepared. Comparing primiparous and multiparous women, 36.1% of primiparous women felt very prepared, compared with 58.6% of multiparous women; 7.0% of primiparous women reported that they did not feel at all prepared, compared with 3.3% of multiparous women.

5.1.4 Antenatal classes

Antenatal classes can help women to prepare for childbirth and provide an important source of information and support. Free NHS classes and private classes are available and it is possible for women to attend more than one type of class. Approximately equal proportions of women who took part in the 2024 survey attended free NHS antenatal classes (17.0%) and private antenatal classes (17.6%); 3.1% of women attended both NHS and private classes. **Figure 5** shows attendance at NHS and private antenatal classes for women across the maternity surveys. Overall attendance at NHS antenatal classes has been declining since the 2010 survey and declined significantly in the 2020 survey during the pandemic with only 7.9% of women attending NHS classes. NHS class attendance increased again by 9.1% (95%CI: 5.1–13.1, p<0.05) in the 2024 survey. Overall attendance at private classes has been increasing since the 2014 survey and the increase between the 2020 and 2024 surveys was 5.0% (95%CI: 1.0–9.0, p<0.05). Therefore, both NHS and private antenatal class attendance have increased post-pandemic, but NHS class attendance has not reached pre-pandemic levels, possibly due to some classes not being reinstated following their suspension during the pandemic.

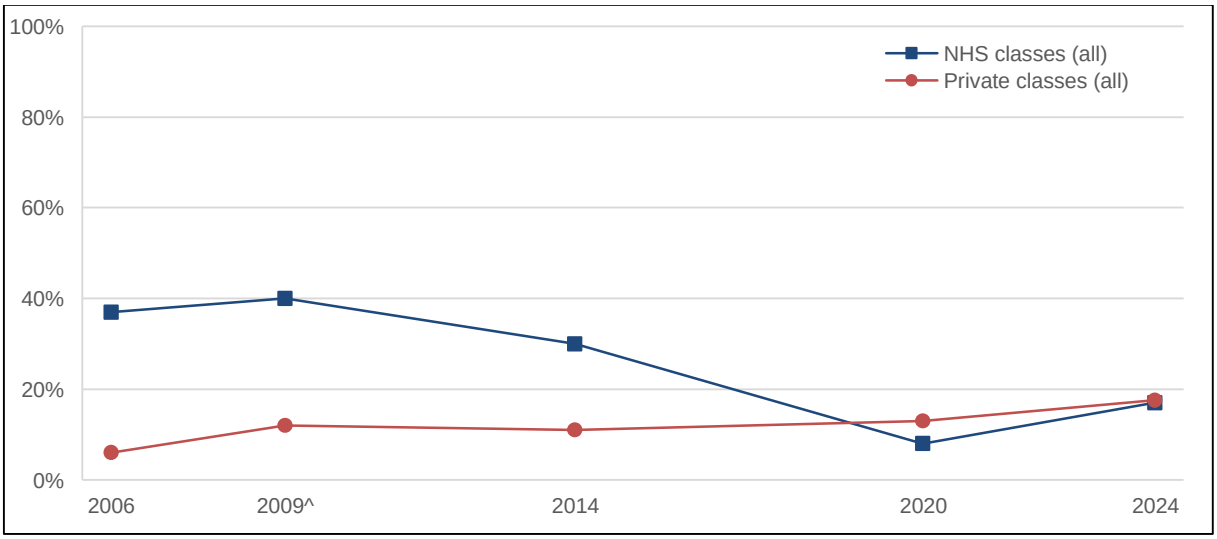

Figure 5: Proportion of women attending NHS and private antenatal classes across the maternity surveys

^ Women gave birth in 2009 and the survey was conducted in 2010

The proportion of primiparous women attending NHS (28.0%) or private (33.6%) antenatal classes was considerably higher than the proportion of multiparous women attending NHS (8.1%) or private (4.9%) classes in the 2024 survey. The lower attendance by multiparous women is to be expected given that NHS classes are often offered only to first-time mothers and more experienced mothers may feel less need for information and support via private classes. **Figure 6** shows attendance at antenatal classes according to parity across the maternity surveys. Although attendance of NHS classes was much higher in primiparous women across all surveys, the pattern of attendance was similar for primiparous and multiparous women. However, attendance of private classes has increased over time for primiparous women, yet has stayed relatively stable at between 3% and 5% for multiparous women. In the 2024 survey, just under half of all first-time mothers did not attend NHS or private antenatal classes.

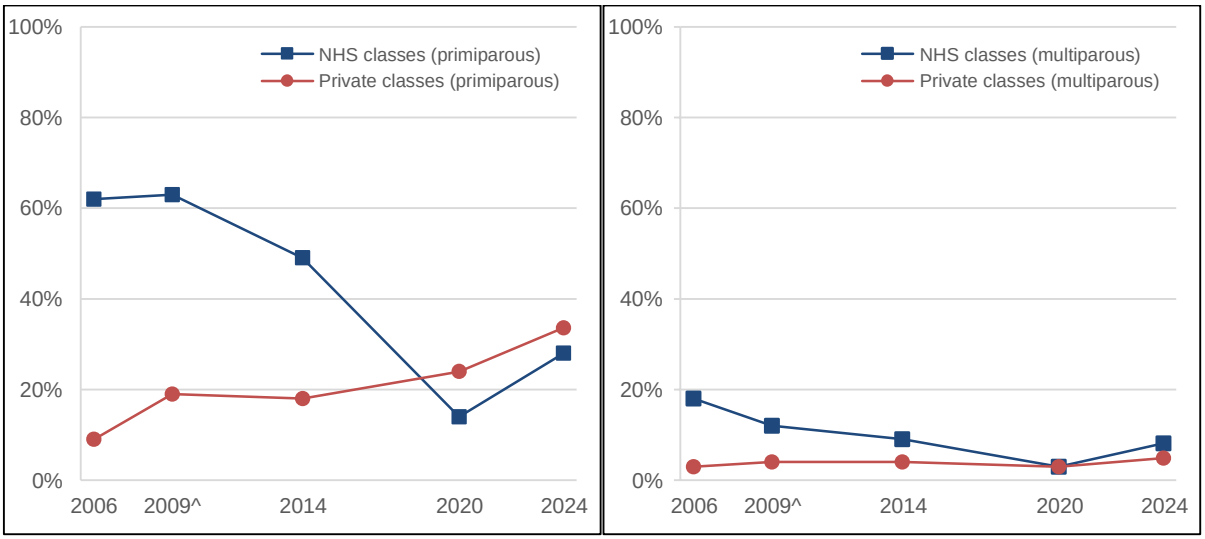

Figure 6: Proportion of primiparous and multiparous women attending NHS and private antenatal classes across the maternity surveys

^ Women gave birth in 2009 and the survey was conducted in 2010

5.1.5 Vaccinations during pregnancy

Vaccinations during pregnancy are an important part of protecting both the mother and the baby from serious infections. Some vaccines are specifically recommended during pregnancy because they help transfer protective antibodies to the baby before birth. Women were asked whether or not they had received the following vaccinations during their pregnancy: flu, whooping cough, respiratory syncytial virus (RSV), and Covid-19. The uptake was highest for whooping cough (81.5%, 95%CI: 79.9–83.0), followed by flu (67.1%, 95%CI: 65.3–68.8) and then Covid-19 (26.3%, 95%CI: 24.8–27.8). The uptake was lowest for RSV (12.1%, 95%CI: 10.9–13.4).

5.1.6 Pregnancy: key findings

In the 2024 survey, most women reported that their pregnancy was planned, with a small number conceiving through fertility treatments. The majority were happy to find out they were pregnant,

though some had mixed feelings or were unhappy. About two-thirds of women attended their pregnancy booking appointment by ten weeks gestation, a rate that has varied slightly across the maternity surveys and remains above estimates from national routine data. Most women were asked about their current mental health and about their personal or family history of mental health problems during their booking appointment. Access to online pregnancy information improved compared with the previous survey in 2020, with more women able to go online freely and fewer without any access. When it came to feeling prepared for childbirth, nearly half felt very ready, but first-time mothers tended to feel less prepared than those who had given birth before. Attendance of private antenatal classes has increased and attendance of NHS antenatal classes has rebounded since the pandemic survey in 2020, although not to pre-pandemic levels (2006 to 2014 surveys), particularly for first-time mothers. Vaccination rates were highest for whooping cough, followed by flu and Covid-19, while very few women received the RSV vaccine during their pregnancy.

5.1.7 Pregnancy: summary data

Table 1: Summary of pregnancy data

	n*	%^
Pregnancy planning		(N=3719)
Planned	2981	74.5
Unplanned	738	25.5
Fertility treatment		(N=3700)
Yes	232	5.0
No	3468	95.0
IVF treatment		(N=3700)
Yes	191	3.9
No	3509	96.1
Reaction to pregnancy		(N=3723)
Overjoyed	2071	52.1
Pleased	766	20.9
Mixed feelings	688	21.5
Unhappy	50	1.7
No particular feelings or other	148	3.9
Timing of booking appointment		(N=3666)
Within 10 weeks	2632	68.8
Between 11–12 weeks	655	19.0
Between 13–18 weeks	313	10.0
Later than 18 weeks	66	2.2
Asked about mental health at booking appointment		(N=3725)
Yes	3042	80.6
No	299	9.0
Don’t know	384	10.4
Asked about mental health history at booking appointment		(N=3708)
Yes	2937	78.9
No	381	10.9
Don’t know	390	10.2
Access to online information		(N=3714)
All the time	3281	85.1
Sometimes	346	11.7
Not at all	87	3.2

Preparedness for childbirth		(N=3723)
Very prepared	1778	48.7
Somewhat prepared	1780	46.4
Not at all prepared	165	4.9
Attendance at antenatal classes[+]		(N=3721)
NHS classes	704	17.0
Private classes	901	17.6
No classes	2300	68.8
Vaccinations[+]		
Flu (N=3680)	2622	67.1
Whooping cough (N=3689)	3169	81.5
Respiratory syncytial virus (N=3605)	417	12.1
Covid-19 (N=3620)	1128	26.3

* Unweighted totals ^ Weighted prevalence [+] Multiple options could be selected

5.2 Childbirth

Summary childbirth data for the respondents to the 2024 survey are presented in **Table 2** in section 5.2.12 on pages 20–21.

5.2.1 Place of birth

The majority of women planned to give birth in hospital (77.1%, 95%CI: 75.6–78.5), but almost a quarter had an alternative birth plan: 13.6% (95%CI: 12.5–14.7) planned to give birth in an alongside midwife-led unit, 4.2% (95%CI: 3.6–4.9) in a freestanding midwife-led unit, and 4.6% (95%CI: 4.0–5.4) planned to give birth at home. In terms of actual place of birth, 89.3% (95%CI: 88.2–90.3) gave birth in hospital, 6.2% (95%CI: 5.4–7.0) in an alongside midwife-led unit, 1.1% (95%CI: 0.8–1.5) in a freestanding midwife-led unit, and 3.0% (95%CI: 2.5 to 3.7) at home. In total, 14.9% of women did not give birth where they had planned to. The proportions of women giving birth in different settings were similar to in the 2020 survey (88.0% in hospital, 8.7% in a midwife-led unit, and 2.4% at home). The proportion of women giving birth outside of hospital settings was slightly higher than the most recent estimate from the UK Midwifery Study System (for midwifery unit births)[28] and the most recent routine data on home births, which shows that 1.7% of births took place at home in 2024.[29] A small proportion (2.0%, 95%CI:1.5–2.6) of women who took part in the 2024 survey had a freebirth, where they planned to and gave birth without a midwife present.

5.2.2 Induction

Induction of labour is a medical intervention that can affect women's birth options and their experience of the birth process.[30] NICE recommends that women should be fully informed about what induction entails and should be involved in the decision of whether or not to be induced.

[28] Newman T, Dennis R, Fitzpatrick K, Heazell AEP, Kenyon S, Sanders J, Rowe R. Numbers and proportions of women giving birth in UK midwifery units since 2016: A secondary analysis of data reported to the UK Midwifery Study System (UKMidSS). Personal communication.
[29] Office for National Statistics. Births in England and Wales, birth registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsinenglandandwalesbirthregistrations Accessed 16 October 2025.
[30] National Institute for Health and Care Excellence. NG207 guidance. Available at: https://www.nice.org.uk/guidance/ng207. Accessed 16 October 2025.

Almost three-quarters (72.5%) of women who took part in the 2024 survey reported that they had gone into labour, and a third (34.9%) of these women reported that their labour was induced. Therefore, a quarter (25.3%, 95%CI: 23.7–26.9) of all women were induced, which is lower than the rate of 32.5% in the routine data for all women giving birth in England during 2023–2024 (Hospital Episode Statistics (HES)).[22] However, it is notable that the method of onset was unknown for over a quarter (26.9%) of women in the HES data. The most frequent method of induction for women in the 2024 survey was by vaginal gel or pessary (65.9%), followed by amniotomy (55.9%), and by a drip (39.0%), and many women had more than one intervention. While the majority of women (97.6%) knew why their labour was induced, 21.3% felt they had not received enough information about the induction process, and 23.6% felt they had insufficient information about how long it might take. In addition, 17.0% of women did not feel they were involved enough in the decision about being induced and 26.0% were not given a choice about whether or not to be induced. For almost a third (31.9%) of women who were induced, the process from the start of their induction until the birth of their baby was under 12 hours. For almost another third (31.8%) of women, the process took between 12–24 hours. Induction took 24–72 hours for 28.0% of women and, for 8.3% of women, it was longer than 72 hours.

5.2.3 Mode of birth

NICE recommends that pregnant women should be offered evidence-based information and support to enable them to make informed decisions about childbirth.[27] Data from previous surveys indicate that the caesarean section rate is gradually rising among survey respondents, increasing from 22.8% in 2006 to 29.9% in 2020. In 2024, the caesarean section rate rose again to 40.1%, an increase of 10.2% (95%CI: 6.7–13.7, $p<0.001$). Just under half (48.5%) of the women in the 2024 survey had a spontaneous vaginal birth and 11.5% had births involving instrumental assistance (forceps or ventouse). The 2024 survey data are very similar to routine data for all women giving birth in England during 2023–2024, which show that 42% of births were caesarean sections, 46% were spontaneous vaginal births, and 11% had instrumental assistance (HES).[22]

Figure 7 shows the mode of birth for all women who took part in the 2024 survey and a breakdown of mode of birth according to parity. Primiparous women were more likely to have an instrumental birth (forceps or ventouse) (19.2%) or a caesarean section (43.5%), compared with multiparous women (5.0% for instrumental birth and 37.2% for caesarean section).

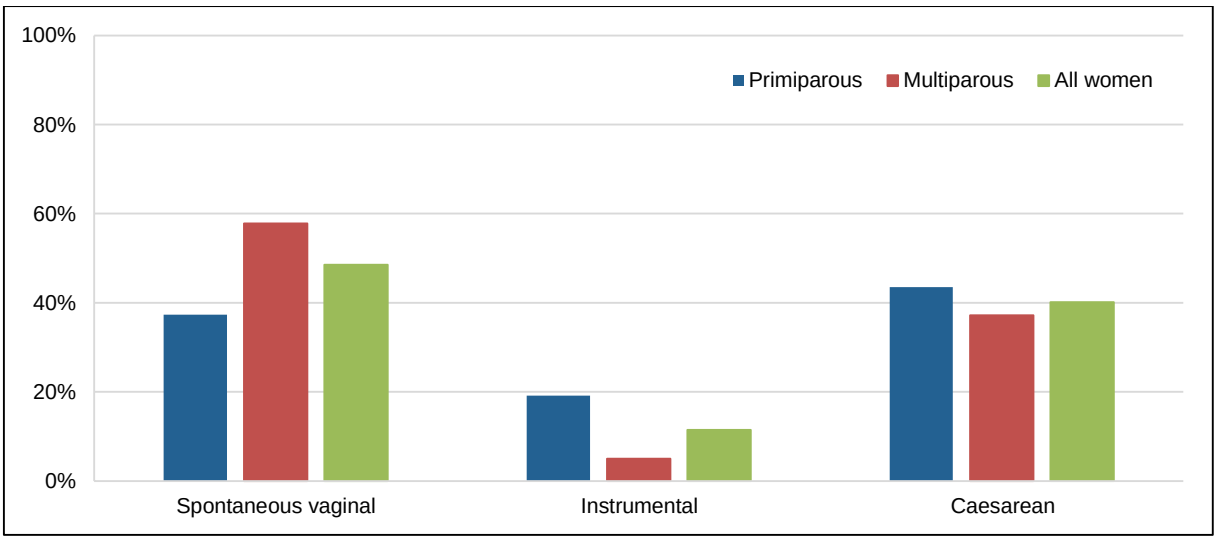

Figure 7: Mode of birth for primiparous, multiparous and all women

For those women in the 2024 survey who had a caesarean section, almost equal numbers were planned (50.7%) and unplanned (49.3%, 95%CI: 46.6–52.1). In comparison, in the 2020 survey, 53.9% of caesarean sections were planned and 46.1% were unplanned. The rate of unplanned caesarean sections in the 2024 survey is lower than in the routine data for all women who gave birth in England in 2023–24, which show that 56% of caesarean sections were carried out as an emergency (HES).[31]

5.2.4 Episiotomies and tears

An episiotomy is a cut made by a healthcare professional into the perineum and vaginal wall to make more space for the baby to be born. A tear happens spontaneously as the baby stretches the vagina during birth. It is also possible for an episiotomy to extend and become a deeper tear.[32] Of the women in the 2024 survey who had a spontaneous vaginal or instrumental birth, 27.6% had an episiotomy, 54.8% had a tear, and 10.9% had both. A small proportion of women were unsure whether they had an episiotomy and/or a tear. Women who had a spontaneous vaginal birth were more likely to have a tear (59.2%) and less likely to have an episiotomy (13.9%), whereas women who had an instrumental birth were more likely to have an episiotomy (85.5%) and less likely to have a tear (36.0%). Primiparous women were more likely to have an episiotomy (46.5%) and more likely to have a tear (61.8%) than multiparous women (13.3% episiotomy and 49.9% tear). The proportion of all women who had a tear (including those who had a caesarean birth in the denominator) was 32.7%, which is slightly below the routine data for all women who gave birth in England in 2023–24 (36%).[22]

[31] NHS Digital. Hospital episode statistics maternity dataset 2023-24. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2023-24. Accessed 16 October 2025.
[32] Royal College of Obstetricians and Gynaecologists. Perineal tears and episiotomies in childbirth. Available at: https://www.rcog.org.uk/for-the-public/perineal-tears-and-episiotomies-in-childbirth/episiotomy/. Accessed 16 October 2025.

5.2.5 Multiple births and sex of baby

In the 2024 survey, 1.2% of respondents had a multiple birth, which is consistent with the overall sample of women selected (respondents and non-respondents), and the sample in turn was representative of all women giving birth in England during the sampling period (see **Appendix F**). There were almost equal numbers of male (49.3%) and female babies (50.7%) born to the women who responded to the 2024 survey.

5.2.6 Gestational age and birth weight

The median gestational age of the babies born to the women in the 2024 survey was 39 weeks (interquartile range=38–40 weeks). The proportion of babies born preterm (before 37 weeks' gestation) was 7.7% (95%CI: 6.8–8.7). The preterm birth rate was consistent with the 2020 survey (7.5%) and also with the most recent routine data available, which show that 7.8% of the babies born in England and Wales during 2024 were preterm (ONS).[33]

The median birth weight of the babies born to women in the 2024 survey was 3,400 grams (interquartile range=3,060–3,700 grams). The proportion of babies who were low birth weight (weighing less than 2,500 grams) was 4.9% (95%CI: 4.1–5.7) in the 2024 survey. The rate of low birth weight babies was lower than in the 2020 survey (6.7%), and was also slightly lower than for the overall sample of women selected for the 2024 survey (respondents and non-respondents) (5.6%) (see **Appendix F**).

5.2.7 Neonatal care

In the 2024 survey, 12.0% (95%CI: 10.9–13.3) of babies were admitted to neonatal care and 72.5% of these babies were discharged within seven days. Almost one in ten babies admitted to neonatal care stayed for longer than 28 days (9.4%). **Figure 8** shows neonatal care admissions according to mode of birth, gestational age and birth weight. For example, of all babies who were born preterm (<37 weeks), 53.4% were admitted to neonatal care, compared with 8.6% of babies who were born at 37 weeks or later. As expected, babies born by caesarean section, preterm or with low birth weight were more likely to be admitted to neonatal care.

[33] Office for National Statistics. Births in England and Wales, linked births. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsinenglandandwaleslinkedbirths. Accessed 16 October 2025.

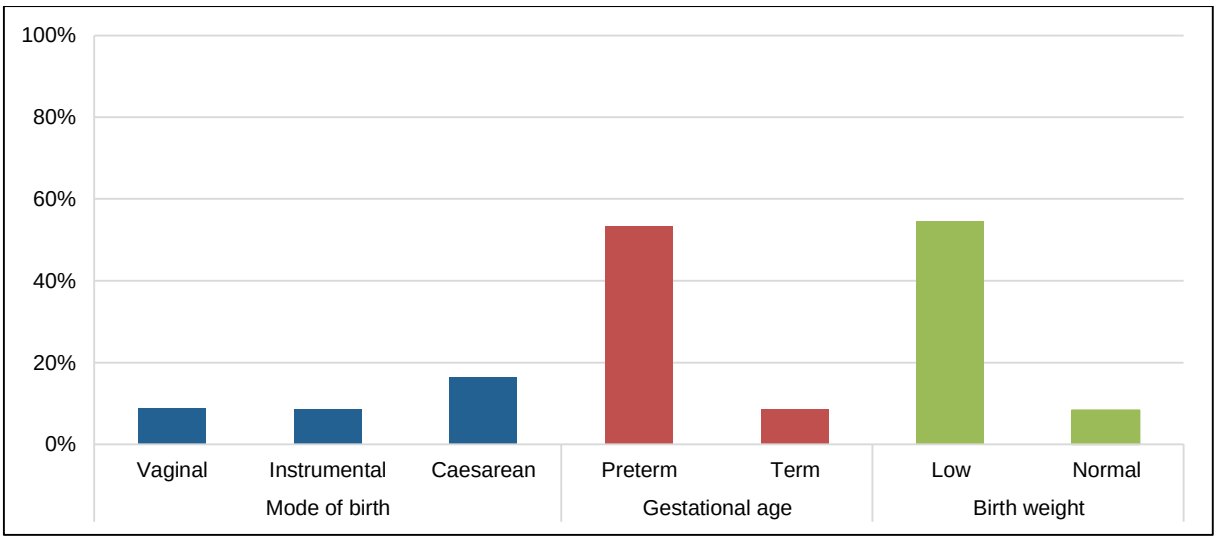

Figure 8: Proportion of neonatal care admissions by mode of birth, gestational age and birth weight

5.2.8 Holding the baby and skin-to-skin contact

Skin-to-skin contact between mother and baby straight after birth helps the baby to regulate temperature, breathing and heart rate, boosts immunity, reduces stress, and supports bonding and successful breastfeeding.[34] The large majority (92.0%, 95%CI: 91.0–92.9) of women in the 2024 survey held their baby immediately or within the first hour after birth and 88.3% (95%CI: 87.1–89.4) of women had skin-to-skin contact with their baby immediately or within the first hour. In the 2020 survey, these figures were 93.4% and 91.3% respectively. This represents a small decrease of 1.4% (-1.4%, 95%CI: -2.6– -0.2, p<0.05) in the proportion of women holding their baby and a slighter larger decrease of 3.0% (-3.0%, 95%CI: -4.4– -1.6, p<0.01) in the proportion of women having skin-to-skin contact soon after birth between the 2020 and 2024 surveys.

Among women who gave birth at 37 weeks' gestation or later, 90.2% (95%CI: 89.1 to 91.3) had skin-to-skin contact with their baby within the first hour after birth. This is notably higher than the 74.7% reported in routine data for May 2024 (NHS Digital MSDS). [22] Therefore, the 2024 survey shows a greater proportion of women experiencing skin-to-skin contact within an hour of birth compared with the routine data for England. However, it is important to note that the MSDS is a maturing dataset and while completeness is improving over time, gaps remain in some areas.[35] For skin-to-skin contact, the MSDS data for May 2024 has a high proportion of missing data (17.3% compared with 1.7% in the 2024 survey).

[34] National Health Service. Skin-to-skin contact with your newborn. Available at: https://www.nhs.uk/start-for-life/baby/baby-basics/caring-for-your-baby/skin-to-skin-contact-with-your-newborn/. Accessed 16 October 2025.
[35] NHS Digital. Maternity services monthly statistics, May-Jun 2024. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics/final-may-2024-provisional-june-2024-official-statistics/data-quality-statement. Accessed 16 October 2025.

5.2.9 Length of hospital stay

Depending on the type of birth and whether or not there are complications, the length of time women stay in hospital after giving birth can vary from a few hours to several weeks or, for some women, even longer. In the 2024 survey, 44.6% of women who gave birth in hospital or a midwife-led unit were discharged within one day (24 hours) after the birth and 70.0% were discharged within two days (48 hours). **Figure 9** shows women's length of stay in hospital after childbirth according to the mode by which they gave birth. Women who had a vaginal birth were more likely to have a shorter stay in hospital, compared with women who had an instrumental or caesarean birth. Longer stays of five or more days were most likely for women who had a caesarean birth.

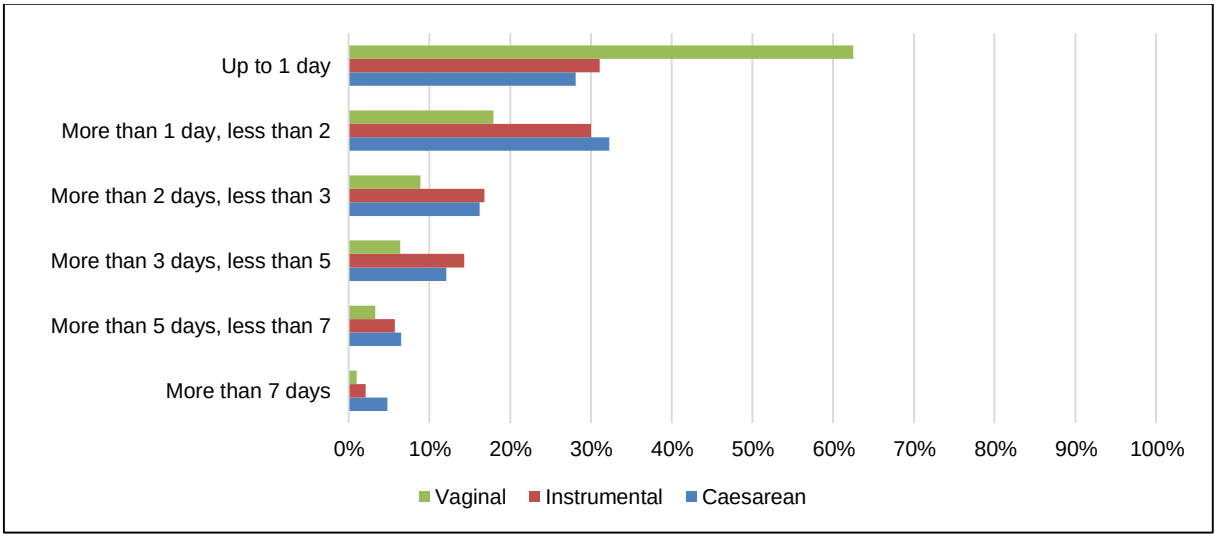

Figure 9: Women's length of postnatal hospital stay according to mode of birth

5.2.10 Childbirth experience

Women were asked about how their experiences of labour and childbirth met with their expectations. More women reported that their labour and/or childbirth was better than they had expected (46.7%) as opposed to being in line with their expectations (27.0%) or worse than they had expected (26.3%). However, primiparous women were more likely to experience the labour and/or childbirth as worse than they were expecting (34.8%), compared with multiparous women (19.4%). The proportions of primiparous and all women who found the birth worse than they were expecting were slightly lower than during the pandemic (38.6% of primiparous women, 19.8% of multiparous women, and 28.4% of all women).

5.2.11 Childbirth: key findings

Most women planned to give birth in hospital, though nearly a quarter chose alternatives such as midwife-led units or home births, with actual birth locations differing to planned locations for a significant number of women. About a quarter of women had their labour induced, yet many of these women felt uninformed about what this entailed or not fully involved in the decision-making

process. Caesarean section rates increased significantly reaching over 40%, with first-time mothers more likely to have caesarean or instrumental births. Many women experienced tears or episiotomies during spontaneous vaginal or instrumental births, with first-time mothers more likely to experience both. About one in eight babies required neonatal care, and most of these babies were discharged within a week. Skin-to-skin contact within an hour after birth for full-term babies showed a slight decline compared with previous years, but remained high and exceeded estimates from national routine data. The length of hospital stays after birth varied widely, with women who had an instrumental or caesarean birth being more likely to have a longer stay. Over a quarter of women rated their childbirth experience as worse than expected, and this was more likely for first-time mothers.

5.2.12 Childbirth: summary data

Table 2: Summary of childbirth data

	n*	%^
Planned place of birth		(N=3723)
Home	193	4.6
Hospital	2747	77.1
Freestanding midwife-led unit	176	4.2
Alongside midwife-led unit	592	13.6
Other	15	0.6
Place of birth		(N=3710)
Home	111	3.0
Hospital	3296	89.3
Freestanding midwife-led unit	48	1.1
Alongside midwife-led unit	244	6.2
Other	11	0.4
Labour		(N=3711)
Yes	2659	72.5
No	1052	27.5
Induction		(N=3706)
Yes	912	25.3
No	1742	47.2
No labour	1052	27.5
Method of labour induction [+]		(N=912)
Vaginal gel or pessary	619	65.9
Amniotomy	491	55.9
Drip	378	39.0
Duration of induction		(N=903)
Under 12 hours	274	31.9
From 12 hours up to 24 hours	278	31.8
From 24 hours up to 48 hours	181	18.1
From 48 hours up to 72 hours	97	9.9
Longer than 72 hours	73	8.3
Mode of birth		(N=3712)
Spontaneous vaginal	1693	48.5
Forceps	310	7.4
Ventouse	154	4.1
Caesarean section	(1555)	(40.1)
Planned	792	20.3
Unplanned	763	19.8

Episiotomy		(N=2154)
Yes	632	27.6
No	1468	69.1
Don't know	54	3.3
Tear		(N=2150)
Yes	1217	54.8
No	837	39.8
Don't know	96	5.5
Single or multiple birth		
Single baby	3679	98.8
Twins or more	49	1.2
Sex of baby		
Male	1863	49.3
Female	1865	50.7
Gestational age in weeks		(N=3712)
<32 weeks	36	1.2
32-36 weeks	241	6.5
37+ weeks	3435	92.3
Median gestational age in weeks (IQR)		39 (38-40)

Birth weight in grams		(N=3614)
<1500 grams	15	0.5
1500-2499 grams	155	4.4
2500+ grams	3444	95.1
Median birth weight in grams (IQR)		3400 (3060-3700)

Baby stayed in neonatal care		(N=3720)
No	3297	88.0
Yes	423	12.0
Length of neonatal stay		(N=423)
≤ 1 day (24 hours)	123	31.8
> 1 day to 7 days	177	40.8
> 7 days to 28 days	78	18.1
> 28 days	45	9.4
When the mother first held the baby		(N=3700)
Immediately	2677	72.9
Not immediately but within an hour	738	19.1
More than one hour later	285	8.0
When mother and baby first had skin-to-skin contact		(N=3666)
Immediately	2371	65.7
Not immediately but within an hour	868	22.6
More than one hour later	427	11.7
Mother's length of hospital admission		(N=3603)
≤ 1 day (24 hours)	1546	44.6
> 1 day to 2 days	978	25.3
> 2 days to 3 days	456	12.8
> 3 days to 5 days	353	9.7
> 5 days to 7 days	174	4.9
> 7 days	96	2.7
Experience of labour and birth		(N=3719)
Better than expected	1669	46.7
More or less as expected	1008	27.0
Worse than expected	1042	26.3

* Unweighted totals ^ Weighted prevalence + Multiple options could be selected IQR=interquartile range

5.3. Maternity care during pregnancy, childbirth and in the postnatal period

Summary maternity care data for the respondents to the 2024 survey are presented in **Table 3** in section 5.3.9 on pages 29–30.

5.3.1 Type of care

Almost all women reported that they had either used the NHS only for their maternity care (97.4%) or they had used both the NHS and private care (2.4%). Only 0.3% of women reported that they had used private care exclusively.

5.3.2 Midwifery care

The Midwifery Continuity of Carer (MCoC) model is a way of delivering maternity care so that women receive dedicated support from the same midwifery or clinical team throughout the three phases of their maternity journey: pregnancy, labour and birth, and the postnatal period.[36] Guidance on delivering MCoC at full-scale was published in 2021 which stipulated that MCoC should be the default model offered to all pregnant women by March 2023.[37] Over half (61.0%, 95%CI: 59.2–62.7) of the women who took part in the 2024 survey reported that there was a single midwife or small team of midwives who looked after them during their pregnancy, labour and birth, and at home during the postnatal period.

Women in the 2024 survey were asked how many different midwives cared for them during their pregnancy and during their labour and childbirth. Most women received care from more than one midwife during their pregnancy: almost half (49.4%) of women were cared for by two or three midwives and a third of women were cared for by four or more midwives (34.0%). During labour and childbirth, 52.6% of women were cared for by two or three midwives, and 36.5% of women were cared for by four or more midwives. The large majority (78.8%) of women reported that they had never met any of the midwives who cared for them during labour and childbirth, which in some cases may be due to different members of their midwifery team being present for the birth.

Women were asked about the contact they had with a midwife at home after the birth of their baby. The majority (91.7%) of women had at least one contact, either face-to-face or over the telephone. Almost half (48.1%) of women had three or more contacts, 28.3% had contact twice, and 15.3% had contact with a midwife only once at home after the birth of their baby. Of the women who had multiple contacts, a third (34.5%) had contact with the same midwife. Women were asked whether they would have liked to have had contact with a midwife more or less often after giving birth. Overall, 34.1% would have liked more contact, 8.7% would have liked less contact, and 57.2% had as much contact as they wanted. **Figure 10** shows how much contact women wanted with a midwife according to how much contact they had. Regardless of how many contacts women had, only 8%–10% said they would have liked fewer, whereas women who had two or fewer contacts were more likely to want more contact, compared with those women who had three or more contacts. Notably,

[36] Royal College of Midwives. Position statement: midwifery continuity of carer. Available at: https://www.rcm.org.uk/wp-content/uploads/2024/06/rcm-position-statement-midwifery-continuity-of-carer-mcoc.pdf. Accessed 16 October 2025.
[37] NHS England. Delivering midwifery continuity of carer at full scale. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf. Accessed 16 October 2025.

41.2% of women who reported no postnatal contact with a midwife indicated that this was what they wanted.

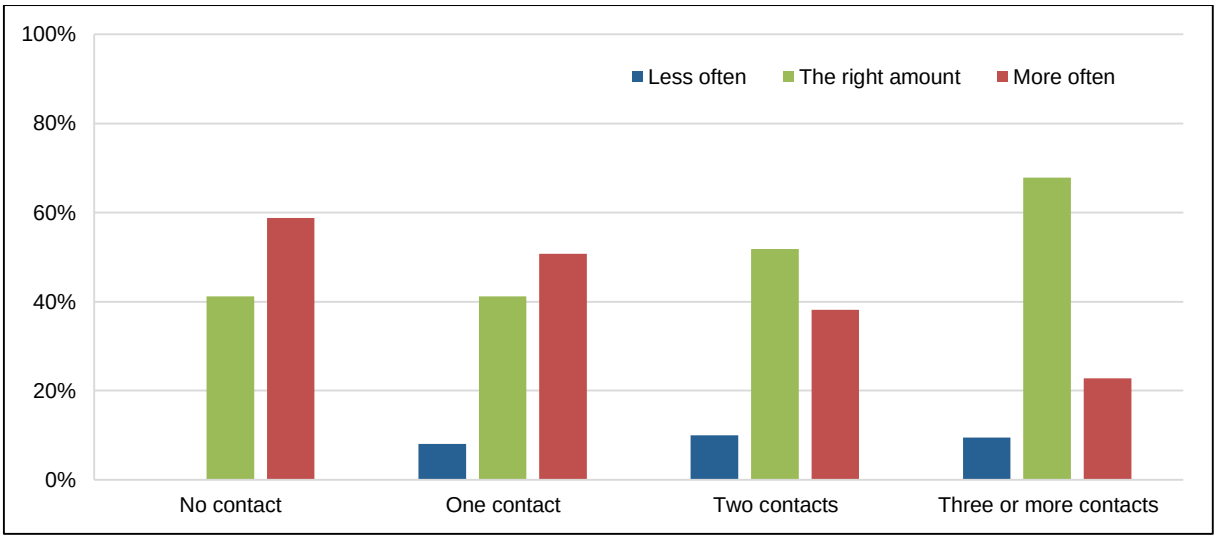

Figure 10: Women's preferred postnatal midwifery contact according to actual midwifery contact

Figure 11 shows the proportion of women who wanted more postnatal contact with a midwife across the maternity surveys. This increased from 18.3% in the 2006 survey to 49.8% in the 2020 survey, before decreasing again to 34.1% in the 2024 survey. Therefore, the proportion of women who wanted more postnatal midwifery contact was highest during the pandemic, but has not returned to pre-pandemic levels in the latest survey.

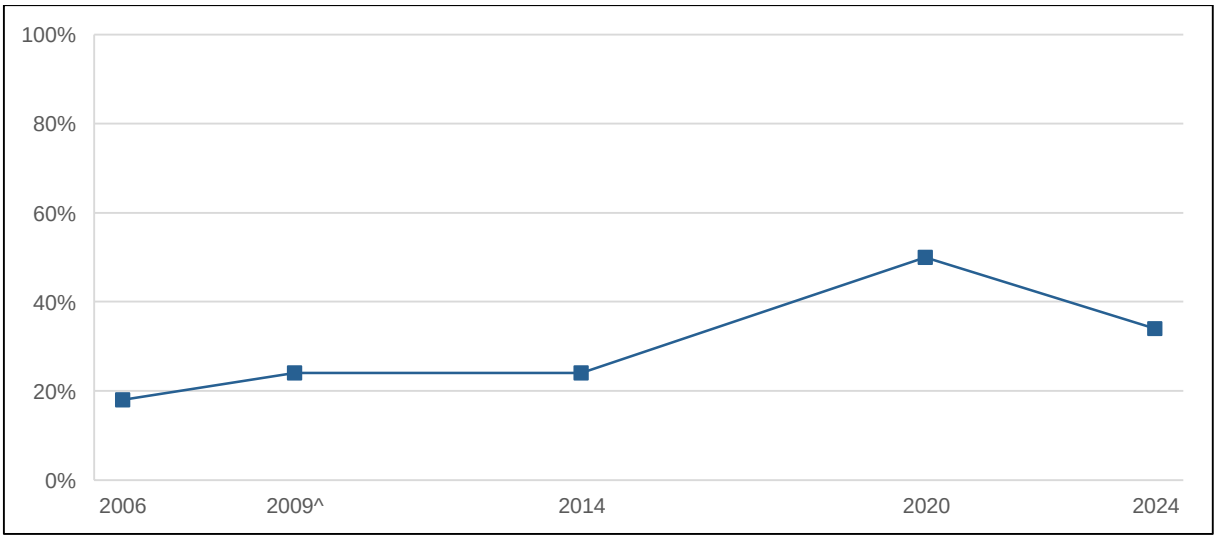

Figure 11: Proportion of women who wanted more postnatal midwifery contact across the maternity surveys

^ Women gave birth in 2009 and the survey was conducted in 2010; women gave birth in 2017 and the survey was conducted in 2018

5.3.3 Six-week postnatal check

A standardised postnatal check for women six (to eight) weeks after childbirth has been included as an essential service in the GP contract since 2020.[38] The six-week check is important to ensure women are feeling well both physically and mentally and that they are recovering from pregnancy and childbirth.[39] In the 2024 survey, 93.0% (95%CI: 92.0–93.9) of women reported that they had a six-week check at their GP surgery. Some of the reasons given for not attending included not being invited or not feeling it was necessary. Some women reported that they had a postnatal check but that it was later than six (to eight) weeks and/or it was over the telephone. **Figure 12** shows the proportion of women who reported that they had a six-week check at their GP surgery across the maternity surveys. The rate fluctuated between 84% and 91% from 2006 to 2020. The proportion of women attending a six-week check was lowest during the pandemic (84.1%) and highest in the 2024 survey (93.0%), an increase of 8.9% (95%CI: 7.5–10.3, p<0.01).

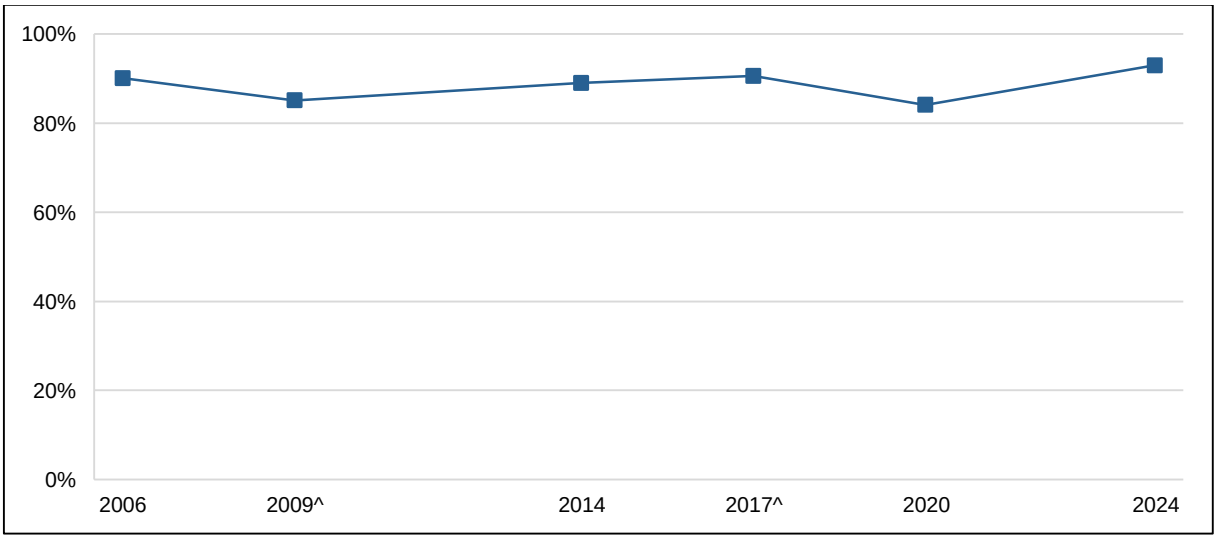

Figure 12: Proportion of women having a six-week check across the maternity surveys

^ Women gave birth in 2009 and the survey was conducted in 2010; women gave birth in 2017 and the survey was conducted in 2018

Note: In the 2020 and 2024 surveys, women were asked whether they had a postnatal check at their GP surgery. In previous surveys, women were asked whether they had a postnatal check with their GP.

Of the women who indicated that they attended a six-week check, 82.4% were carried out by a GP, 6.1% by a nurse, 6.0% by a health visitor, 1.8% by another health professional, and 3.7% of women were unsure who carried out the check. The majority of women reported that they had time to talk about their own health, but 15.4% said they talked only about the baby. In addition to checking on women's health and wellbeing following pregnancy and childbirth, the six-week check should include discussion about contraception and family planning and, for some women, a blood pressure

[38] British Medical Association. GP contract agreement Feb 2020. Available at: https://www.bma.org.uk/media/2024/gp-contract-agreement-feb-2020.pdf. Accessed 16 October 2025.
[39] National Health Service. Postnatal check. Available at: https://www.nhs.uk/conditions/pregnancy-and-baby/postnatal-check/. Accessed 16 October 2025.

check is also indicated. Most women in the 2024 survey could recall discussing contraception and family planning (85.9%) and 61.3% of women could recall having their blood pressure taken.

Women are particularly vulnerable during the postnatal period and it is critical that mental health is assessed so that those women with mental health needs can be identified and supported.[40] In the 2024 survey, 79.9% (95%CI: 78.4–81.4) of women were asked about their mental health in the postnatal period and 83.8% of these women indicated that this was at their six-week check. **Figure 13** shows the proportion of women who were asked about their mental health during the postnatal period across the maternity surveys. This declined from 88.2% in the 2014 survey to 73.7% in the 2020 survey, before increasing again by 6.2% (95%CI: 4.1–8.3, p<0.01) in the 2024 survey. Still, one in five women who took part in the 2024 survey were either not asked about their mental health (15.5%) or could not recall being asked about their mental health (4.6%) during the postnatal period.

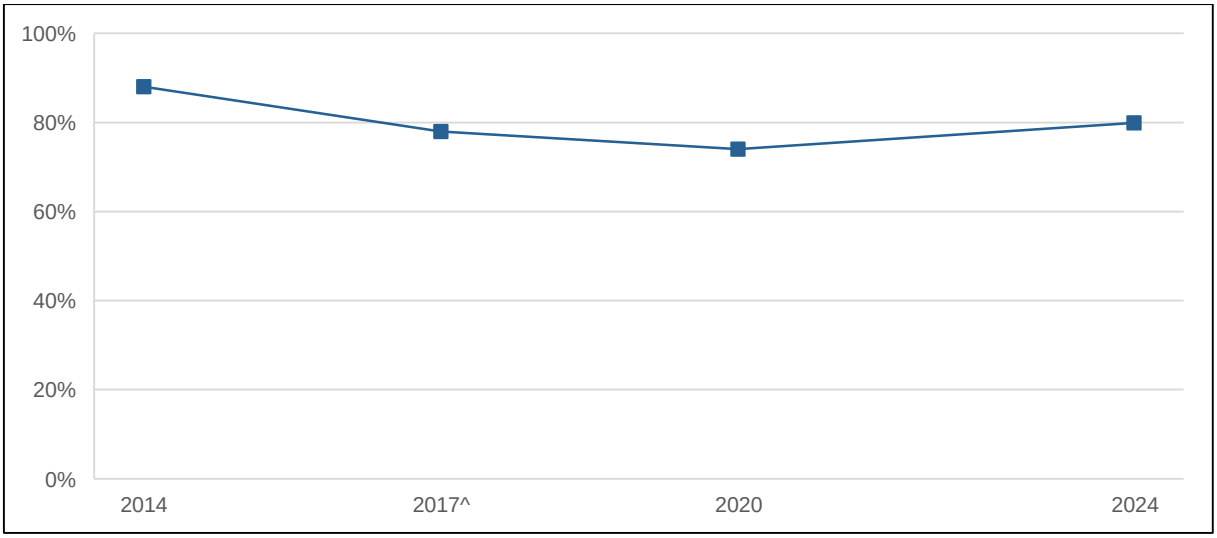

Figure 13: Proportion of women who were asked about their mental health during the postnatal period across the maternity surveys

^ Women gave birth in 2017 and the survey was conducted in 2018

5.3.4 Perception of health professional behaviour

Respectful care is essential across all maternity care settings and serves as a key indicator of the overall quality of care. Women were asked about how health professionals behaved towards them during different phases of their maternity care: during pregnancy, labour and childbirth, and in hospital after childbirth. The questions addressed five different aspects of health professional behaviour and women indicated whether staff always, sometimes or never behaved towards them in this way: being talked to in a way they could understand, being listened to, being treated with respect, kindness, and as an individual. **Figure 14** shows the proportion of women who reported

[40] National Institute for Health and Care Excellence. CG192 guidance. Available at: https://www.nice.org.uk/guidance/cg192. Accessed 16 October 2025.

that health professionals always displayed each of these behaviours towards them. The proportions vary between 65% and 84% depending on the particular aspect of behaviour and the maternity phase. The aspects of behaviour most frequently recognised by women were always being talked to in a way they could understand, and always being treated with respect and kindness, whereas the aspect of behaviour least frequently recognised was always being listened to. Women reported more positive experiences during pregnancy, labour and childbirth than in hospital after childbirth. In the previous survey in 2020, women were asked this question only in relation to their care during labour and childbirth. The proportion of women who recognised each of the aspects of health professional behaviour during labour and childbirth was lower in 2024, compared with in 2020 (see pink striped bars in **Figure 14**).

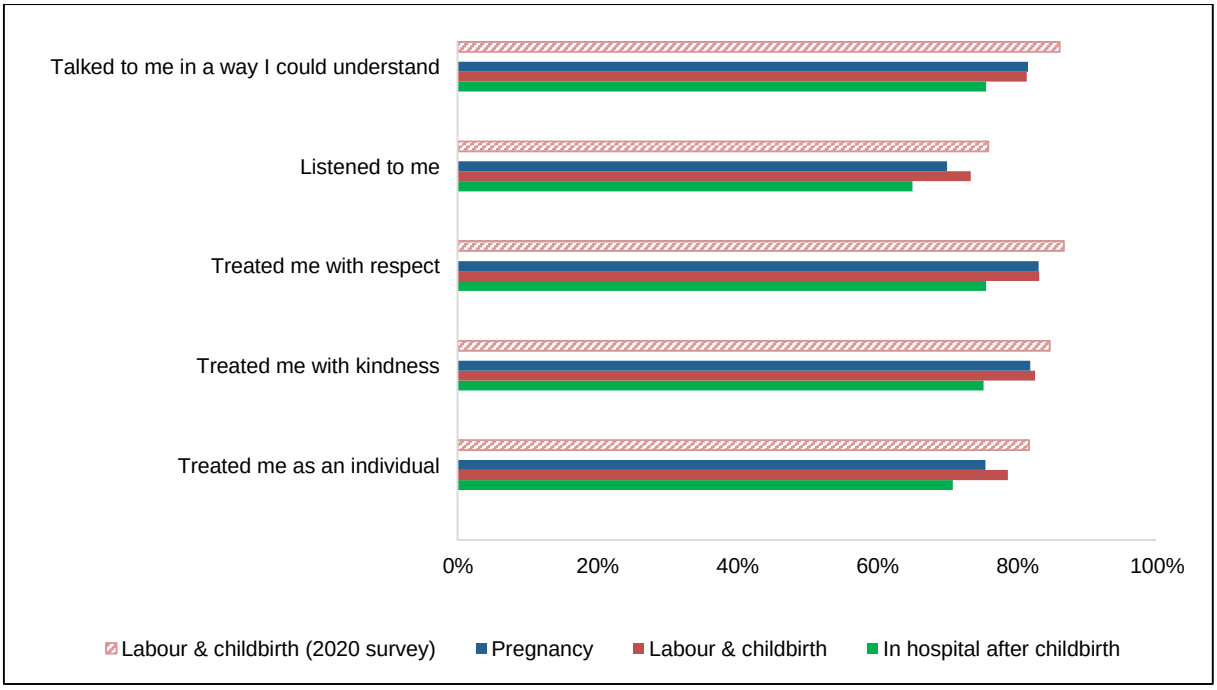

Figure 14: Proportion of women who were always talked to in a way they could understand, listened to, treated with respect, kindness, and as an individual by health professionals

5.3.5 Trust and confidence in health professionals

Trust forms the bedrock of the relationship between women and maternity health care professionals, fostering an environment where women feel safe, respected, and empowered to make informed decisions about their care. Women were asked whether they had trust and confidence in the health professionals caring for them during pregnancy, labour and childbirth, and in hospital after childbirth. Overall, 59.9% of women reported that they definitely had trust and confidence in health professionals during pregnancy, 68.1% during labour and childbirth, and 58.5% in hospital after childbirth. Between 5% and 10% of women were unsure or did not have trust and confidence across the maternity phases, and again the findings were least positive towards health professionals in hospital after childbirth. The figure for labour and childbirth in the 2024 survey is slightly lower than the figure the CQC reported in their 2024 maternity survey

(70.3%), although the CQC figure excluded those women who reported that they did not know or could not remember.[25]

5.3.6 Involvement in decisions

Involving women in decisions about their maternity care is essential to providing personalised, women-centred care, as described in Better Births.[26] In the 2024 survey, 74.3% of women reported that they were always involved enough in decisions about their pregnancy care. **Figure 15** shows the proportion of women who were sufficiently involved in decisions across the maternity surveys. There has been a gradual increase over time, from 61.9% in the 2010 survey to 74.3% in the 2024 survey, with the exception of during the pandemic, when the proportion dropped to 53.6%. The figure in the 2024 survey is lower than the CQC reported in their 2024 maternity survey (79.6%) although the CQC figure excluded those women who reported that they were unsure about their involvement in decisions.[25] One in five (21.3%) women in the 2024 survey reported that they were sometimes involved in decisions about their pregnancy care with 4.4% of women reporting that they were either unsure or were not involved enough.

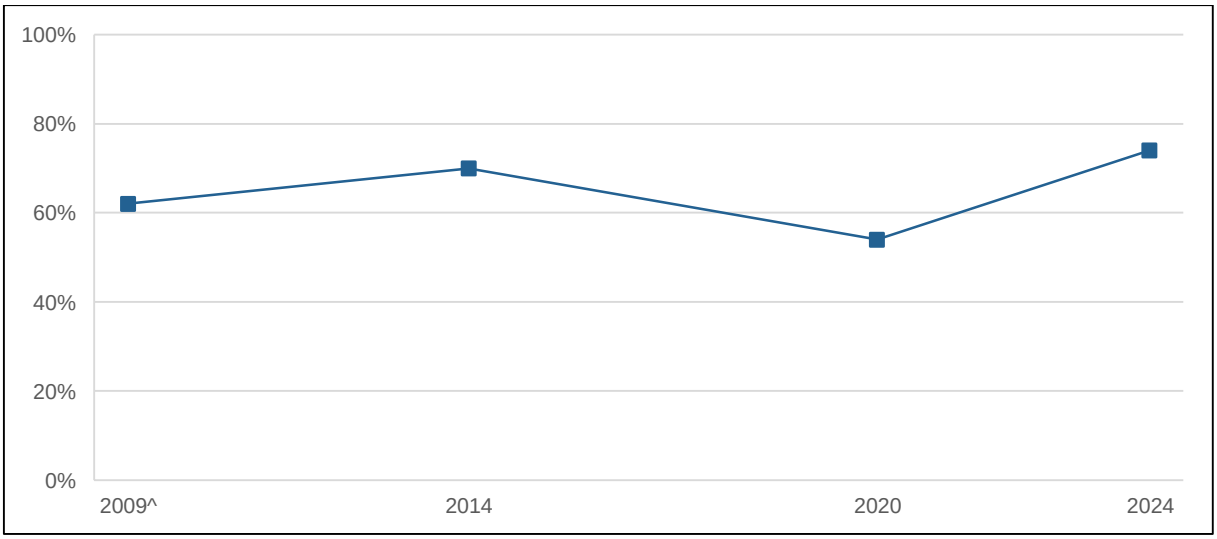

Figure 15: Proportion of women who were always involved in decisions about their pregnancy care across the maternity surveys

^ Women gave birth in 2009 and the survey was conducted in 2010

Note: The 2010 survey asked about involvement with decisions about overall maternity care, whereas the 2014, 2020 and 2024 surveys asked specifically about involvement with decisions about pregnancy care.

The proportion of women in the 2024 survey who reported that they were always involved enough in decisions about their care during labour and childbirth was lower than for during pregnancy (65.5%) and 8.9% were either not involved enough or were unsure.

5.3.7 Satisfaction with care

Women were asked how satisfied they felt with the overall care they had received during their pregnancy, labour and childbirth, and the postnatal period. A significant minority of women were

dissatisfied with their care, and some of these women may have had a traumatic experience. However, the vast majority were satisfied with their care, particularly during pregnancy (84.3%) and labour and childbirth (83.6%) – fewer women were satisfied with their postnatal care (71.8%). The proportions of women who reported satisfaction with care during the three maternity phases across the maternity surveys are shown in **Figure 16**. Overall satisfaction with care during pregnancy, labour and childbirth was high and relatively stable from 2006 to 2024 (84% to 88%). There was no change in overall satisfaction with pregnancy care or care during labour and childbirth between the 2020 and 2024 surveys. Overall satisfaction with care during the postnatal period was relatively stable between 2006 and 2014 (76% to 80%). There was a steep decline in 2020 when only 52.9% of women reported that they were satisfied with the care they received after the birth of their baby. The decline has been partly reversed in 2024 with 71.8% of women reporting satisfaction with their postnatal care, an increase of 18.9% (95%CI: 16.3–21.5, p<0.001), yet this is still below pre-pandemic levels of satisfaction. Across all maternity surveys, more women were satisfied with their care during pregnancy, labour and childbirth than with their care during the postnatal period.

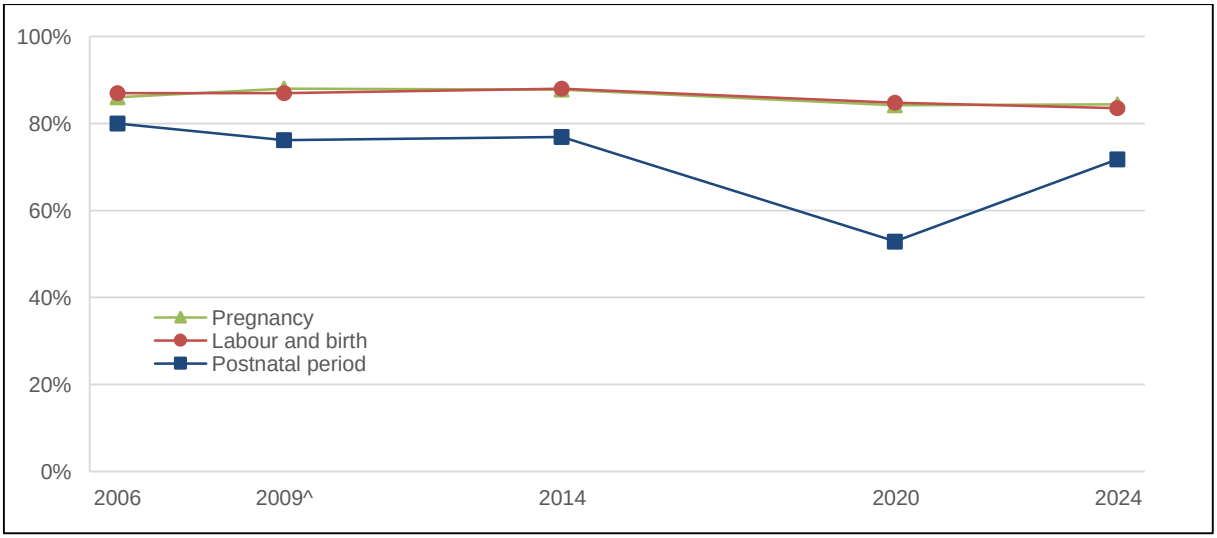

Figure 16: Proportion of women who were satisfied with their care during the perinatal period across the maternity surveys

^ Women gave birth in 2009 and the survey was conducted in 2010

5.3.8 Maternity care: key findings

The majority of women in the 2024 survey accessed maternity care through the NHS, with only a small proportion relying exclusively on private services. Over half of the women experienced midwifery continuity of carer, receiving all their midwifery care from the same team of midwives, although most interacted with multiple midwives throughout pregnancy and childbirth. Most women had postnatal contact with a midwife, yet a significant proportion expressed a desire to see a midwife more often, especially those who had fewer contacts. The proportion of women wanting more postnatal contact decreased from during the pandemic, most likely due to more contact being available. Most women had a six-week postnatal check, with the majority being performed by GPs. An increase was seen in women being asked about their mental health after childbirth, though one

in five still were either not asked or did not recall being asked. Perceptions of health professional behaviour were generally positive, especially regarding respect and kindness, although women did not always feel they were listened to. Women had higher trust and confidence in professionals during labour and childbirth than during pregnancy or in hospital after childbirth. Involvement in decision-making was higher during pregnancy than during labour and childbirth, however, and had improved during pregnancy compared with previous years. Overall satisfaction with maternity care remained high during pregnancy and childbirth but was lower for postnatal care. Although satisfaction with postnatal care dropped significantly during the pandemic, it rebounded in 2024, yet was still lower than pre-pandemic levels of satisfaction and continues to lag behind satisfaction levels for other phases of maternity care.

5.3.9 Maternity care: summary data

Table 3: Summary of maternity care data

		2024 survey (N=3728)
	n*	%^
Type of care		(N=3723)
NHS	3620	97.4
Private	10	0.3
Both	93	2.4
Continuity of carer		(N=3717)
Yes	2148	61.0
No	1307	30.5
Don't know	262	8.5
Number of midwives during pregnancy		(N=3725)
One	586	16.6
Two	1024	27.7
Three	843	21.7
Four	408	10.9
Five or more	864	23.1
Number of midwives during labour and birth		(N=3317)
One	342	10.9
Two	986	29.8
Three	742	22.8
Four	412	12.2
Five or more	835	24.3
Number of midwife contacts in the postnatal period		(N=3724)
None	300	8.3
One	594	15.3
Two	1036	28.3
Three or more	1794	48.1
Preference for contact with a midwife		(N=3684)
Less often	257	8.7
More often	1259	34.1
Saw them the right amount	2168	57.2

Maternal postnatal check-up at GP surgery		(N=3723)
Yes	3474	93.0
No	249	7.0
Asked about mental health after childbirth		(N=3722)
Yes	3035	79.9
No	544	15.5
Don't know	143	4.6
Involvement in decisions during pregnancy		(N=3717)
Always	2760	74.3
Sometimes	812	21.3
No / Don't know	145	4.4
Involvement in decisions during labour and childbirth		(N=3695)
Always	2381	65.5
Sometimes	993	25.6
No / Don't know	321	8.9
Confidence and trust in health professionals during pregnancy		(N=3715)
Definitely	2200	59.9
To some extent	1317	34.4
No / Don't know	198	5.7
Confidence and trust in health professionals during labour and childbirth		(N=3710)
Definitely	2524	68.1
To some extent	975	26.0
No / Don't know	211	5.9
Confidence and trust in health professionals in hospital after childbirth		(N=3696)
Definitely	2082	58.5
To some extent	1233	31.6
No / Don't know	381	9.9
Satisfaction with care during pregnancy		(N=3720)
Very satisfied	1835	50.4
Satisfied	1313	33.9
Neither satisfied nor dissatisfied	284	8.3
Dissatisfied	220	5.5
Very dissatisfied	68	1.9
Satisfaction with care during labour and birth		(N=3707)
Very satisfied	2109	57.8
Satisfied	970	25.8
Neither satisfied nor dissatisfied	243	6.9
Dissatisfied	233	5.5
Very dissatisfied	152	4.1
Satisfaction with postnatal care		(N=3708)
Very satisfied	1302	38.1
Satisfied	1286	33.7
Neither satisfied nor dissatisfied	438	11.4
Dissatisfied	447	10.6
Very dissatisfied	235	6.2

* Unweighted totals ^ Weighted prevalence ⁺ Multiple options could be selected

5.4 Maternal health and lifestyle

Summary data on maternal health and lifestyle for the respondents to the 2024 survey are presented in **Table 4** in section 5.4.7 on page 34–35.

5.4.1 Physical health after childbirth

A woman's body undergoes many transformations during pregnancy and childbirth and it can take time for women to fully recover. Women in the survey were asked how they had been feeling physically since they had given birth. The proportion of women who reported feeling unwell in the

first few days following childbirth was 33.8%. In the days prior to taking part in the survey, 8.5% of women described feeling unwell and 32.0% reported that they were either very tired or exhausted all the time. **Figure 17** shows the physical health problems reported by women in the 2024 survey at three different timepoints during the postnatal period: one month, three months and six months after childbirth. The most commonly reported health problems one month after childbirth were painful wounds (38.5%), painful breasts (38.4%), and fatigue (29.6%). Three months after childbirth, fatigue (22.5%) was the most commonly reported physical health problem followed by painful sexual intercourse (15.0%) and painful breasts (14.2%). Six months after childbirth, fatigue was still the most commonly reported problem (23.4%) followed by sleep problems (not related to the baby) (11.7%) and stress incontinence (11.2%). With the exception of painful intercourse and sleep problems, all health problems were most prevalent one month after childbirth. Aside from painful intercourse, all health problems tended to decrease in prevalence between one and three months after childbirth. Some health problems decreased further by six months, including painful wounds and breasts, but the prevalence of incontinence (stress and bowel), fatigue, and sleep problems was either similar at three and six months, or had increased by six months.

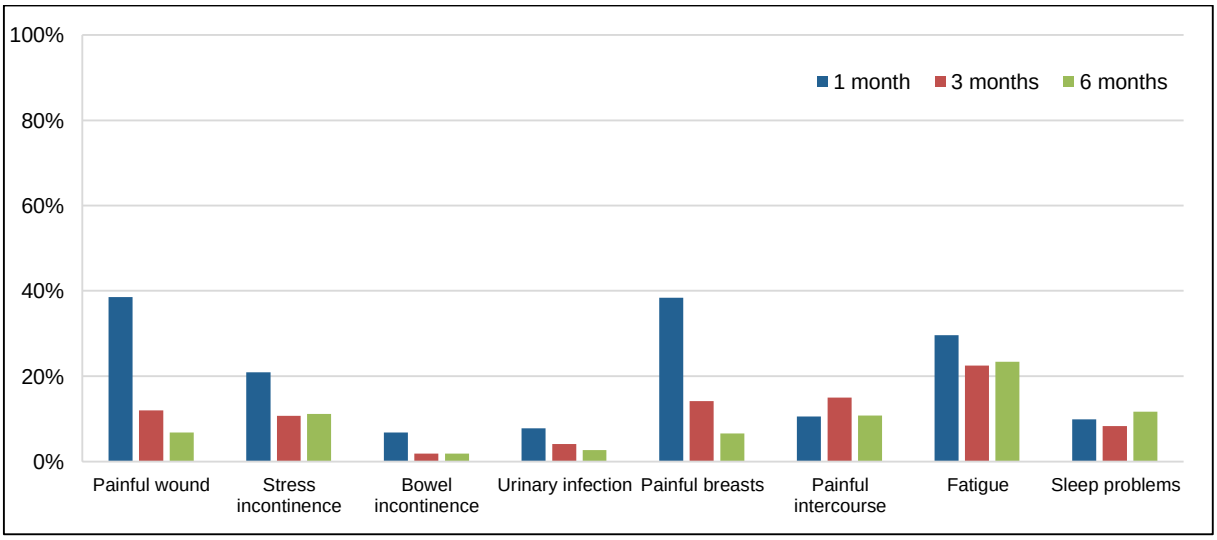

Figure 17: Prevalence of physical health problems at three timepoints during the postnatal period in the 2024 survey

5.4.2 Smoking

Reducing smoking during pregnancy was one of the key objectives in the Tobacco Control Plan published in July 2017.[41] The target was to reduce smoking in pregnancy from 10.7% to 6.0% or less by the end of 2022. In the 2024 survey, 22.6% of women reported that they had ever smoked cigarettes, 3.2% (95%CI: 2.5–4.0) of women reported that they smoked cigarettes after they found out about their pregnancy, and 3.7% of women reported that they were smoking cigarettes at the

[41] Department of Health and Social Care. Towards a smoke-free generation: tobacco control plan for England. Available at: https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england. Accessed 16 October 2025.

time they took part in the survey. These figures are lower than in the 2020 survey in which 32.4% of women reported that they had ever smoked tobacco cigarettes and 6.3% smoked cigarettes after they found out about their pregnancy. Therefore, there was a 3.1% decrease (-3.1%; 95%CI: -7.3–1.1, p=0.21) in the proportion of women smoking after they were aware they were pregnant between the 2020 and 2024 surveys.

National routine data indicate that 6.3% of women who gave birth in England between April and June 2024 were smoking tobacco at the time they gave birth, which was a decrease compared with previous years (NHS Digital Smoking at Time of Delivery (SATOD v2)).[42] However, the prevalence in the routine data is still higher than in the 2024 survey, which may be due to the different methods and timing of data collection, non-response bias, or reporting bias in the 2024 survey.

5.4.3 Vaping

Current UK guidelines support vaping as a harm reduction strategy for pregnant women who are unable to quit smoking using other methods.[43] The Royal College of Midwives has stated that if a pregnant woman chooses to use an e-cigarette to quit smoking, they should be supported to do so.[44] The women who took part in the 2024 survey were asked about their use of electronic cigarettes or vaping devices. Overall, 18.5% of women reported that they had ever vaped, 5.9% (95%CI: 5.0–6.9) of women reported that they vaped after they found out about their pregnancy, and 10.3% of women reported that they were vaping at the time they took part in the survey. Of the women who vaped during pregnancy, 60.5% reported having ever smoked cigarettes, and 1.2% of women reported dual smoking and vaping during pregnancy.

The vaping figures for the 2024 survey are higher than in the 2020 survey in which 15.0% of women reported that they had ever vaped and 3.3% reported that they had vaped after they found out about their pregnancy. Therefore, there was a 2.6% increase (95%CI: -1.6–6.8, p=0.26) in the proportion of women who were vaping after they were aware of their pregnancy between the 2020 and 2024 surveys. Of the women in the 2024 survey who reported ever vaping, the majority confirmed that the vapes contained nicotine, at least some of the time (89.5%). **Figure 18** shows the proportion of women who had ever smoked or vaped, or who smoked or vaped during pregnancy across the maternity surveys. While smoking has declined over time, vaping has steadily increased.

[42] NHS Digital. Statistics on women's smoking status at time of delivery England Q1 2024-25. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/statistics-on-womens-smoking-status-at-time-of-delivery-england-q1-2024-25. Accessed 16 October 2025.
[43] National Institute for Health and Care Excellence. NG209: Nicotine replacement therapies and e-cigarettes in pregnancy. Available at: https://www.nice.org.uk/guidance/ng209/evidence/j-nicotine-replacement-therapies-and-ecigarettes-in-pregnancy-update-pdf-10890777860. Accessed 16 October 2025.
[44] Royal College of Midwives. Position Statement: Smoking in Pregnancy. Available at: https://www.rcm.org.uk/wp-content/uploads/2024/09/RCM_Position-Statement_Conference_2024_smoking_in_pregnancy_2.pdf. Accessed 16 October 2025.

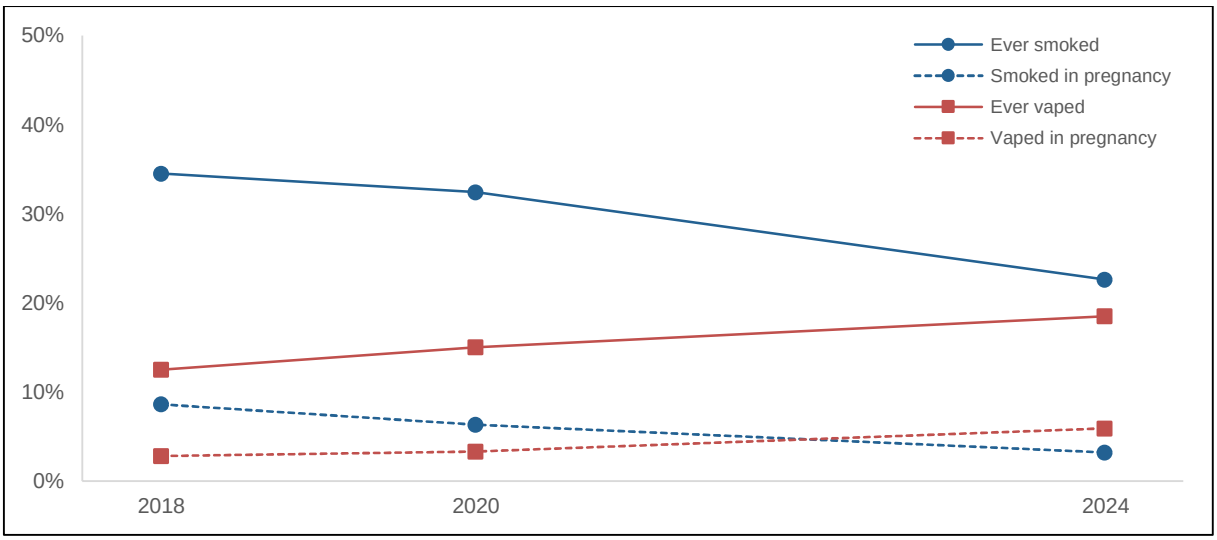

Figure 18: Proportion of women who had ever smoked or vaped, or who smoked or vaped during pregnancy across the maternity surveys

^ Women gave birth in 2017 and the survey was conducted in 2018

There are no routine data available on the prevalence of vaping in women specifically during pregnancy but there are data on vaping in women generally. Data from 2023 show that between 15.6% and 24.6% of women aged 16 to 49 years (but not specifically perinatal women) surveyed in England reported ever having used a vaping device and between 5.2% and 8.7% identified as daily users (ONS).[45] Therefore, the prevalence estimate for vaping during pregnancy of 5.9% in the 2024 survey is consistent with the published estimates for daily vaping in the general population of women, although these data sources are not directly comparable and the estimates from the 2024 survey may be prone to non-response bias or reporting bias. The estimates from the 2024 survey are also consistent with the findings from a systematic review of studies conducted between 2015 and 2020, which included UK based studies and reported that between 1.2% and 7.0% of women were vaping during pregnancy.[46]

5.4.4 Passive smoking

In terms of passive smoking, 9.5% (95%CI: 8.4–10.7) of the women in the 2024 survey lived with a partner who smoked tobacco during their pregnancy and 12.2% (95%CI: 10.9–13.5) of women were living with a smoker (either a partner and/or somebody else who smoked) during their pregnancy. This was a decrease of 4.6% (-4.6%, 95%CI: -6.1– -3.1, p<0.001) compared with in the 2020 survey (16.8%). At the time they took part in the survey, 7.9% (95%CI: 6.9–9.0) of women were living with a partner who smoked tobacco and 10.3% (95%CI: 9.2–11.6) of women were living with a smoker (either a partner and/or somebody else who smoked) at the time they took part in

[45] Office for National Statistics. E-cigarette use in Great Britain. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/datasets/ecigaretteuseingreatbritain. Accessed 16 October 2025.
[46] Calder R, Gant E, Bauld L, McNeill A, Robson D, Brose LS. Vaping in pregnancy: a systematic review. Nicotine Tob Res. 2021;23:1451–1458. doi: 10.1093/ntr/ntab017.

the survey. This was a decrease of 4.4% (-4.4%, 95%CI: -5.7– -2.9, p<0.001) compared with in the 2020 survey (14.7%).

5.4.5 Alcohol

According to the NICE guidelines, there is no known safe level of alcohol consumption during pregnancy and the UK Chief Medical Officers' low-risk drinking guidelines state that the safest approach is to avoid alcohol altogether to minimise risks to the baby.[47] Women were asked about their use of alcohol during their pregnancy and since the birth of their baby. A small minority (4.4%) of women reported that they had consumed any alcohol during their pregnancy and, of these women, 79.1% had an alcoholic drink monthly or less frequently, and 98.3% limited their intake to one or two alcoholic drinks on any one day. Over half (52.1%) of women reported having alcohol since giving birth. The majority of these women reported that they either had an alcoholic drink monthly or less frequently (61.2%), or between two and four times per month (28.8%). One in ten women (10.0%) who had consumed any alcohol since giving birth had an alcoholic drink at least twice per week. On a typical day when women were drinking alcohol, 75.9% would consume one or two alcoholic drinks, 18.7% would consume three or four alcoholic drinks, and 5.4% would consume at least five alcoholic drinks.

5.4.6 Maternal health and lifestyle: key findings

The 2024 survey gathered data on various aspects of maternal health. Women reported a variety of physical health problems after childbirth, including fatigue, painful wounds, and breast discomfort. Most health problems improved over time, yet some persisted or worsened, in particular fatigue, sleep problems and stress incontinence. The survey also collected information about substance use during and after pregnancy. Smoking rates were lower in 2024 than in 2020, but vaping prevalence had increased. Alcohol consumption was low during pregnancy, though more women reported drinking alcohol after they had given birth.

5.4.7 Maternal health and lifestyle: summary data

Table 4: Summary of maternal health and lifestyle data

		2024 survey (N=3728)
	n*	%^
Physical health after childbirth		(N=3724)
Very well	703	20.8
Quite well	1707	45.4
Quite unwell	906	22.9
Very unwell	408	10.9

[47] National Institute for Health and Care Excellence. QS204: advice on avoiding alcohol in pregnancy. Available at: https://www.nice.org.uk/guidance/qs204/chapter/Quality-statement-1-Advice-on-avoiding-alcohol-in-pregnancy. Accessed 16 October 2025.

Physical health at time of survey		(N=3707)
Very well	1432	38.5
Quite well	1967	53.0
Quite unwell	273	7.5
Very unwell	35	1.0
Fatigue at time of survey		(N=3695)
Not very tired	765	23.0
Quite tired	1722	45.0
Very tired	812	21.0
Exhausted all the time	396	11.0
Ever smoked tobacco		(N=3703)
No	2889	77.4
Yes	814	22.6
Smoked tobacco after aware of pregnancy		(N=3709)
No	3626	96.8
Yes	83	3.2
Smoked tobacco at time of survey		(N=3715)
No	3612	96.3
Yes	103	3.7
Ever vaped		(N=3703)
No	3096	81.5
Yes	607	18.5
Vaped after aware of pregnancy		(N=3714)
No	3545	94.1
Yes	169	5.9
Vaped at time of survey		(N=3717)
No	3416	89.7
Yes	301	10.3
E-cigarettes / vaping device contained nicotine		(N=604)
Always	344	58.3
Sometimes	189	31.2
No, never	41	6.5
I don't know	30	4.1
Lived with smoker during pregnancy		(N=3700)
No	3341	87.8
Partner only	275	8.9
Somebody else only	69	2.7
Both partner and someone else	15	0.6
Live with smoker currently		(N=3692)
No	3392	89.7
Partner only	235	7.5
Somebody else only	56	2.4
Both partner and someone else	9	0.4
Alcohol during pregnancy		(N=3713)
No	3507	95.6
Yes	206	4.4
Alcohol since childbirth		(N=3708)
No	1529	47.9
Yes	2179	52.1

* Unweighted totals ^ Weighted prevalence

5.5 Perinatal mental health

Summary data on perinatal mental health for the respondents to the 2024 survey are presented in **Table 5** in section 5.5.7 on pages 42–43.

5.5.1 Pre-existing maternal mental health problems

Women were asked if they had been diagnosed with any mental health problems before their pregnancy. They were given a checklist of conditions to choose from, including an "other mental health problem" option, where they could also provide additional details if they wished. One in five (20.8%) women indicated that they had been diagnosed with one or more of the mental health problems in the checklist and/or another mental health problem that was not listed. **Figure 19** shows the distribution of different pre-existing mental health problems for the women who indicated that they had a diagnosis. Some women reported that they had been diagnosed with more than one mental health problem and they are represented within each of the relevant diagnostic categories. The most prevalent pre-existing diagnoses were anxiety disorder (15.6%, 95%CI: 14.2–17.0), depressive disorder (8.8%, 95%CI: 7.8–10.0), and post-traumatic stress disorder (PTSD) (3.3%, 95%CI: 2.7–4.0). These prevalence estimates are similar to those documented for perinatal women in the literature.[48] [49] [50] Less prevalent diagnoses were eating disorder (1.6%, 95%CI: 1.2–2.2), obsessive-compulsive disorder (OCD) (1.3%, 95%CI: 1.0–1.8), personality disorder (<1%), bipolar disorder (<1%), and psychotic disorder (<1%). Approximately 2% of women indicated that they had another mental health problem, either not included in the checklist or not diagnosed.

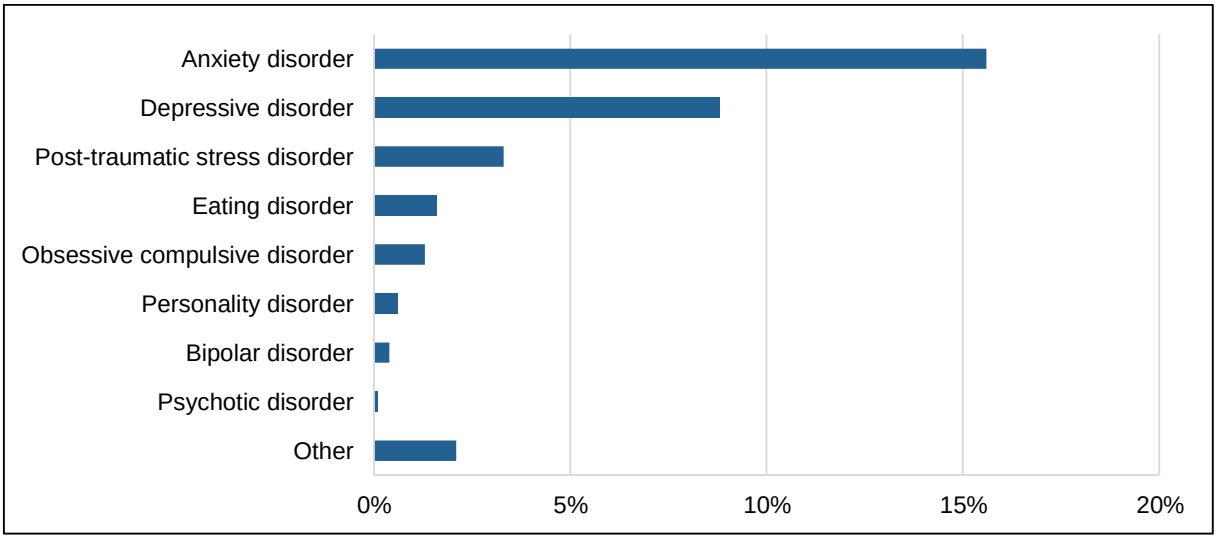

Figure 19: Prevalence of pre-existing mental health problems

Note: Percentages shown are out of all women; some women were diagnosed with more than one mental health problem and are represented in each relevant diagnostic category

[48] Dennis CL, Falah-Hassani K, Shiri R. Prevalence of antenatal and postnatal anxiety: systematic review and meta-analysis. Br J Psychiatry. 2017;210:315-323. doi: 10.1192/bjp.bp.116.187179.
[49] Yildiz PD, Ayers S, Phillips L. The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. J Affect Disord. 2017;208:634-645. doi: 10.1016/j.jad.2016.10.009.
[50] Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol. 2005;106:1071-1083. doi: 10.1097/01.AOG.0000183597.31630.db.

5.5.2 Common maternal postnatal mental health problems

The 2024 survey included standardised self-report measures for the most common postnatal mental health problems: depression (Edinburgh Postnatal Depression Scale, EPDS), anxiety (2 item Generalised Anxiety Disorder Scale, GAD-2), and post-traumatic stress (PTS) (Primary Care PTSD screen, PC-PTSD-5). These measures ask about symptoms during the previous week (EPDS), fortnight (GAD-2), or month (PC-PTSD-5) and provide an indication of clinically significant levels of depression, anxiety, and PTS. The prevalence in the 2024 survey was 22.5% (95%CI: 21.0–24.2) for depression, 16.1% (95%CI: 14.8–17.6) for anxiety, and 11.8% (95%CI: 10.5–13.0) for PTS. Overall, 29.8% of women scored above the cut-off on at least one of these three self-report mental health measures. It is important to emphasise that the mental health measures are not diagnostic; rather, elevated scores (above the recommended cut-offs) serve as an indicator of increased likelihood for the presence of mental health problems and signal a referral for further assessment.

Postnatal depression has been assessed using the EPDS in the maternity surveys since 2014, anxiety has been assessed using the GAD-2 since 2018, and PTS has been assessed using the PC-PTSD-5 screen since 2018. Therefore, it is possible to observe change over time across the maternity surveys and previous publications have reported prevalence rates up to 2020.[11] [51] **Figure 20** presents updated data, incorporating findings from the 2024 survey. The prevalence of postnatal depression rose from 10.3% in 2014 to 16.0% in 2018, followed by a sharp increase to 23.9% during the pandemic in 2020. Although rates declined slightly by 2024 to 22.5%, the reduction was small (-1.5%, 95%CI: -5.3–2.3. p=0.44) suggesting that elevated levels of postnatal depression have persisted in the post-pandemic period. Postnatal anxiety showed a steady upward trend, increasing from 13.7% in 2018 to 15.1% in 2020, with a further modest rise of 1.0% (95%CI: -2.9–5.1, p=0.59) to 16.1% in 2024. Similarly, postnatal PTS rose from 9.7% in 2018 to 11.5% in 2020, and then to 11.8% in 2024 (+0.3%, 95%CI: -3.7–4.5, p=0.85). Overall, the data indicate that the prevalence of these three common postnatal mental health problems has remained high in the years following the pandemic, underscoring the enduring impact on maternal mental health.

[51] Harrison S, Quigley MA, Fellmeth G, Stein A, Ayers S, Alderdice F. The impact of the Covid-19 pandemic on postnatal anxiety and posttraumatic stress: Analysis of two population-based national maternity surveys in England. J Affect Disord. 2024;356:122-136. doi: 10.1016/j.jad.2024.04.003.

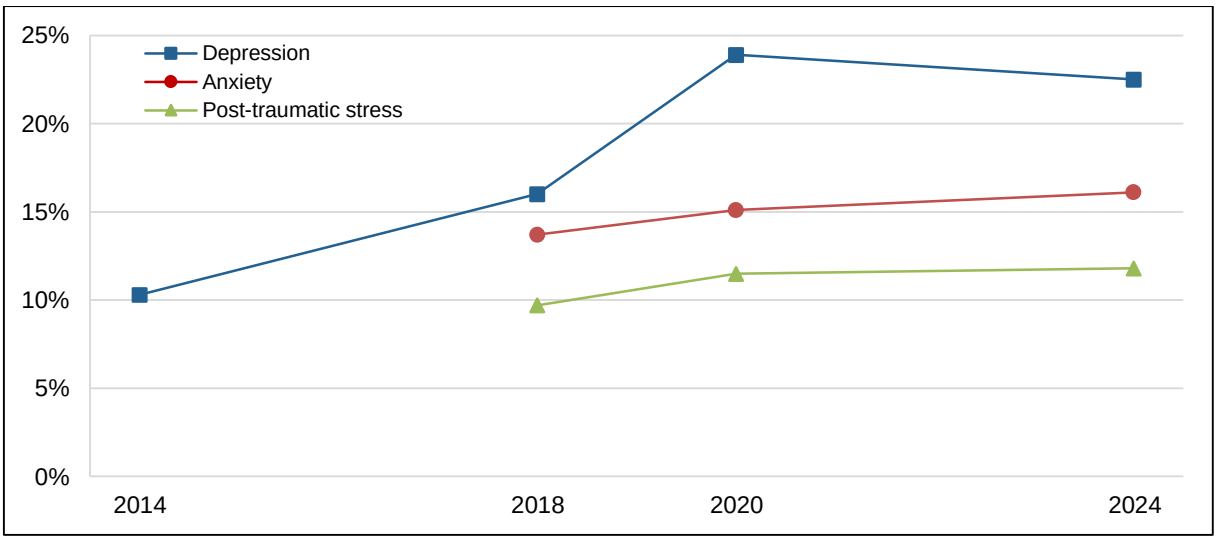

Figure 20: Prevalence of postnatal depression, anxiety and post-traumatic stress (PTS) across the maternity surveys

^ Women gave birth in 2017 and the survey was conducted in 2018

Women were asked about OCD for the first time in the 2024 survey and symptoms were assessed using the 4 item Obsessive-Compulsive Inventory (OCI-4), a brief screening tool which has been validated in perinatal populations and shown to have good psychometric properties.[52] Overall, 28.0% (95%CI: 26.4–29.7) of women scored above the recommended cut-off on the OCI-4. While this figure appears high, it is important to note that the OCI-4 is designed for early detection of OCD symptoms and prioritises sensitivity, particularly in populations where OCD may be under-recognised, such as perinatal women. In addition to the questions on the OCI-4, women were asked to self-identify whether they had experienced symptoms of OCD or received treatment during pregnancy and/or since giving birth. In total, 6.1% of women reported having experienced symptoms or having received treatment for OCD: 1.6% during pregnancy, 2.4% since giving birth, and 2.2% across both periods. Women were also asked about their experience of intrusive thoughts – defined as sudden, unwanted, and distressing – which are characteristic of OCD. Women were asked about any intrusive thoughts they experienced one, three, and six months after the birth. At one month, 12.3% reported experiencing intrusive thoughts, which declined to 8.8% at three months, before rising again to 10.1% at six months. Taken together, the findings from these different measures suggest that intrusive thoughts and other OCD symptoms affect a significant proportion of women during the perinatal period. Routine screening may play a vital role in identifying those in need of support and facilitating timely access to appropriate interventions.

5.5.3 Symptoms and diagnosis of depression and anxiety

In addition to assessing postnatal depression and anxiety using standardised measures, the 2024 survey asked women to self-identify whether they had experienced symptoms of depression or

[52] Abramowitz JS, Myers NS, Friedman JB, Juel EK, Nestadt G, Kimmel M, et al. Psychometric properties of the OCI-4: a brief screening tool for perinatal obsessive-compulsive disorder. Arch Womens Ment Health. 2025;28:895-902. doi: 10.1007/s00737-024-01539-w.

anxiety during their pregnancy or after giving birth. They were also asked whether they had received a diagnosis for depression or anxiety from a health professional. During pregnancy, 12.2% of women experienced symptoms of depression and 37.8% of these women had a diagnosis. Anxiety symptoms were more common affecting 47.7% of women during pregnancy and 17.2% of these women had a diagnosis. After giving birth, 20.6% of women experienced symptoms of depression and 39.5% of these women had a diagnosis. Finally, anxiety symptoms affected 49.4% of women after giving birth and 21.7% of these had a diagnosis. Therefore, while anxiety symptoms were more prevalent both during pregnancy and following childbirth, women experiencing depression symptoms were more likely to receive a diagnosis. **Figure 21** shows the proportions of women experiencing symptoms and receiving a diagnosis of depression and/or anxiety during the perinatal period.

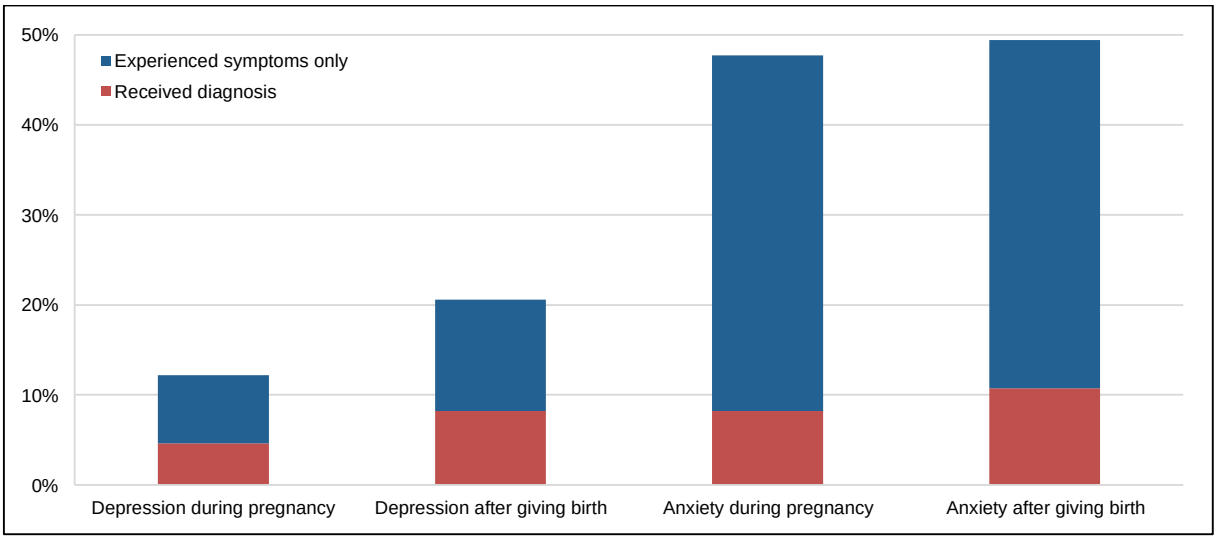

Figure 21: Proportions of women experiencing symptoms only or a diagnosis of perinatal depression and/or anxiety

5.5.4 Support and treatment for depression and anxiety

Women who reported experiencing symptoms of depression and/or anxiety during the perinatal period were asked about the support and treatment they received. **Figure 22** shows the proportions of women who received no support or treatment, support only, psychological therapy (+/- support), medication (+/- support), or combined therapy and medication (+/- support). Overall, women experiencing symptoms of depression, whether during pregnancy or after giving birth, were more likely to receive support, psychological therapy, and medication compared with women experiencing symptoms of anxiety. This finding is consistent with the most recent Adult Psychiatric Survey in 2023/4, which found that women (aged 16–74 years and not specifically perinatal) were

more likely to receive treatment (psychological therapy and/or medication) if they had a depressive episode (62.9%), compared with generalised anxiety disorder (56.9%).[53]

Importantly, the 2024 survey findings show that the majority of women who experienced symptoms of depression and/or anxiety did not receive any treatment (between 54.5% and 77.3% (combined grey and blue bars)). Furthermore, almost half of the women who experienced symptoms of depression (43.0% during pregnancy and 43.9% after giving birth) and over half of the women who experienced symptoms of anxiety (57.4% during pregnancy and 60.2% after giving birth) did not receive any support or treatment (grey bars). This is concerning as it is well established that unaddressed perinatal mental health problems can have significant and lasting impacts on the mother, child, and wider family.[54] While it is important to recognise that the presence of symptoms of depression or anxiety does not always indicate a mental health problem requiring intervention, it could be argued that all women experiencing such symptoms would benefit from appropriate support. Encouragingly, women who had a diagnosis of depression or anxiety during the perinatal period were more likely to report that they had received support and/or treatment, particularly after giving birth (**Figure 23**).

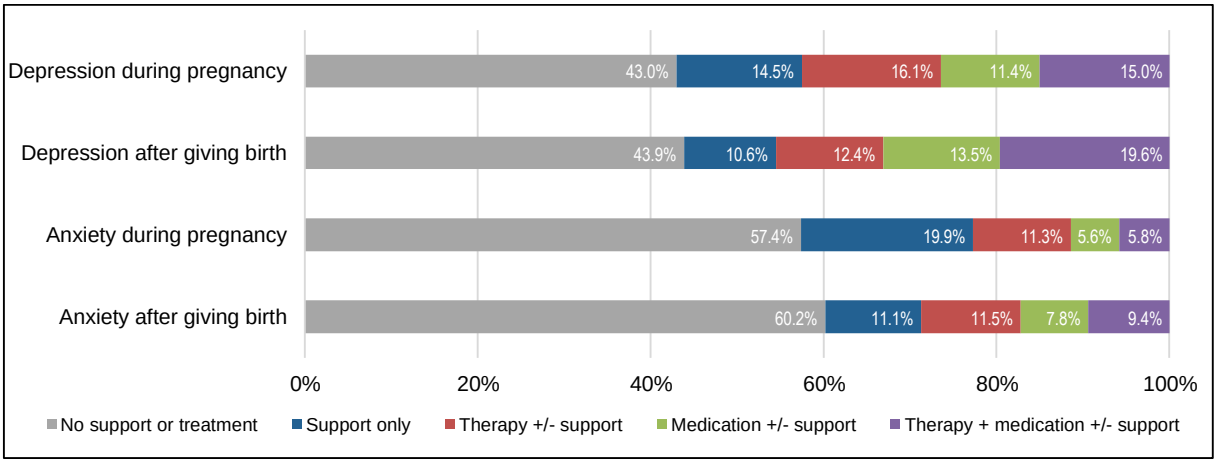

Figure 22: Proportions of women with symptoms of depression or anxiety who received support and/or treatment during pregnancy or after giving birth

[53] NHS Digital. Survey of mental health and wellbeing England 2023-24. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24. Accessed 16 October 2025.
[54] NHS England. Perinatal mental health. Available at: https://www.england.nhs.uk/mental-health/perinatal/. Accessed 16 October 2025.

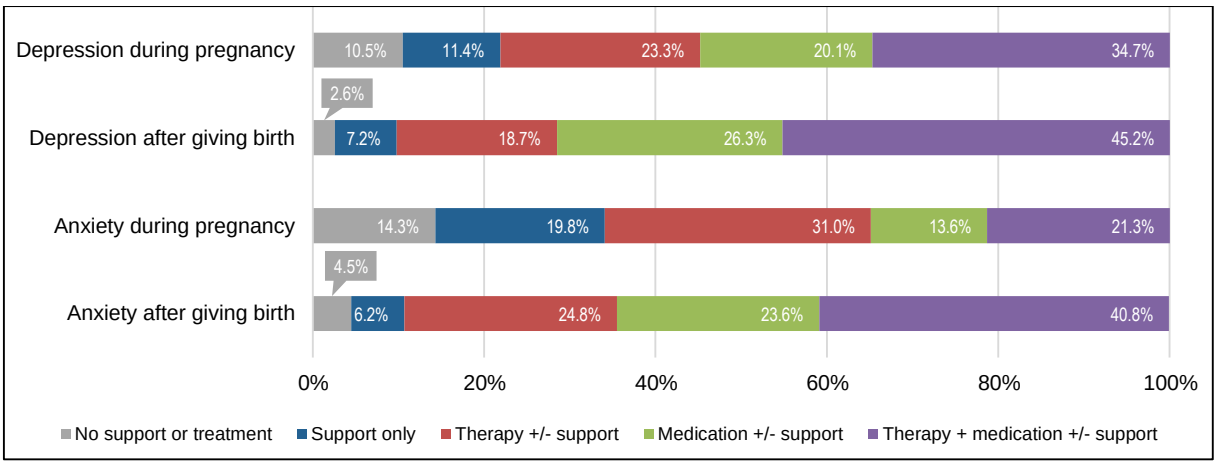

Figure 23: Proportions of women who were diagnosed with depression or anxiety who received support and/or treatment during pregnancy or after giving birth

5.5.5 Partner mental health

The NHS Long Term Plan committed to supporting fathers and partners, who may also experience mental health challenges during the perinatal period.[17] Women were asked about their partner's mental health in the 2024 survey. For those women who reported that they had a partner, 17.6% indicated that their partner had experienced mental health problems, 74.9% reported that they had not, and 7.5% were unsure. Those women who reported that their partner had experienced mental health problems were also asked about the timing. The majority of women indicated that the onset of their partner's mental health problems was prior to their pregnancy (85.0%), 4.9% indicated that the onset was during their pregnancy, and 10.1% indicated that it was since the birth of their baby (**Figure 24**). For one in five (21.0%) women whose partner experienced mental health problems, the onset was prior to their pregnancy but the mental health problems continued throughout their pregnancy and after the birth.

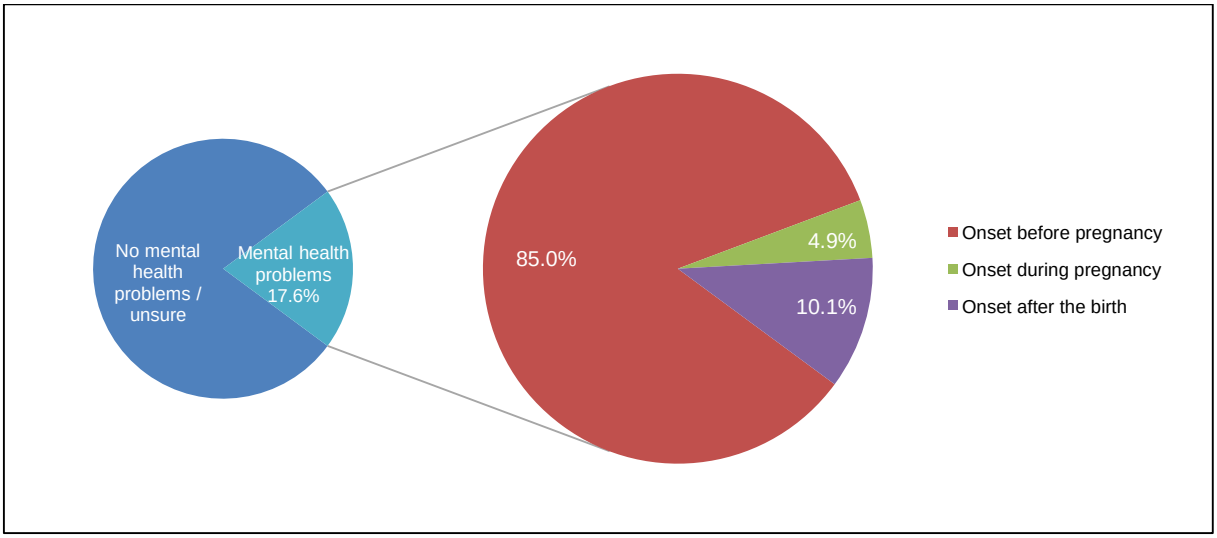

Figure 24: Onset of partner mental health problems

Among the partners who had experienced mental health problems, 61.0% had received treatment, 34.8% had not and it is unclear for the remaining 4.2%. Among the women who reported that their partner had experienced mental health problems, 43.3% experienced mental health problems themselves – scoring above the recommended cut-off on the self-report measures of postnatal depression, anxiety and/or PTS.

5.5.6 Perinatal mental health: key findings

One in five women had been diagnosed with a mental health problem before their pregnancy; most often these were common mental health problems including depression, anxiety or post-traumatic stress disorder. Almost thirty percent of women scored above the recommended cut-off on at least one standardised measure assessing depression, anxiety, or post-traumatic stress during the postnatal period. Many women also reported experiencing symptoms of depression and/or anxiety during pregnancy and in the period after giving birth, although the number receiving a diagnosis was considerably lower. The likelihood of women receiving support or treatment for mental health problems varied according to the specific problem and when it occurred: women with symptoms or a diagnosis of depression were the most likely to receive support and/or treatment. The 2024 survey also gathered data on partner mental health, with a significant proportion of women reporting that their partners had mental health conditions, most often with onset prior to their pregnancy.

5.5.7 Perinatal mental health: summary data

Table 5: Summary of perinatal mental health data

		2024 survey (N=3728)
	n*	%^
Pre-existing mental health problems		(N=3637)
Anxiety disorder[+]	546	15.6
Depressive disorder[+]	297	8.8
Posttraumatic stress disorder[+]	120	3.3
Eating disorder[+]	59	1.6
Obsessive compulsive disorder[+]	53	1.3
Personality disorder[+]	17	0.6
Bipolar disorder[+]	13	0.4
Psychotic disorder[+]	<10	<0.3
Other[+]	70	2.1
Common mental health problems (standardised measures)		
Postnatal depression (EPDS) (N=3677)	761	22.5
Postnatal anxiety (GAD-2) (N=3689)	544	16.1
Postnatal PTS (PC-PTSD-5) (N=3699)	404	11.8
At least one common mental health problem (N=3631)	1022	29.8
Self-identified depression and/or anxiety symptoms during pregnancy		
Depression (N=3718)	375	12.2
Anxiety (N=3719)	1752	47.7
Depression and anxiety (N=3714)	331	10.9
Diagnosis of depression or anxiety during pregnancy		
Depression (N=372)	130	37.8
Anxiety (N=1745)	274	17.2

Support for depression symptoms during pregnancy		(N~375)
Support / advice[+]	190	50.9
Psychological therapy[+]	119	32.4
Medication[+]	105	27.9
Support for anxiety symptoms during pregnancy		(N~1752)
Support / advice[+]	618	37.8
Psychological therapy[+]	293	17.5
Medication[+]	174	11.6
Self-identified depression and/or anxiety symptoms after childbirth		
Depression (N=3694)	714	20.6
Anxiety (N=3699)	1892	49.4
Anxiety and depression (N=3672)	640	18.5
Diagnosis of depression or anxiety after childbirth		
Depression (N=714)	274	39.5
Anxiety (N=1890)	373	21.7
Support for depression symptoms after childbirth		(N~714)
Support / advice	342	48.6
Psychological therapy	233	32.5
Medication	230	34.0
Support for anxiety symptoms after childbirth		(N~1892)
Support / advice	597	33.2
Psychological therapy	382	21.3
Medication	297	17.6
Partner mental health problems		(N=3521)
No	2622	74.9
Unsure	234	7.5
Yes	665	17.6
Onset of partner mental health problems		(N=664)
Onset before pregnancy[+]	559	85.0
Onset during pregnancy[+]	32	4.9
Onset since the birth[+]	73	10.1

* Unweighted totals ^ Weighted prevalence [+] Multiple options could be selected

5.6 Infant feeding

Summary data on infant feeding for the respondents to the 2024 survey are presented in **Table 6** in section 5.6.5 on pages 49–50.

5.6.1 Breastfeeding

Current national and international guidance recommends exclusive breastfeeding for the first six months of infancy.[55] The women in the 2024 survey were asked how they had intended to feed their baby. Just over half (53.3%) of women had intended to feed their baby breast milk only, just over a quarter (26.6%) had intended to feed their baby a combination of breast milk and infant formula, 16.1% of women had intended to use infant formula only, and a small number (4.0%) of women had not decided how they would feed their baby. The majority (85.9%, 95%CI: 84.5–87.2) of women reported that they had initiated breastfeeding (including breast milk feeding). **Figure 25** shows the breastfeeding initiation rates across the maternity surveys from 2006 to 2024; the rates increased between 2006 and 2010 and have been fairly stable thereafter (between 83.7% and

[55] World Health Organisation. Breastfeeding. Available at: https://www.who.int/westernpacific/health-topics/breastfeeding. Accessed 16 October 2025.

85.9%). The figures include all babies who were put to the breast at all, even if it was on one occasion only, and also includes those babies who were given expressed breast milk.

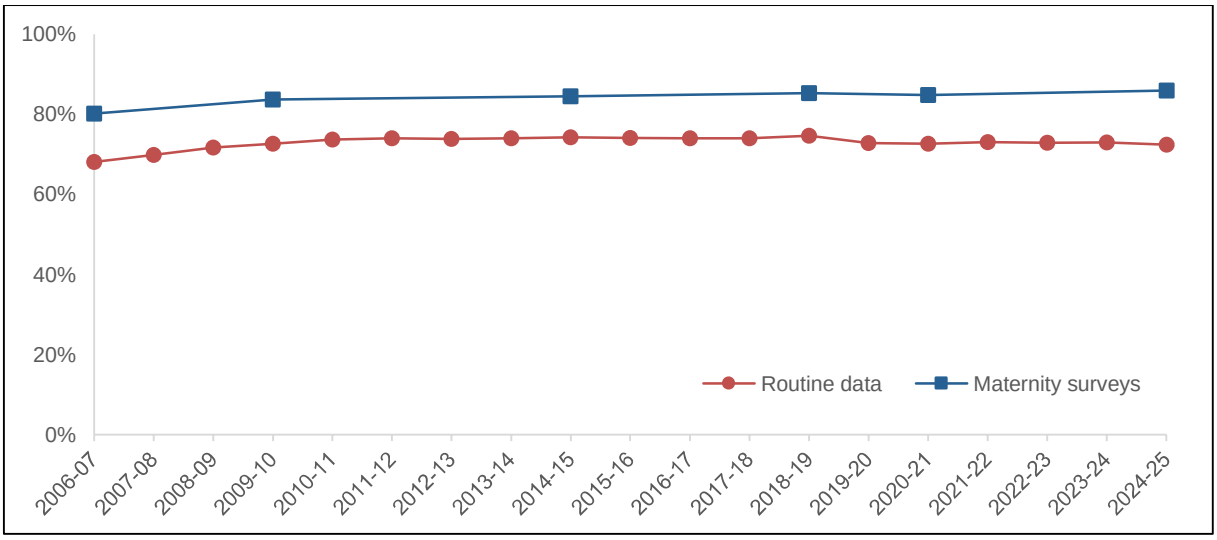

Figure 25: Rates of breastfeeding initiation by year of birth across the maternity surveys and from routine data

Note: 2024–25 routine data point is based on MSDS monthly statistic for May 2024

Figure 25 also shows the breastfeeding initiation rates reported by the Department for Health and Social Care (currently NHS Digital MSDS) for England from 2006–7 to 2024–25. Overall, the trend shows a slight increase in the rate of breastfeeding initiation up until 2010–11, with relatively stable rates thereafter. Consistent with previous maternity surveys, the breastfeeding initiation rate for women in the 2024 survey was considerably higher than in national routine data, which show that the proportion of babies who received breast milk as their first feed in May 2024 was 73.4% (NHS Digital MSDS).[22] The rate may be higher in the 2024 survey due to non-response bias; however, due to data completeness (6.5% missing data for babies first feed in May 2024) and/or quality issues, MSDS data may also not be nationally representative.[22] The forthcoming publication of the findings from the 2023 Infant Feeding Survey (IFS)[56] will also serve as a useful comparison for the 2024 survey data.

Figure 26 shows the proportions of women who were giving their baby any breast milk at birth, six weeks and six months in the 2018, 2020 and 2024 surveys and across the IFS from 1995 to 2010. The overall trend shows that the proportion of women breastfeeding at each of these time points has increased over time with more women initiating breastfeeding and continuing to breastfeed for longer. In the 2024 survey, 70.1% (95%CI: 68.3–71.8) of women were breastfeeding when their baby was six weeks old and 53.4% (95%CI: 51.5–55.2) were breastfeeding when their baby was six months old.

[56] Ipsos. Infant Feeding Survey 2023. Available at: https://infantfeedingsurvey.ipsos.com/2023/. Accessed 16 October 2025.

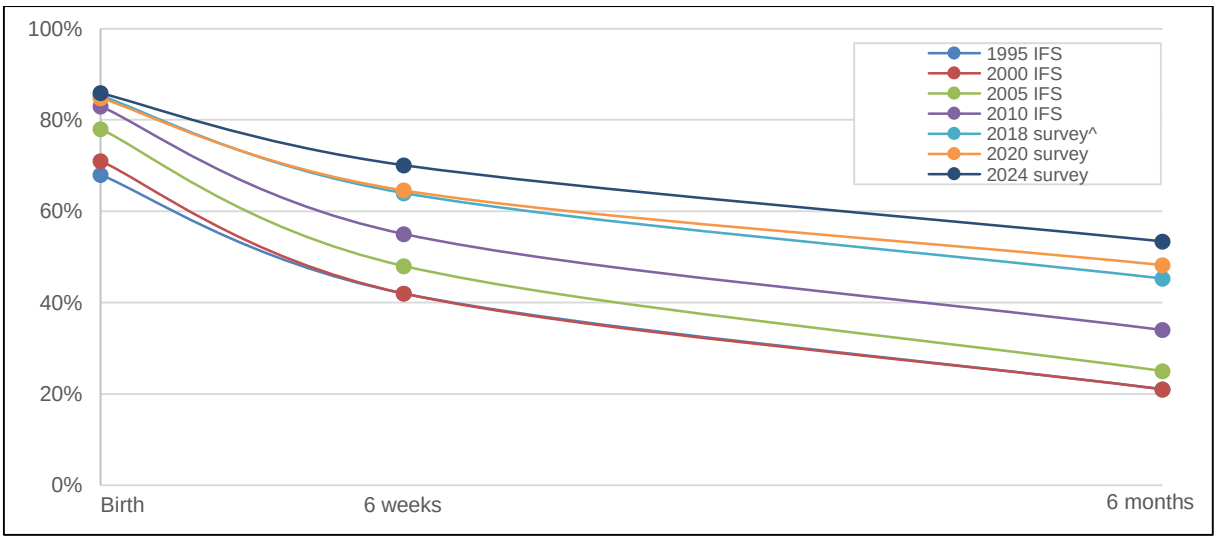

Figure 26: Breastfeeding rates at birth, 6 weeks and 6 months across the maternity surveys and infant feeding surveys

^ Women gave birth in 2017 and the survey was conducted in 2018
IFS=Infant Feeding Survey

Consistent with previous maternity surveys, the breastfeeding rate at six weeks reported by women in the 2024 survey was considerably higher than in national routine data for the first quarter of 2024–2025, which show that 59.3% of babies were breastfeeding at six to eight weeks (Office for Health Improvement and Disability (OHID)).[57] The rates in the 2024 survey may be higher due to non-response bias; however, as with NHS Digital, OHID may have issues with data quality, in particular a substantial number of women where breastfeeding status is unknown (10%).

Although the data from the maternity surveys and IFS suggest that duration of breastfeeding has increased over time, women who initiated breastfeeding but who were no longer breastfeeding when they took part in the 2024 survey were asked whether they breastfed for as long as they intended, and 69.8% indicated that they would have liked to breastfeed for longer.

5.6.2 Breastfeeding support

Breastfeeding support plays a crucial role in helping women initiate and continue breastfeeding successfully. It addresses practical, emotional, informational, and social barriers that many mothers face. Women who initiated breastfeeding were asked about the support they received. Almost three quarters (73.9%) of women reported that they had received help or advice with breastfeeding when they were in hospital or the birth centre after the birth, 10.7% of women indicated that they did not need help or advice, and the remaining women either did not receive any help or advice (14.1%) or could not remember whether they had received any or not (1.3%). Of the women who reported that they had received help or advice with breastfeeding in hospital or the birth centre, most (84.3%) indicated that the help was from midwifery teams, followed by breastfeeding specialists or lactation

[57] Office for Health Improvement and Disparities. Breastfeeding at 6-8 weeks data 2024-25. Available at: https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-data-for-2024-to-2025. Accessed 16 October 2025.

consultants (39.3%), and other health professionals (16.7%). Some women also received help and advice from family and friends (12.5%) and/or partners (7.6%) (**Figure 27**).

Women who initiated breastfeeding were also asked whether they had received any help or advice with breastfeeding at home since giving birth. Almost two thirds of women (61.8%) reported they had, 17.8% indicated that they did not need help or advice, and the remaining women either did not receive any help or advice (19.5%), or could not remember whether they had any or not (1.0%). Women who indicated that they had received help or advice with breastfeeding were asked about the sources of help and advice and could give multiple responses to the question. The most frequently cited sources were: midwifery teams (61.8%), health visitors (58.9%), breastfeeding specialists or lactation consultants (34.6%), family and friends (18.7%), and breastfeeding support groups or voluntary organisations (18.4%). Other sources of help and advice were cited but each by less than 10% of women: other health professionals, peer supporters, children's centres, national breastfeeding helpline, and partners. In addition, 8.9% of women received help and advice from a social media forum and 2.1% via an app (**Figure 27**).

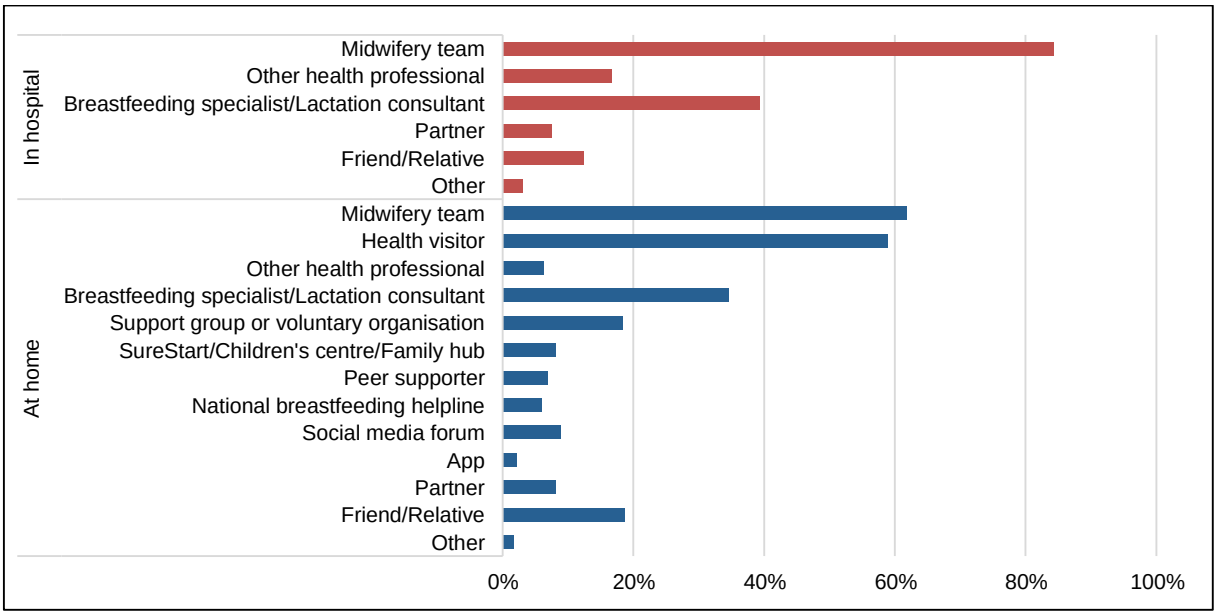

Figure 27: Sources of breastfeeding support at home after childbirth in the 2024 survey

Note: Denominator is number of women who indicated that they had received support

NICE recommends that breastfeeding care is tailored to the woman's individual needs and provides face-to-face support and written, digital or telephone information to supplement (but not replace) face-to-face support.[58] Women were asked about how any breastfeeding help or advice was given and the question allowed multiple responses. Regardless of the source, the majority of women received help or advice face-to-face (72.8%–97.4%). Fewer women received help or advice by

[58] National Institute for Health and Care Excellence. NG194: planning and supporting babies feeding. Available at: https://www.nice.org.uk/guidance/ng194/chapter/Recommendations#planning-and-supporting-babies-feeding. Accessed 16 October 2025.

telephone or video call (8.2%–26.9%) and even fewer women received help or advice via SMS (2.5%–22.5%) (**Figure 28**).

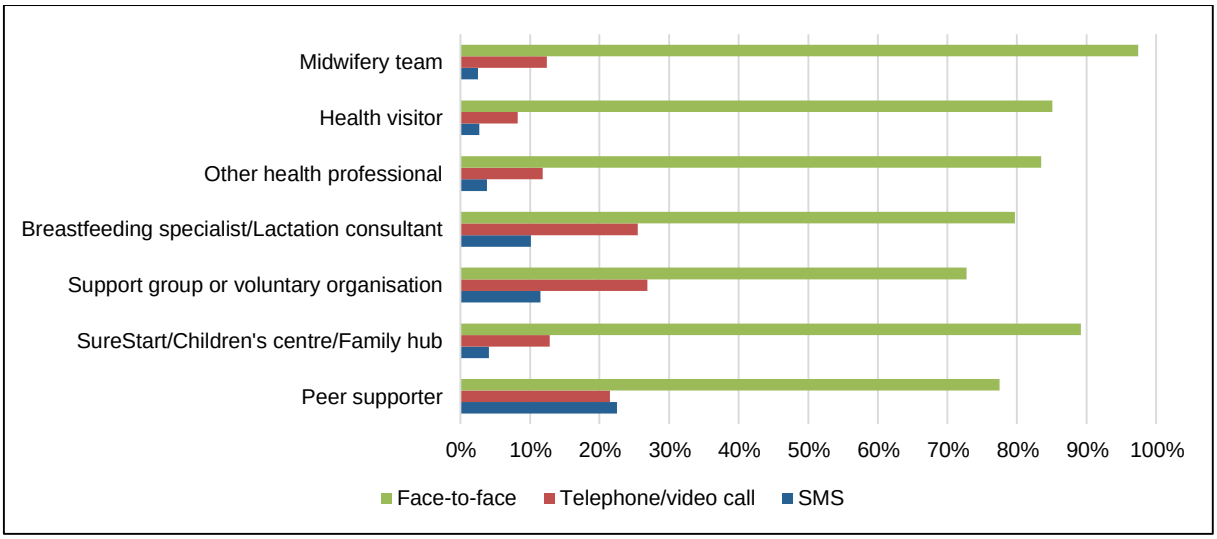

Figure 28: Modes of breastfeeding support at home after childbirth in the 2024 survey

Figure 29 shows the proportion of women who indicated that they would have liked more help with breastfeeding their baby across the maternity surveys. The proportion was similar in the 2014 and 2018 surveys (~30%), increased to 46.2% in the 2020 survey and then declined to 36.3% in the 2024 survey. This represents a 9.9% decrease (-9.9%, 95%CI: -13.5– -6.3, p<0.001) between the 2020 and 2024 surveys.

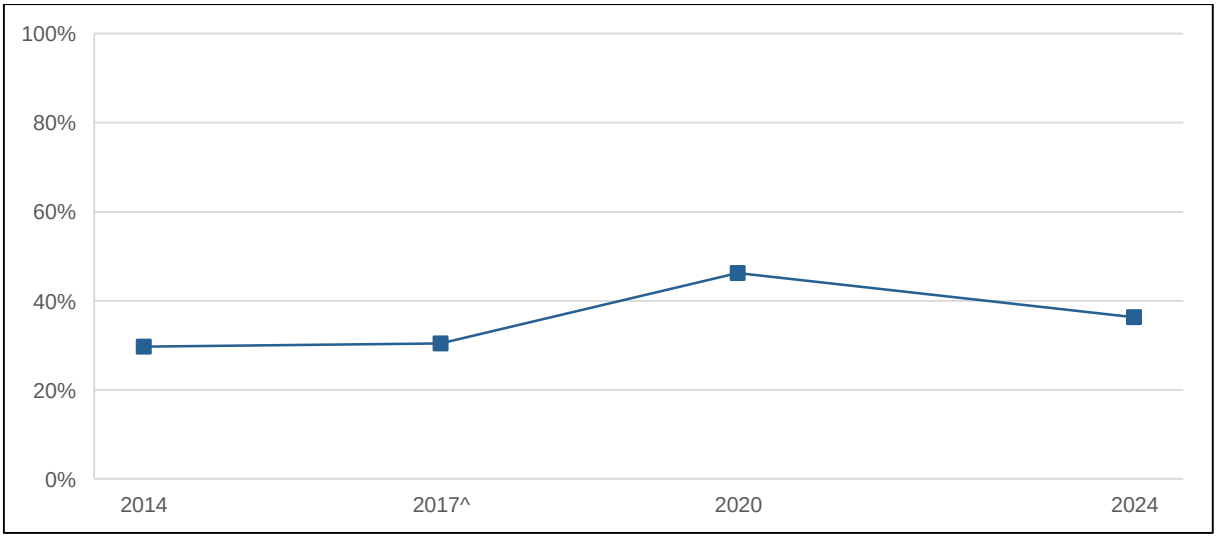

Figure 29: Proportion of women wanting more help with breastfeeding across the maternity surveys

^ Women gave birth in 2017 and the survey was conducted in 2018

Note: Denominator is number of women who indicated that they initiated breastfeeding

5.6.3 Formula feeding and introduction of solids

Four out of five women had given formula milk to their baby at the time they took part in the survey (79.5%). Almost half of those women had given formula milk to their baby from birth (45.4%). The UK health departments recommend that solid foods should be introduced to babies when they are around six months old.[59] The majority of women who took part in the 2024 survey had introduced solid food to their baby (94.2%). **Figure 30** shows the proportion of women who introduced solid food to their baby by the ages of four, five, and six months across the maternity surveys. The proportion of women who had introduced solid food by six months was between 92% and 98% from 2006 to 2024. The proportion introducing solids earlier—at four or five months—has declined over time. This suggests that more mothers are choosing to wait until their baby is older before starting solid foods.

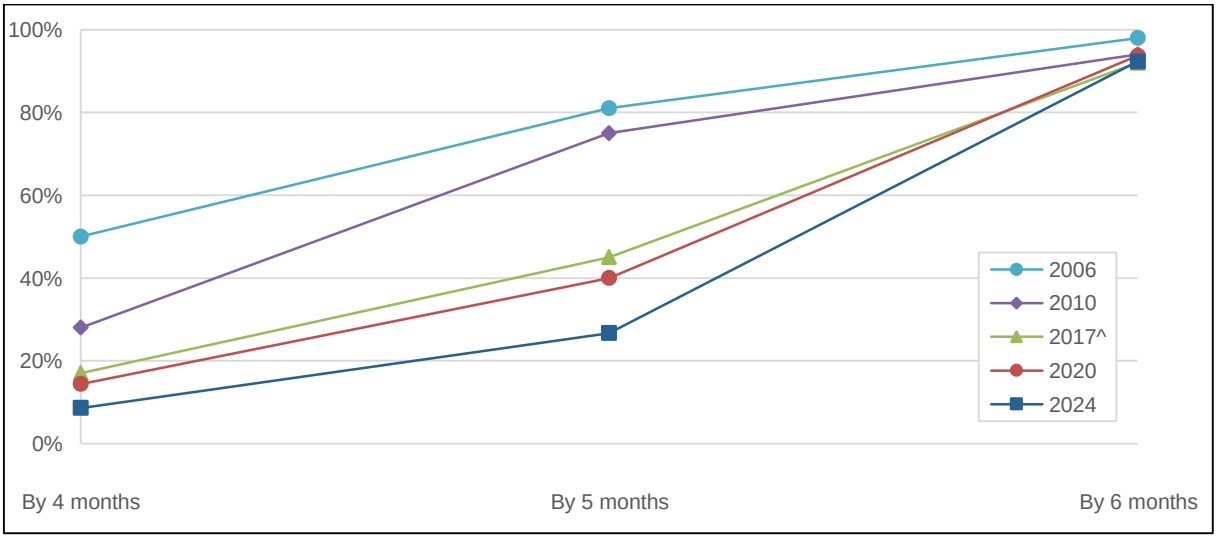

Figure 30: Proportion of women introducing solid food to their baby by 4, 5 and 6 months of age across the maternity surveys

^ Women gave birth in 2017 and the survey was conducted in 2018

5.6.4 Infant feeding: key findings

In the 2024 survey, over half of women intended to breastfeed only, and about a quarter planned a combination of breastfeeding and formula feeding. A high proportion of women initiated breastfeeding, with rates remaining consistent with previous survey data, yet higher than estimates from routine data. Breastfeeding continuation at six weeks and six months increased in the 2024 survey compared with previous surveys, and many women who had stopped breastfeeding reported that they would have liked to continue for longer. While most women had introduced solid food to their baby, the proportion doing so before six months declined again in 2024, continuing the trend of mothers waiting longer to introduce solids. Most women received breastfeeding support in

[59] National Health Service. Solid foods and weaning. Available at: https://www.nhs.uk/conditions/pregnancy-and-baby/solid-foods-weaning. Accessed 16 October 2025.

hospital, primarily from midwives and breastfeeding specialists, and many women also received support at home, mostly from midwives and health visitors. Over a third of women who initiated breastfeeding wanted more professional help – this figure was lower than during the pandemic but higher than in pre-pandemic surveys.

5.6.5 Infant feeding: summary data

Table 6: Summary of infant feeding data

		2024 survey (N=3728)
	n*	%^
Mother's feeding intentions		(N=3723)
Only formula	522	16.1
Only breastmilk	2083	53.3
Combination of formula and breastmilk	936	26.6
Had not decided	182	4.0
Mother initiated breastfeeding		(N=3727)
No	460	14.1
Yes	3267	85.9
Duration of breastfeeding		(N=3515)
Never breastfed	460	15.1
Less than 6 weeks	490	14.8
6-8 weeks	181	4.8
9-13 weeks	157	4.5
14-25 weeks	270	7.4
26 weeks or longer	1957	53.4
Breastfeeding help and advice in hospital		(N=3254)
No, not needed	336	10.7
No	441	14.1
Don't know	35	1.3
Yes	2442	73.9
Sources of breastfeeding help and advice+		(N=2442)
Midwifery team	2108	84.3
Other health professional	391	16.7
Breastfeeding specialist	992	39.3
Partner	189	7.6
Family or friend	304	12.5
Other	87	3.1
Breastfeeding help and advice at home		(N=3250)
No, not needed	573	17.8
No	602	19.5
Don't know	19	0.9
Yes	2056	61.8
Sources of breastfeeding help and advice+		(N=2056)
Midwifery team	1279	61.8
Health visitor	1184	58.9
Other health professional	121	6.4
Breastfeeding specialist	795	34.6
Breastfeeding support group	443	18.4
Children's Centre	185	8.2
Peer supporter	161	6.9
National breastfeeding helpline	144	6.0
Social media forum	198	8.9
App	46	2.1
Partner	180	8.2
Family or friend	413	18.7
Other	36	1.7

Satisfaction with breastfeeding support		(N=3256)
Wanted/needed more support	1213	36.3
Did not want/need more support	2043	63.7
Mother initiated formula feeding		(N=3716)
No	771	20.5
Yes	2945	79.5
Timing of initiation of formula feeding		(N=2939)
From birth	1255	45.4
Mother introduced solid food to baby		(N=3717)
No	189	5.8
Yes	3528	94.2
Timing of introduction of solid food		(N=3705)
≤ 4 months (0–17 weeks)	273	8.6
> 4 months up to 5 months (18–22 weeks)	672	18.1
> 5 months up to 6 months (23–26 weeks)	2493	65.6
> 6 months or not at time of survey (>26 weeks)	267	7.7

* Unweighted totals ^ Weighted prevalence ⁺ Multiple options could be selected

6. Conclusion

This report draws on findings from the latest national maternity survey "You & Your Baby 2024", which captured the experiences of women who gave birth in England during May 2024. A total of 3,728 participants were recruited using a nationally representative sample of birth registration records provided by the Office for National Statistics.

Broader representation: We heard from a wide range of women with diverse characteristics, circumstances and experiences in the 2024 survey. When compared with previous surveys, it is notable that a higher proportion of responses were from women born outside the UK and women who identified as being from a minority ethnic group. The 2024 survey also included a higher proportion of responses from women living in the least advantaged areas in England, compared with our recent surveys. This shift in the distribution of respondent characteristics is partly due to the changing demographic profile of women giving birth in England. In addition, although the overall response rate declined compared with in the 2020 survey, the decrease was less pronounced among some groups of women who are typically less likely to respond, resulting in a more demographically diverse sample in 2024 and improved inclusion of voices sometimes underrepresented. For the first time in the 2024 survey, questions on sexual orientation, gender identity, language and religious beliefs were included, as well as multiple indicators of socioeconomic circumstances, including use of food banks and access to transport. With these additional data, future analyses can examine variation in health outcomes and maternity care experiences across diverse groups of women.

Some progress, some persistent challenges: Taken together, the findings from the 2024 survey reveal a complex picture, with some areas of maternal health and maternity care experiences showing improvement over time or recovery since our pandemic survey in 2020. Other areas, however, still lag behind those of women who gave birth before the pandemic. Therefore, the

findings suggest that the residual impact of the pandemic on health services and society as a whole may continue to influence maternity services and shape women's experiences.

Maternity care experiences were mixed: Perceptions of healthcare professionals were generally positive but a significant minority of women did not always feel they were listened to or treated with kindness, with respect or as an individual. This is concerning because these basic care principles should be consistently upheld for all women across all maternity settings. Involvement in decisions improved in pregnancy but remained lower during labour and childbirth. Trust in professionals on the other hand was highest during labour and childbirth, yet lower postnatally, especially for first-time mothers. While fewer women wanted more postnatal visits compared with during the pandemic, many still felt support was lacking. Encouragingly, more women received six-week checks and were asked about their postnatal mental health, yet one in five still missed this important aspect of care.

Satisfaction with postnatal care still lags behind: Overall satisfaction with maternity care remained high during pregnancy and childbirth. Although satisfaction with postnatal care improved compared with during the pandemic, it still fell short of pre-pandemic levels and remained lower than satisfaction reported for earlier stages of maternity care. These findings underline the importance and value to women of high-quality care throughout the maternity journey. The postnatal period is an extremely vulnerable time for women and the significance of a positive postnatal experience for long-term health outcomes for both mother and baby cannot be overstated.

Mental health problems were common: One in five women had a prior mental health diagnosis, primarily depression, anxiety, or post-traumatic stress disorder. Almost thirty percent of women scored above the clinical threshold on at least one standardised measure assessing symptoms of depression, anxiety, or post-traumatic stress during the postnatal period. A substantial number of women also recognised that they had experienced symptoms of anxiety and/or depression during pregnancy and/or the postnatal period, yet many did not receive support or treatment. For the first time, the survey captured symptoms of obsessive-compulsive disorder (OCD) which were reported by a significant minority of women, an important finding given that OCD is often under-recognised in perinatal populations. Many women also reported that their partner had experienced mental health problems, often beginning before their pregnancy and, for some, continuing through the perinatal period. This is an especially important finding because the needs of partners are often overlooked in maternity settings. The findings reveal the scale and significance of perinatal mental health problems and highlight the urgent need for improved identification and a range of support services including low resource interventions and information available for all women and their partners.

Smoking down but vaping up: Fewer women smoked tobacco during their pregnancy but more women were vaping. This finding is key because it reflects a shift in maternal health behaviour that carries both potential benefits and new risks. While it is often seen as a harm-reduction tool, vaping is not risk-free and there are limited long-term data on the effects of vaping during pregnancy.

Breastfeeding rates were encouraging: Breastfeeding initiation rates remained high and more women were breastfeeding for longer, which are encouraging findings. While most women received hospital-based support, fewer had help after being discharged home, a critical time when women may feel overwhelmed and isolated and breastfeeding challenges can occur. The fact that over a third of women still wanted more help shows a clear unmet need, though it is reassuring that this has improved since the pandemic.

Strengths: There are a number of strengths to the national maternity surveys, in particular the large nationally representative sample sizes and the application of survey weights to increase the generalisability of the findings to the wider population of women giving birth in England. Where possible, external validation of the estimates has also been provided using routine data for England or findings from the maternity surveys conducted by the Care Quality Commission. Another key strength is surveying women six months after childbirth—later than other maternity surveys—which enables the collection of detailed information on postnatal experiences over a longer period. The consistency in methodology between the 2024 survey and previous surveys enables comparisons over time, both with our pandemic and pre-pandemic surveys. The 2024 survey incorporated more detailed questions on mental health than previous surveys and provides key insight into an area that has been highlighted as a priority. Therefore, the national maternity surveys offer a number of advantages over other smaller studies: they provide a combination of large-scale sampling, the application of survey weights, external validation of survey estimates, carefully considered timing, and comprehensive topic coverage. These strengths position the surveys as a methodologically rigorous and reliable source of evidence on women's health and maternity experiences.

Limitations: The main limitation of the 2024 survey is the relatively low response rate, which aligns with those seen in other recent population-level health surveys and reflects common challenges faced by large-scale surveys. Although survey weights were applied to mitigate the effects of non-response bias, it is possible that non-response was influenced by unmeasured factors and this limitation should be taken into account when interpreting the survey findings. In addition, the analysis of trends over time is limited for some outcomes due to changes in question wording, made to align with current policies and practices and to ensure clarity and transparency for respondents, following recommendations from our Parent, Patient and Public Involvement (PPI) network. Finally, more detailed analyses examining health outcomes and maternity care experiences across different sociodemographic groups have yet to be conducted. These planned analyses will focus on health inequalities and will be presented in forthcoming publications.

Final thoughts: The 2024 survey highlights both progress and persistent challenges in maternal health and maternity care. While satisfaction with pregnancy and childbirth remains high, postnatal support and mental health care still need improvement. Good quality, equitable care is essential to ensure all women in England have safe, respectful, and supportive maternity experiences.

Appendix A: Survey methods

Survey design

The ways in which respondents can take part in the maternity surveys have changed over time (**Figure A1**). The 2006 survey relied exclusively on paper questionnaires but online participation has been offered in addition to paper questionnaires since 2010. In the 2020 survey, a "push-to-web" approach was trialled alongside the standard approach.[60] "Push-to-web" – where potential participants are invited via mail to complete the survey online – can offer advantages, including lower costs and improved data quality. In 2024, the survey adopted a fully "push-to-web" approach.

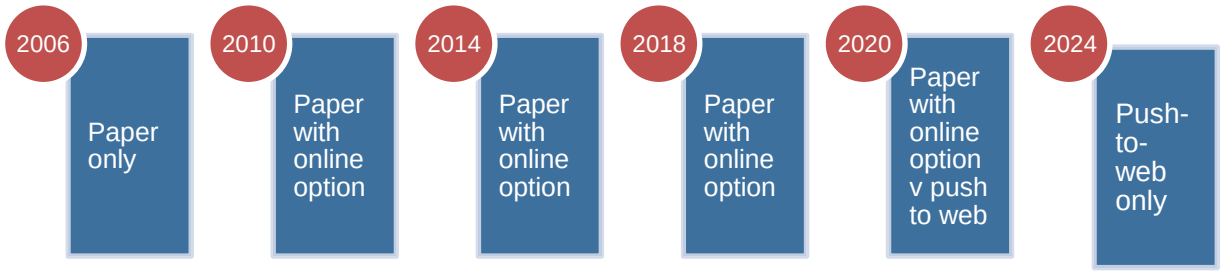

Figure A1: Response modes in each of the maternity surveys from 2006 to 2024

In the 2024 survey, women were encouraged to take part online using a website link or QR code printed on the invitation letter, a unique survey ID number and an individual password. All invitation letters included step-by-step instructions for how to complete the questionnaire online. The letters also advised women that they could request a paper copy of the questionnaire and Freepost return envelope by emailing the survey team or by contacting the survey helpline. Women were also advised in multiple languages that they could contact the survey helpline for help completing the survey over the telephone, with or without the assistance of an interpreter. The questionnaire was identical for women who took part by post or online. For women taking part over the telephone, there was the option to complete a shortened version of the questionnaire to reduce the burden on the women taking part, particularly if an interpreter was involved.

Sample size

Based on the response rate to the "push-to-web" component of the 2020 maternity survey (~27%), we calculated that inviting 16,000 women to the 2024 survey would provide sufficient data to estimate the prevalence of most outcomes with reasonable precision and allow comparisons across key outcomes in different groups of women, such as different age groups or socioeconomic groups. In the 2024 survey, we received 3,728 responses – a 23.6% response rate. With this sample size,

[60] Harrison S, Alderdice F, Quigley MA. Impact of sampling and data collection methods on maternity survey response: A randomised controlled trial of paper and push-to-web surveys and a concurrent social media survey. BMC Med Res Methodol. 2023;23(1):10. doi: 10.1186/s12874-023-01852-5.

we had approximately 90% power to detect a difference of five percentage points in a common outcome (e.g. postnatal depression: 20% vs. 15%), and to detect a smaller difference in less common outcomes (e.g. postnatal post-traumatic stress: 11% vs. 9%).

Data analysis: Survey response and representativeness

For our initial analysis, we described the response rate to the 2024 survey and compared the response rate to those in our previous maternity surveys. To assess the representativeness of the respondents, we compared the sociodemographic characteristics of the women who responded to the 2024 survey with those of the women who were selected but who did not respond. The sociodemographic characteristics we compared were provided by ONS: age group (16–19, 20–24, 25–29, 30–34, 35–39 or 40+ years); birth registration status (registration in married names, joint registration by both parents living at the same address, joint registration by both parents living at different addresses, or sole registration); mother's country of birth; index of multiple deprivation (IMD) for mother's address (grouped into quintiles); region of residence (grouped into nine regions in England); parity (primiparous (first-time mother) or multiparous (previous live birth)); sex of baby; whether it was a single or multiple birth, and birth weight (low birth weight (<2,500g) and normal birth weight (2,500g and above). Differences between respondents and non-respondents were compared using chi-square tests and the significance level was set at $p<0.05$ for all analyses (**Appendix F**).

We also show the characteristics of respondents to the 2024 survey alongside the characteristics of respondents to previous maternity surveys including: age group; birth registration status; mother's country of birth; IMD; region of residence; parity (as described above) in addition to ethnicity (White British, White Other, Bangladeshi, Indian, Pakistani, Black African, Black Caribbean, Other), further education (completed education aged <19 years, completed education aged 19 years or older), and cohabitation status (living with partner, not living with partner) (**Appendix H**).

Data analysis: Survey results

For our main analysis, survey-weighted descriptive statistics (e.g. proportions and medians) were estimated for survey respondents across all outcomes. For the majority of outcomes, the proportion of missing data was small (less than 5%) and therefore most results are based on a complete-case analysis. For most analyses, descriptive data are presented for all respondents. For some analyses, descriptive data are presented separately across subgroups, for example, by parity or mode of birth. To protect respondent confidentiality and to ensure that individuals cannot be identified through the data, small cell counts (<10) are either suppressed or aggregated.

Where possible, results from the 2024 survey are compared with those from our previous maternity surveys. Although similar topics have been included across the surveys, adjustments to questions have been made to improve clarity for respondents and to reflect current issues of interest. Therefore, the results are compared with the most recent survey with comparable data (estimating the difference between two proportions with a 95% confidence interval (CI)). For some data, trends over multiple surveys are presented. It is important to note that the findings presented from surveys carried out prior to 2014 are unweighted. The surveys conducted in 2010 and 2018 recruited women who had given birth during the previous calendar year, hence the dates shown in trend analysis figures correspond to dates of birth, as opposed to dates of survey completion.

Some results are compared with findings from the Care Quality Commission (CQC) maternity surveys. The 2024 CQC maternity survey is used for the comparisons, as it includes women who gave birth in February 2024, which most closely aligns with our sample of women who gave birth in May 2024. The CQC has subsequently published its most recent maternity survey, which includes women who gave birth in 2025.[61]

Where available, results from the 2024 survey (with 95% CIs) are also compared with national routine data pertaining to the same period of births or with the most recent data available. For example, data published by ONS, NHS Digital, NHS England, or the Office for Health Improvement and Disparities are used as a point of comparison. The data analysis was undertaken using STATA statistical software package – version 18.5.

Parent, Patient and Public Involvement

The national maternity surveys are an ongoing programme of work and each survey is based closely on earlier surveys to allow the assessment of change over time. Our previous surveys have all included extensive Parent, Patient and Public Involvement (PPI), including cognitive interviews and written feedback from individuals with diverse characteristics, backgrounds and experiences in order to assess the content, face validity and acceptability of the questionnaire and other survey materials.

The 2024 survey was undertaken by the NIHR Policy Research Unit in Maternal and Neonatal Health and Care (PRU-MNHC), which includes two PPI Co-Leads as part of the core team, in addition to a Task Group with four members: https://www.npeu.ox.ac.uk/pru-mnhc/public-involvement. The PPI Co-Leads and Task Group were involved in the design of the 2024 survey from the outset and drew on their vast network to gain additional input to the survey. Input from the PPI network was sought for the design of survey materials including the topics and questions

[61] Care Quality Commission. Maternity survey 2025. Available at https://www.cqc.org.uk/publications/surveys/maternity-survey. Accessed 8 January 2026.

included in the questionnaire, and the language used in the questionnaire, invitation letter and participant information sheet. As a result of this feedback, changes were made to the language across these materials to improve clarity and sensitivity.

The survey findings were shared with PPI representatives and policymakers at the inaugural PRU-MNHC Academy in November 2025 to aid interpretation. PPI was also sought for co-production of an infographic summary report and planning the dissemination strategy. The infographic summary report is published on the survey website alongside this report to highlight the key findings for the women who took part in the survey and other lay audiences.

We also engage with our PPI Co-Leads, Task Group and wider network in the preparation of our academic papers which are based on findings from the survey. In particular, we gain input on the interpretation of survey results, drafting of lay summaries, and co-production of infographic summaries of the papers: https://www.npeu.ox.ac.uk/maternity-surveys/our-results/information-for-parents.

Ethics

Ethical approval for the study was obtained from Oxford Central University Research Ethics Committee (CUREC reference: R95723/RE001) on 3 October 2024. Amendments were approved on 27 November 2024 (CUREC reference: R95723/RE002) and 15 January 2025 (CUREC reference: R95723/RE003).

Appendix B: Questionnaire content

Table A1: Questionnaire content

Section	Topics
Your pregnancy	Singleton or multiple pregnancy Sex and age of baby Gestational age and birth weight Pregnancy planning Fertility treatment Reaction to pregnancy Type of healthcare Timing of booking appointment Mental health assessment at booking appointment Pregnancy-related health problems Fear of childbirth Vaccinations during pregnancy Number of midwives during pregnancy Attendance at antenatal classes Access to information online Preparedness for childbirth Care from health professionals during pregnancy Involvement in decisions about care during pregnancy Confidence and trust in health professionals during pregnancy Satisfaction with care during pregnancy
Your labour and the birth of your baby	Planned and actual place of birth Reasons for changes to planned place of birth Freebirth Labour and induction Mode of birth Episiotomy and tearing Number of midwives during labour and birth Holding the baby and skin-to-skin contact Care from health professionals during labour and birth Involvement in decisions about care during labour and birth Confidence and trust in health professionals during labour and birth Experience of labour and birth Labour and birth expectations Satisfaction with care during labour and birth
After the birth of your baby	Hospital admission following the birth and length of stay Views about length of stay Admission for neonatal care and length of stay Continuity of carer Contact with midwives after the birth Maternal postnatal six-week check Content of postnatal six-week check Mental health assessment after the birth Physical health after the birth Care from health professionals after the birth Confidence and trust in health professionals after the birth Satisfaction with care after the birth
Feeding your baby	Initiation of breastfeeding Duration of breastfeeding Sources of breastfeeding support in hospital Sources of breastfeeding support at home Mode of breastfeeding support at home Initiation of formula feeding Introduction of solid food
Your health and wellbeing	Long-term health conditions or disabilities Mental health problems before pregnancy Anxiety during pregnancy and after the birth Diagnosis and support for anxiety Depression during pregnancy and after the birth Diagnosis and support for depression Post-traumatic stress symptoms during pregnancy and after the birth Severe mental health problems during pregnancy and after the birth Physical and mental health problems one, three and six months after the birth Partner's mental health

Your lifestyle and support	Sources of support Tobacco use during and after pregnancy Electronic cigarette / vaping device use during and after pregnancy Passive smoking during and after pregnancy Alcohol use during and after pregnancy
You and your household	Age Education Previous pregnancy Previous birth Employment Food bank use Access to transport Sexual orientation Gender identity Household composition Religion Country of birth Length of time living in the UK Ethnicity Language

Appendix C: Recruitment in the 2024 survey

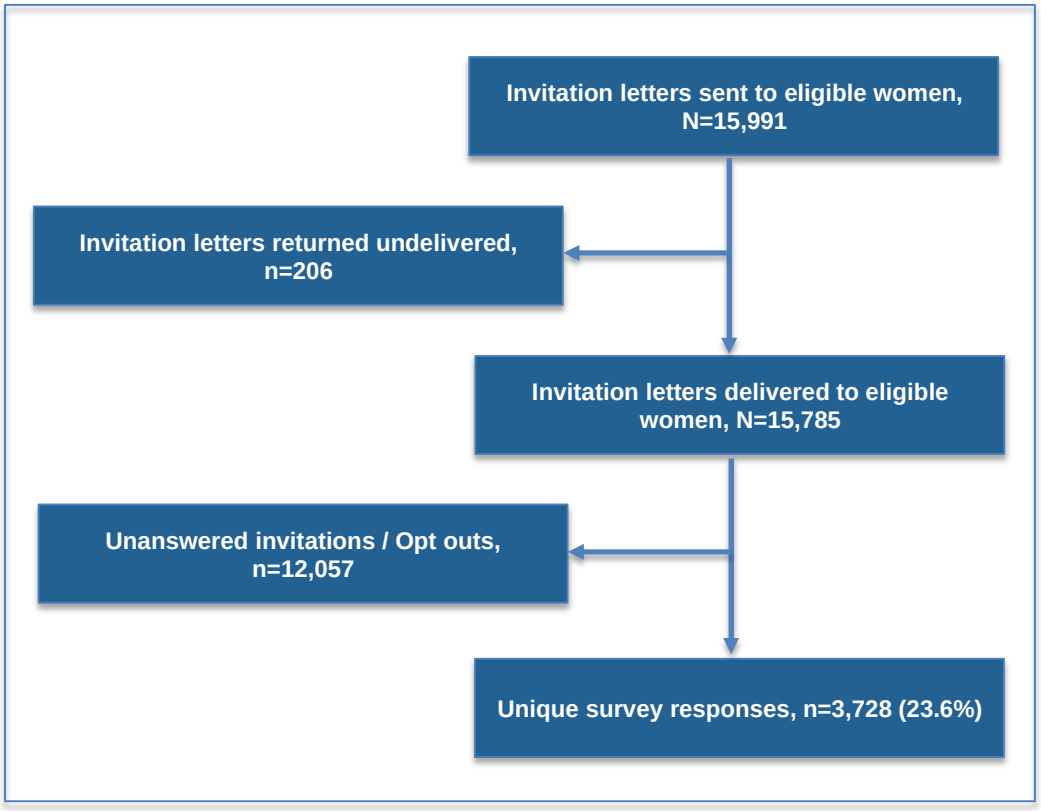

Figure A2: Flowchart of recruitment in the 2024 survey

Appendix D: Response rates across different groups of women

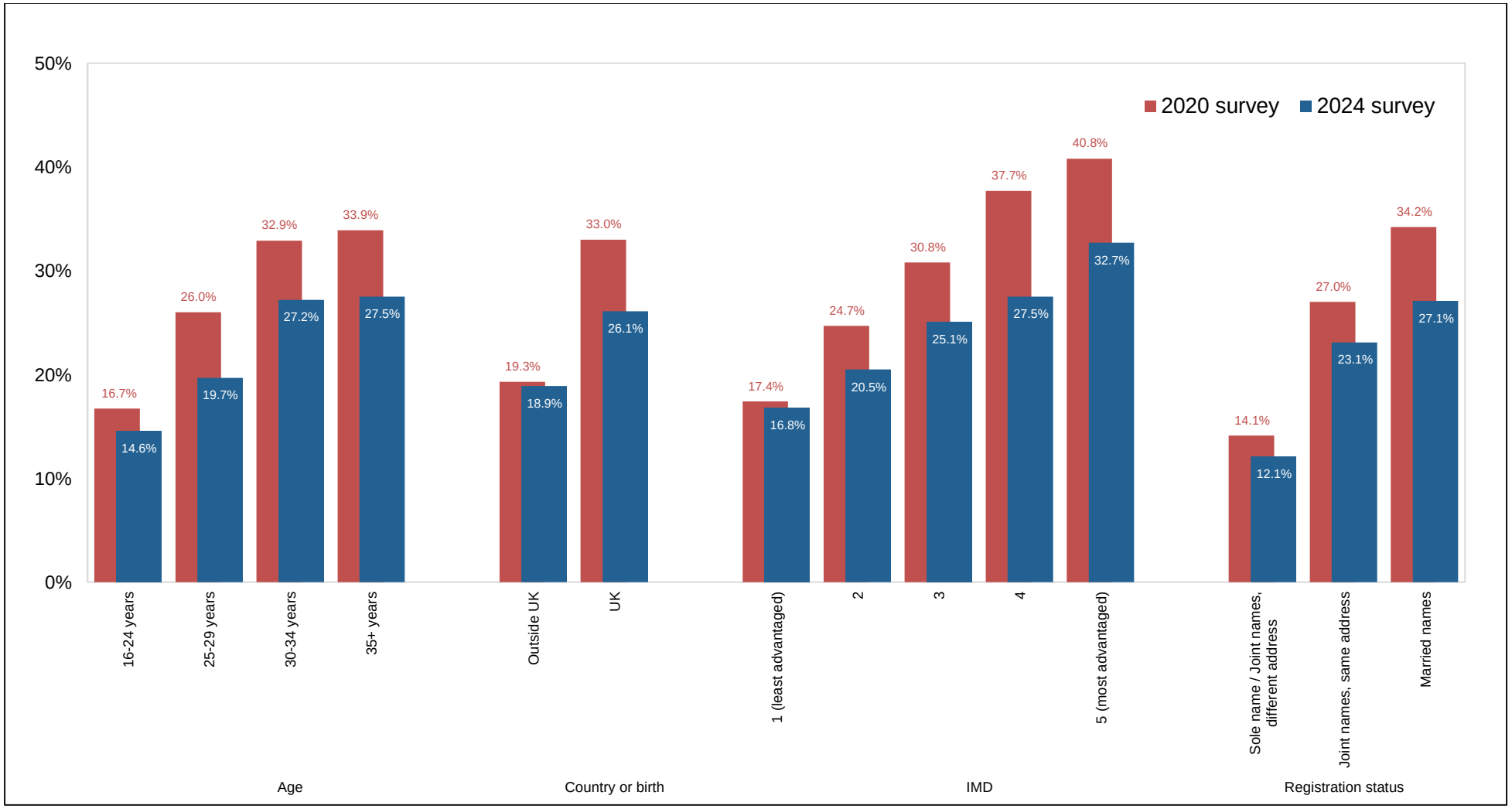

Figure A3: Response rates across different groups of women in the 2020 and 2024 surveys

Appendix E: Respondent characteristics

Table A2: Characteristics of respondents in the 2024 survey

		n	%*
Age group (N=3728)	16–19 years	53	1.4
	20–24 years	263	7.1
	25–29 years	792	21.2
	30–34 years	1471	39.5
	35–39 years	943	25.3
	40+ years	206	5.5
Country of birth (N=3728)	UK	2696	72.3
Ethnicity (N=3669)	White British	2487	67.8
	White Other	347	9.5
	Bangladeshi	54	1.5
	Indian	153	4.2
	Pakistani	115	3.1
	Black African	208	5.7
	Black Caribbean	33	0.9
	Other	272	7.4
Main language (N=3715)	English	3164	85.2
Birth registration status (N=3728)	Registration in married names	2294	61.5
	Joint registration (same address)	1157	31.0
	Joint registration (different address)	185	5.0
	Sole registration	92	2.5
Living with partner (N=3728)	Yes	3312	88.8
Region of residence (N=3728)	North East	143	3.8
	North West	464	12.5
	Yorkshire & the Humber	346	9.3
	East Midlands	304	8.2
	West Midlands	419	11.2
	East of England	455	12.2
	London	564	15.1
	South East	638	17.1
	South West	395	10.6
Index of multiple deprivation (N=3728)	1st (least advantaged)	662	17.8
	2nd	711	19.1
	3rd	785	21.1
	4th	760	20.4
	5th (most advantaged)	810	21.7
Use of food banks <12 months (N=3702)	Yes	143	3.9
Access to transport (N=3710)	No	532	14.3
Education (N=3708)	Degree (or equivalent)	2204	59.4
	A-level (or equivalent)	850	22.9
	GCSE (or equivalent)	426	11.5
	No qualifications	67	1.8
	Other	34	0.9
	Prefer not to say	127	3.4
Employment (N=3701)	Employed and working	302	8.2
	Employed and on maternity leave	2505	67.7
	Self-employed and working	61	1.7
	Self-employed and on maternity leave	122	3.3
	Unemployed	618	16.7
	Other	93	2.5
Religion (N=3713)	Buddhist	18	0.5
	Christian	1346	36.3
	Hindu	81	2.2
	Jewish	22	0.6
	Muslim	320	8.6
	Sikh	39	1.1
	No religion	1764	47.5
	Other / Prefer not to say	123	3.3

Sexual orientation (N=3701)	Heterosexual	3463	93.6
	Gay / Lesbian	20	0.5
	Bisexual	110	3.0
	Other / Prefer not to say	108	2.9
Gender identity (N=3711)	Woman	3689	99.4
	Other / Prefer not to say	22	0.6

* Missing data excluded

Appendix F: Respondent v non-respondent characteristics

Table A3: Characteristics of respondents and non-respondents in the 2024 survey

	Respondents		Non-respondents		p-value[1]
	N=3728		N=12057		
Maternal data	**n**	**%***	**n**	**%***	
Age group					<0.001
16–19 years	53	1.4	314	2.6	
20–24 years	263	7.1	1538	12.8	
25–29 years	792	21.2	3238	26.9	
30–34 years	1471	39.5	3941	32.7	
35–39 years	943	25.3	2410	20.0	
40+ years	206	5.5	616	5.1	
Birth registration status					<0.001
Registration in married names	2294	61.5	6188	51.3	
Joint registration (same address)	1157	31.0	3862	32.0	
Joint registration (different address)	185	5.0	1443	12.0	
Sole registration	92	2.5	564	4.7	
Country of birth					<0.001
UK	2696	72.3	7627	63.3	
(Outside UK)	(1032)	(27.7)	(4430)	(36.7)	
Bangladesh	32	0.9	226	1.9	
India	105	2.8	552	4.6	
Pakistan	74	2.0	485	4.0	
Africa	252	6.8	876	7.3	
Caribbean	18	0.5	51	0.4	
Europe	361	9.7	1361	11.3	
Other	190	5.1	879	7.3	
Index of multiple deprivation					<0.001
1st (least advantaged)	662	17.8	3285	27.3	
2nd	711	19.1	2756	22.9	
3rd	785	21.1	2339	19.4	
4th	760	20.4	2008	16.7	
5th (most advantaged)	810	21.7	1669	13.8	
Region of residence					<0.001
North East	143	3.8	538	4.5	
North West	464	12.5	1644	13.6	
Yorkshire & the Humber	346	9.3	1141	9.5	
East Midlands	304	8.2	962	8.0	
West Midlands	419	11.2	1367	11.3	
East of England	455	12.2	1315	10.9	
London	564	15.1	2373	19.7	
South East	638	17.1	1806	15.0	
South West	395	10.6	911	7.6	
Parity	**(N=3701)**		**(N=11910)**		<0.001
Primiparous	1900	51.3	5102	42.8	
Multiparous	1801	48.7	6808	57.2	
Single or multiple birth					0.647
Single	3679	98.7	11910	98.8	
Multiple	49	1.3	147	1.2	
Sex of baby					0.050
Male	1863	50.0	6247	51.8	
Female	1865	50.0	5810	48.2	
Birth weight	**(N=3614)**		**(N=11750)**		0.008
Low birth weight (<2500g)	170	4.7	689	5.9	
Normal birth weight (2500g+)	3444	95.3	11061	94.1	

[1] Significance level for Chi-square test comparing respondents and non-respondents to the 2024 survey
* Missing data excluded

Appendix G: Survey weights and external validity of data

For the 2024 survey, the sociodemographic variables provided by ONS for all respondents and non-respondents were fitted in a logistic regression model with response to the survey as the outcome. The resulting coefficients (adjusted log odds ratios) were used to derive survey weights, which were assigned to each respondent so that the weighted sociodemographic distribution of the sample closely matched the sociodemographic distribution of all eligible women in the sampling frame, which in turn was representative of all women giving birth in England during the same period. **Table A4** shows the distribution of the variables that were used to create the survey weights for the 2024 survey.

Table A4: Distribution of variables used to create the survey weights for the 2024 survey

	ONS Sample (N=15785) %	Respondents (N=3728) unweighted %	Respondents (N=3728) weighted %
Age			
<25 years	13.7	8.5	14.0
25–29 years	25.5	21.2	25.4
30–34 years	34.3	39.5	34.2
35+ years	26.5	30.8	26.3
Birth registration status			
Registration in married names	53.7	61.5	53.2
Joint registration (same address)	31.8	31.0	32.1
Joint registration (different address)	10.3	5.0	10.9
Sole registration	4.2	2.5	3.9
Country of birth			
UK	65.4	72.3	64.6
Bangladesh	1.6	0.9	1.6
India	4.2	2.8	4.2
Pakistan	3.5	2.0	3.8
Africa	7.2	6.8	7.7
Caribbean	0.4	0.5	0.4
Europe	10.9	9.7	11.0
Other	6.8	5.1	6.7
Index of multiple deprivation			
1st (least advantaged)	25.0	17.8	26.6
2nd	22.0	19.1	20.9
3rd	19.8	21.1	19.5
4th	17.5	20.4	17.5
5th (most advantaged)	15.7	21.7	15.5
Region of residence			
North East	4.3	3.8	4.4
North West	13.4	12.5	13.3
Yorkshire and the Humber	9.4	9.3	9.7
East Midlands	8.0	8.2	8.4
West Midlands	11.3	11.2	11.7
East of England	11.2	12.2	10.7
London	18.6	15.1	18.1
South East	15.5	17.1	15.5
South West	8.3	10.6	8.2
Parity*			
Primiparous	44.4	51.0	44.1
Multiparous	54.5	48.3	54.9

* Missing data not excluded (N=27)

Estimates of selected maternity indicators based on national routine data are available from published reports, and these estimates are used to assess the external validity of the survey data. **Table A5** shows how unweighted and weighted estimates from the 2024 survey data compare with estimates based on routine data. For some indicators, the weighted estimates from the survey data are close to estimates from routine data, particularly where we are able to compare the survey data to ONS data, which is the gold standard in terms of completeness and quality. However, it should be noted that the most recent ONS data available for some indicators are for 2022. In most instances where there are discrepancies, the source of the published data is HES, MSDS or OHID, which may be subject to completeness and/or quality issues.[62]

Table A5: External validity of unweighted and weighted 2024 survey data

	Published data		2024 survey data	
	Source		**Respondents unweighted**	**Respondents weighted**
		%	**%**	**%**
Multiple birth	ONS sample	1.2	1.3	1.2
Home birth	ONS[1]	1.9	3.0	3.0
Gestational age	ONS[1]			
<32 weeks		1.2	1.0	1.2
32–36 weeks		6.6	6.5	6.5
37+ weeks		92.2	92.5	92.3
Birth weight	ONS sample			
<1500 grams		0.6	0.4	0.5
1500–2499 grams		5.0	4.3	4.4
2500+ grams		94.4	95.3	95.1
Caesarean section	MSDS[2]	42.0	41.9	40.1
Ethnicity	HES[3]			
White British		55.1	66.7	59.3
White Other		10.7	9.3	9.9
Bangladeshi		2.3	1.5	2.2
Indian		5.2	4.1	5.0
Pakistani		5.4	3.1	4.7
Black African		5.0	5.6	6.8
Black Caribbean		0.9	0.9	1.0
Other		12.4	7.3	9.0
Not stated / Unknown		3.1	1.6	2.2
Skin-to-skin ≤1 hr (37+ weeks gestation only)	MSDS[2]	74.7	90.2	90.2
Booking appointment	MSDS[2]			
Within 10 weeks		63.5	71.8	68.8
Within 12 weeks		78.3	89.7	87.9
Breastfeeding initiation	MSDS[2]	73.0	87.7	85.9
Breastfeeding at 6–8 weeks	OHID[4]	59.3	73.0	70.1
Smoking at birth	MSDS[5]	6.3	2.2	3.2
Vaping (all women aged 16+ years)	ONS[6]			
Ever		13.8	16.4	18.5
Current		8.3	4.6	5.9

ONS: Office for National Statistics MSDS: Maternity Services Dataset HES: Hospital Episode Statistics
OHID: Office for Health Improvement and Disparities

[62] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2023-24/data-quality-statement-msds Accessed 20 June 2025.

All published data are for live births.

[1] ONS Birth characteristics 2022 (England, not stated excluded) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthcharacteristicsinenglandandwales. Accessed 20 June 2025.

[2] NHS Maternity Statistics, England 2023-24 (not stated excluded) https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2023-24. Accessed 20 June 2025.

[3] Hospital Episode Statistics. Maternal ethnicity for those who were admitted or discharged from a birth admission in May 2024. Personal communication. 2025

[4] Breastfeeding at 6 to 8 weeks: data for 2024 to 2025 https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-data-for-2024-to-2025. Accessed 20 June 2025.

[5] Statistics on Mother's Smoking Status at Time of Delivery, England 2024-25 Quarter 1 https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/statistics-on-womens-smoking-status-at-time-of-delivery-england-q1-2024-25. Accessed 28 August 2025.

[6] E-cigarette use in England 2023 (women only but not specific to women during pregnancy) https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/ecigaretteuseinengland. Accessed 20 June 2025

Appendix H: Respondent characteristics across maternity surveys

Although the broad distribution of respondent characteristics was similar across the surveys, there were some subtle changes in the distributions of respondent characteristics over time (**Table A6**). For example, there were small decreases in the proportion of younger mothers, those registering the birth in their sole name, and those living in less advantaged areas between 2006 and 2020. In the 2024 survey, however, the proportion of sole registrations did not change (compared with in the 2020 survey), the proportion of the youngest mothers (aged 16–19 years) increased marginally (from 1.0% to 1.4%), and the proportion of women living in the least advantaged areas increased from 15.1% to 17.8%. The proportion of respondents who were born outside the UK increased between 2006 and 2014, then decreased in 2018 and 2020, before increasing again in the 2024 survey (from 20.3% to 27.7%). The proportion of respondents who self-identified as being of White British ethnicity was between 74.2% and 80.6% from 2006 to 2020, and then decreased to 67.8% in the 2024 survey. There was some variation but no clear patterns in the regional distribution of respondents over time. The proportion of women leaving full-time education aged 19 years and older increased over time, although the data from the 2024 survey are not directly comparable due to the question being updated to reflect attainment of qualifications as opposed to age at completion of education. The observed changes over time are likely to reflect the shifting sociodemographic characteristics of women who give birth in England and the characteristics of those who respond to surveys.

Table A6: Comparison of respondent characteristics across the maternity surveys

Year of survey		**2006**		**2010**		**2014**		**2018**		**2020**		**2024**
(Year mother gave birth)		**(2006)**		**(2009)**		**(2014)**		**(2017)**		**(2020)**		**(2024)**
	n	**%***	**n**	**%***	**n**	**%***	**n**	**%***	**n**	**%***	**n**	**%***
Age group	N=2934		N=5332		N=4569		N=4509		N=4611		N=3728	
16-19 years	115	3.9	179	3.4	101	2.2	59	1.3	44	1.0	53	1.4
20-24 years	452	15.4	729	13.7	538	11.8	359	8.0	355	7.7	263	7.1
25-29 years	702	23.9	1376	25.8	1228	26.9	1055	23.4	1117	24.2	792	21.2
30-34 years	959	32.7	1740	32.6	1587	34.7	1713	38.0	1785	38.7	1471	39.5
35-39 years	601	20.5	1068	20.0	874	19.1	1054	23.4	1089	23.6	943	25.3
40+ years	105	3.6	240	4.5	241	5.3	269	6.0	221	4.8	206	5.5
Registration status			N=5332		N=4569		N=4509		N=4611		N=3728	
Married names	N/A	62.5	3278	61.5	2744	60.1	2865	63.5	2886	62.6	2294	61.5
Joint names (same address)	N/A	27.7	1550	29.1	1395	30.5	1322	29.3	1392	30.2	1157	31.0
Joint names (different address)	N/A	5.8	311	5.8	291	6.4	216	4.8	220	4.8	185	5.0
Sole name	N/A	3.9	193	3.6	139	3.0	106	2.4	113	2.5	92	2.5
Index of multiple deprivation	N=2954		N=5331		N=4570		N=4509		N=4611		N=3728	
1st (least advantaged)	601	20.3	1091	20.5	894	19.6	706	15.7	698	15.1	662	17.8
2nd	576	19.5	1013	19.0	977	21.4	869	19.3	876	19.0	711	19.1
3rd	624	21.1	1131	21.2	935	20.5	945	21.0	957	20.8	785	21.1
4th	551	18.7	1041	19.5	865	18.9	1006	22.3	1070	23.2	760	20.4
5th (most advantaged)	602	20.4	1055	19.8	899	19.7	983	21.8	1010	21.9	810	21.7

Country of birth		N=2882		N=5332		N=4569		N=4509		N=4611		N=3728
UK	2402	83.3	4180	78.4	3485	76.3	3479	77.2	3674	79.7	2696	72.3
Ethnicity		N=2919		N=5237		N=4428		N=4357		N=4548		N=3669
White British	2353	80.6	4012	76.6	3286	74.2	3255	74.7	3465	76.2	2487	67.8
White Other	199	6.8	475	9.1	429	9.7	524	12.0	446	9.8	347	9.5
Bangladeshi	18	0.6	32	0.6	43	1.0	38	0.9	41	0.9	54	1.5
Indian	78	2.7	142	2.7	161	3.6	103	2.4	143	3.1	153	4.2
Pakistani	71	2.4	129	2.5	132	3.0	78	1.8	101	2.2	115	3.1
Black African	76	2.6	160	3.1	127	2.9	80	1.8	101	2.2	208	5.7
Black Caribbean	21	0.7	27	0.5	27	0.6	12	0.3	22	0.5	33	0.9
Other	103	3.5	260	5.0	223	5.0	267	6.1	229	5.0	272	7.4
Region of residence				N=5332		N=4561		N=4509		N=4611		N=3728
North East	N/A	4.9	230	4.3	191	4.2	161	3.6	207	4.5	143	3.8
North West	N/A	13.5	642	12.0	589	12.9	505	11.2	514	11.1	464	12.5
Yorkshire and the Humber	N/A	10.3	509	9.5	434	9.5	420	9.3	416	9.0	346	9.3
East Midlands	N/A	9.1	407	7.6	383	8.4	368	8.2	364	7.9	304	8.2
West Midlands	N/A	11.0	501	9.4	426	9.3	424	9.4	473	10.3	419	11.2
East of England	N/A	10.9	643	12.1	524	11.5	549	12.2	541	11.7	455	12.2
London	N/A	12.5	915	17.2	780	17.1	782	17.3	768	16.7	564	15.1
South East	N/A	17.8	952	17.9	793	17.4	869	19.3	824	17.9	638	17.1
South West	N/A	10.0	533	10.0	441	9.7	431	9.6	504	10.9	395	10.6
Age when leaving education		N=2892		N=5165		N=4474		N=4460		N=4563		N=3546[1]
19 years or over	1195	41.3	2617	50.7	2509	56.1	2883	65.5	2823	61.9	2532	71.4
Living with partner		N=2944		N=5293		N=4571		N=4509		N=4611		N=3728
Yes	2592	88.0	4654	87.9	3980	87.1	4045	89.7	4144	89.9	3312	88.8
Parity		N=2844		N=5213		N=4423		N=4509		N=4596		N=3701
Primiparous	1165	41.0	2610	50.1	2206	49.9	2320	51.5	2329	50.7	1900	51.3

* Missing data excluded
[1] Education question was different in the 2024 survey and data are not comparable with previous surveys