



Maternal and Newborn Health in Halton Report 2026



Reference

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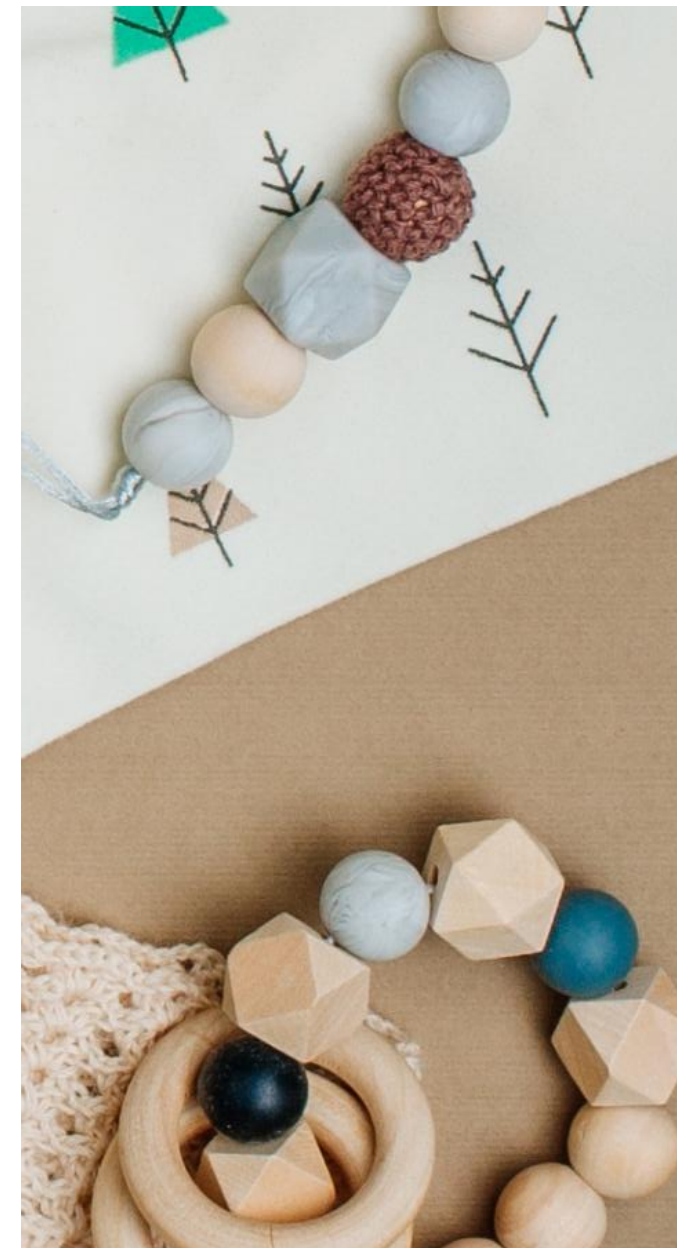


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Executive summary

Each year, approximately 5,200 births occur in Halton. Halton Region Public Health offers a range of programs and services to support families and promote healthy pregnancies, births, and early childhood development. These include SmartParent, a prenatal and parenting text-messaging program; online prenatal education and support; the Halton Breastfeeding Connection, which provides telephone support for expectant and breastfeeding parents; the Healthy Babies Healthy Children (HBHC) home-visiting program; and a variety of parenting support and neighbourhood-based groups.

The **Maternal and Newborn Health in Halton 2026** report provides a snapshot of the health and well-being of mothers and infants across Halton Region. This report presents data on key maternal and newborn health indicators to inform the planning, delivery, and evaluation of programs, services, and policies that support the health and well-being of expectant and new mothers and their newborns. Highlights from the report can be found in the infographic on the following page.

Important notes about this report:

- For the purposes of this report, the terms woman, women, female or mother refer to people who were assigned female at birth, recognizing that an individual's gender identity may differ from their anatomical, physiological or genetic assignment. This aligns with the indicators and data sources used in this report.
- Differences mentioned throughout the report are statistically significant unless otherwise specified.
- For some analyses, multiple years of data (e.g., 2021-2023) were combined to generate reportable estimates.
- For figures shown in this report, a single asterisk (*) is used to indicate results that should be interpreted with caution due to high variability. A double asterisk (**) is used where a result cannot be reported because there are too few individuals in the group (six or fewer), or the level of uncertainty is too high.



Maternal and Newborn Health in Halton: Report Highlights

1

Pregnancy rates in Halton declined from 2013 to 2020, reached their lowest point in 2020, then rose slightly without significant change. Halton's rate is lower than Ontario's.



2

Halton's population is aging and the proportion of females of reproductive age (15 to 49) is decreasing. However, because Halton's population overall is growing, the number of females of reproductive age is expected to continue increasing through at least 2050.

3

In Halton, the average woman has about 1.3 children over her lifetime.

For the population to naturally replace itself without declining, that number would need to be about 2.1 children per woman.



4



The average age of first-time mothers in Halton has increased from 28 in 1993 to 32 in 2023.

5

More than one-third of all births in Halton are to mothers aged 35 or older.



6



The percentage of women who said they experienced anxiety during pregnancy more than doubled between 2013 (7.6%) and 2023 (18.7%).

7

The percentage of mothers breastfeeding exclusively at hospital discharge (following birth) decreased between 2013 (63.6%) and 2023 (48.5%).



8

Most babies in Halton are born full-term and at a healthy birthweight, though rates of pre-term and small-for-gestational-age births have increased over time.

9

Most women in Halton report healthy behaviours during pregnancy, though there continue to be challenges related to weight management, gestational diabetes, and mental health.



10

Serious health outcomes for newborns, including congenital anomalies and infant mortality, remain uncommon in Halton.



How information in this report can be used

Planning and Service Delivery

An aging population, declining fertility, and later childbearing underscore the importance of supportive policies and programs that enable women and families to achieve their reproductive goals. Municipal differences in age structure can inform planning and allocation of prenatal, birth, and early-years resources.

Education, Prevention, and Early Support

Prenatal education and early-pregnancy support, including screening for gestational diabetes and mental health concerns, and guidance on nutrition and physical activity, remain essential given rising risks related to weight, metabolic health, and mental health. Continued focus on the early postpartum period, including breastfeeding education and newborn follow-up, can support healthy infant development.

Health Equity and Access to Care

Reducing barriers to prenatal care, contraception, and fertility services, and tailoring supports for populations facing greater challenges can help address inequities in maternal and infant outcomes.

Demographics and social determinants of health

This section describes the demographic profile of women of reproductive age (i.e., aged 15 to 49) in Halton and how the population structure is changing over time. It also summarizes key social determinants of health (e.g., income, education, family structure, immigration and cultural diversity) that can shape maternal and infant health by influencing access to resources, supports, and healthcare. Findings are presented for Halton overall, with additional detail by municipality where available, and comparisons to Ontario for selected indicators.



What the Data Tell Us

- Halton's age structure varies by municipality. Milton has the highest proportion of women of reproductive age, while Oakville has the largest number. Oakville and Halton Hills have fewer children and younger families, suggesting a possible decline of birth rates in the future, while Burlington's more even age distribution reflects an older, stable population.
- The number of women of reproductive age in Halton has increased and is projected to continue increasing through at least 2050. However, they are expected to make up a slightly smaller share of the population as Halton continues to age.
- Women in Halton are having children later in life, with births to mothers aged 35+ becoming more common, particularly in Burlington and Oakville. Compared with Ontario, women aged 15 to 44 in Halton are less likely to live in low income or be single parents, and more likely to have higher education, be immigrants or from culturally diverse communities, and access prenatal care early in pregnancy.

How This Information Can Be Used

- 1 Health providers and planners can use municipality-level differences in population age structure to anticipate future demand for prenatal, birth, and early-years services. Milton's higher share of women of reproductive age and Oakville's larger number of women in this age group suggest service needs may be greater in these areas.
- 2 Programs and services may consider the continued rise in older first-time parents and advanced maternal age, particularly in Burlington and Oakville, when planning screening, counselling, and referral pathways to appropriate clinical and community supports.
- 3 Ongoing monitoring of population changes and social determinants of health can help guide culturally safe, accessible approaches. It can also help to identify subgroups who may still face barriers, such as delayed access to prenatal care, or who require additional supports and services.

Population pyramids

A population pyramid shows how a population is divided by age and sex. It provides insights into demographic trends and future societal needs. Widening (or narrowing) at any point in a population pyramid suggests that a particular age group has a larger (or smaller) population compared to other age groups.

A triangular-shaped pyramid (i.e., a wide base) suggests a rapidly growing population with high birth and death rates, while an inverted triangle (i.e., a narrow base) reflects a declining population with low birth rates and an aging demographic. A rectangular shape shows a stable population. A wide middle can be due to immigration, lower birth rates or an aging population.

Figure 1 shows the population pyramids for each municipality in Halton for 2023:

- Burlington has the lowest percentage of females of reproductive age (42% or 42,586 females) in Halton. The more rectangular pyramid shows a population that is similar across age groups.
- Oakville has the largest number of females of reproductive age (54,590 females or 46%), with many in their early and late reproductive years. The narrow base may indicate a future decline in births that could impact long-term population growth.
- Milton has the highest percentage of females of reproductive age in Halton (52% of females, or 38,690 females), with many in their mid or late reproductive years. Milton’s pyramid shows a relatively stable, but slightly aging population.
- Halton Hills has the smallest number of females of reproductive age (14,932 females or 45%). The pyramid shows that many of these women are in their early or late reproductive years. The narrow base suggests a possible decline of birth rates in the future.

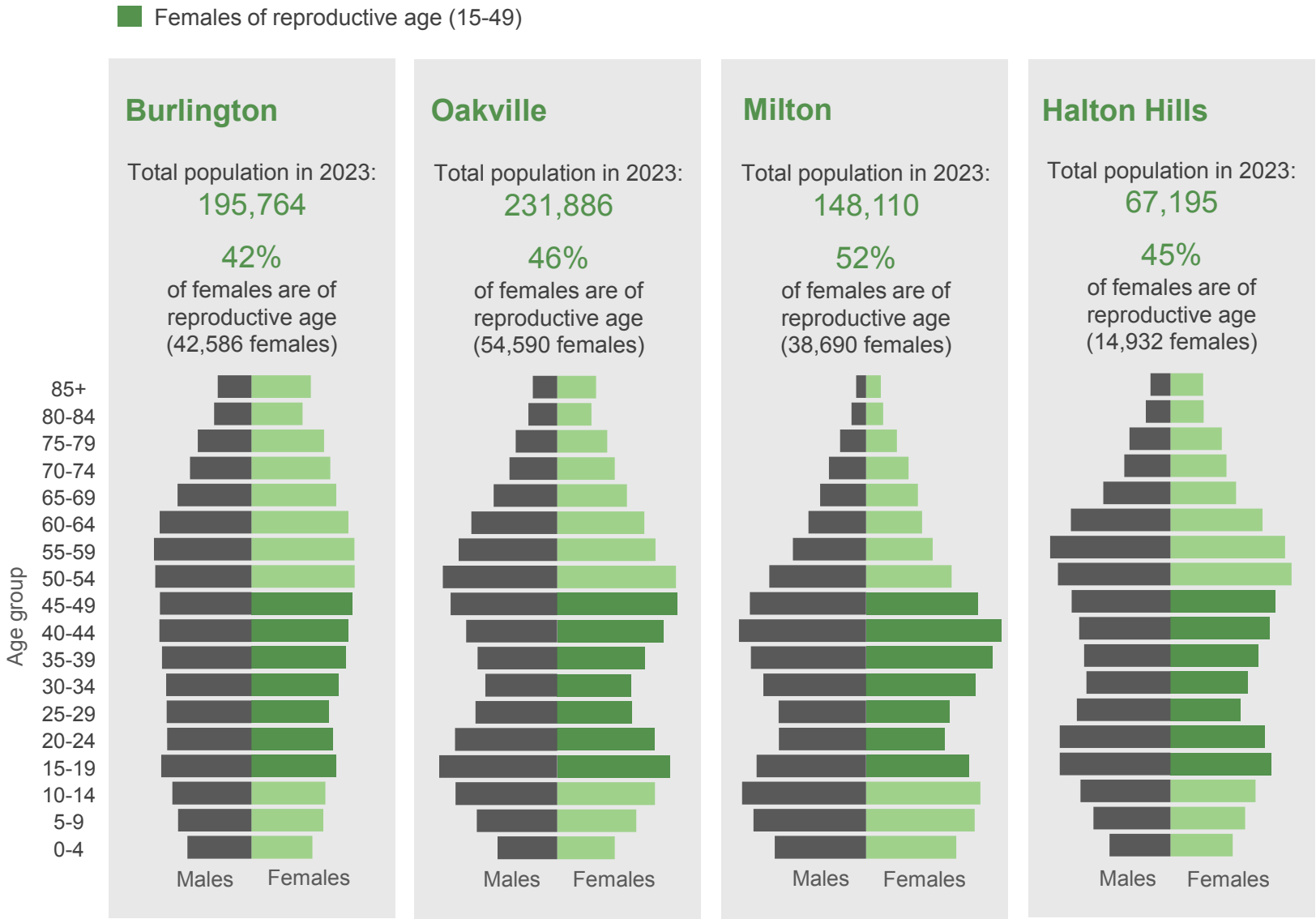
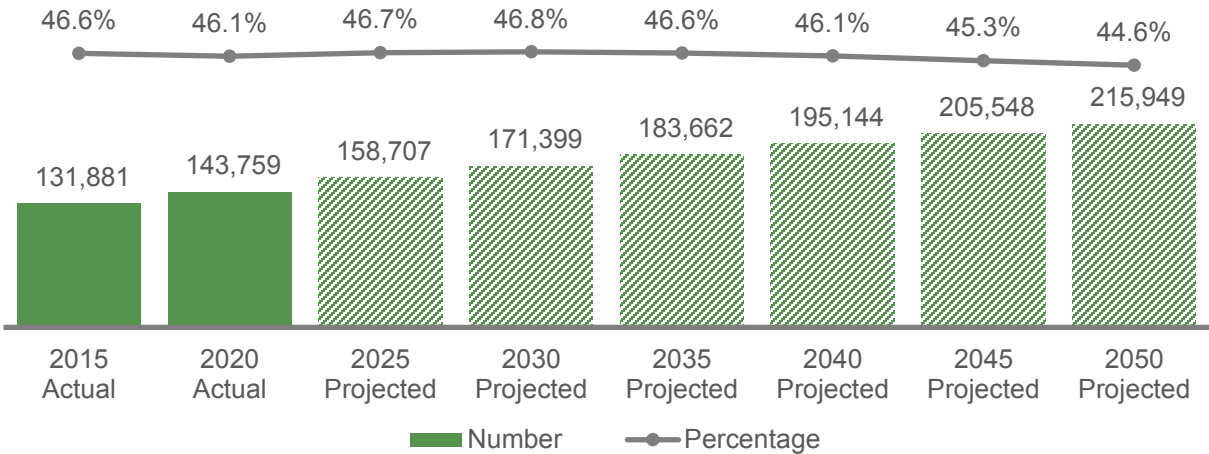


Figure 1: Population pyramids, by age and sex, Milton, Oakville, Halton Hills and Burlington, 2023

Data: Population Estimates [2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted February 2, 2025.



Figure 2: Number and percentage of females of reproductive age (15-49), Halton, 2015-2050



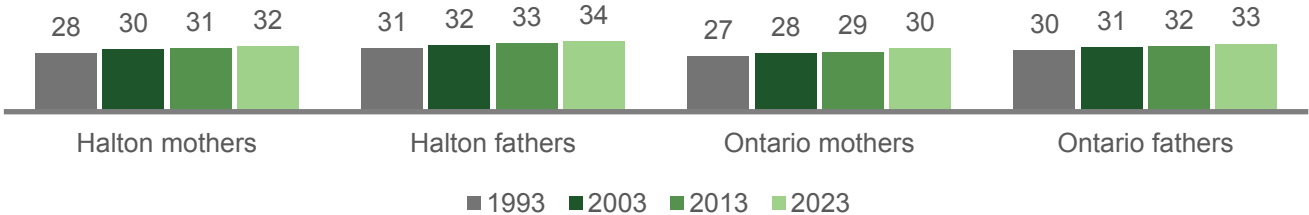
Number of women of reproductive age

Figure 2 shows the number of females in Halton who are of reproductive age, meaning they are between the ages of 15 and 49. Data are shown in five-year increments from 2015 through 2050. The number of females who are aged 15 to 49 has increased over time and is projected to continue increasing through at least 2050 as Halton’s population grows. However, due to Halton’s aging population, the percentage of females who are of reproductive age is expected to decrease slightly over time. While females in this age group made up roughly 47% of Halton’s population in 2015, they are expected to account for approximately 45% by 2050.

Average age of first-time mothers and fathers

Figure 3 shows the average age of mothers and fathers at the time of their first infant’s birth in Halton and Ontario. Data are shown in ten-year increments from 1993 through 2023. Similar to Ontario, the average age of first-time mothers and fathers has increased over time from 28 to 32 years of age for Halton mothers and from 31 to 34 years of age for Halton fathers.

Figure 3: Average age of mothers and fathers at first infant’s birth, Halton and Ontario, 1993, 2003, 2013, 2023



Data for Figure 2: Population Estimates [2015, 2020]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted February 2, 2025. Population Projections [2025, 2030, 2035, 2040, 2045, 2050]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted February 2, 2025. Data for Figure 3: Ontario Vital Statistics [1993, 2003, 2013, 2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted March 24, 2025.

Advanced maternal age

The term “advanced maternal age” refers to pregnancy at or after the age of 35. Higher maternal age is associated with increased risk of certain health conditions or outcomes for mothers, including gestational diabetes, high blood pressure, and chances of having a cesarean section. It is also linked to risks for the infant, such as pre-term delivery, low birth weight, perinatal death, and neonatal intensive care unit admission (Statistics Canada, 2022).

Between 2013 and 2023, the percentage of mothers who were aged 35 or older when they gave birth or gave birth to their first child increased significantly in Halton and Ontario (Figure 4 and Figure 5). In 2023, Halton women were more likely to be aged 35 or older when they gave birth or became first-time mothers compared to mothers in Ontario.

In 2023, Burlington and Oakville had higher proportions of mothers who were aged 35 or older when they gave birth compared to Milton or Halton Hills (Figure 6). Milton had a lower proportion of first-time mothers aged 35 or older compared to Burlington or Oakville. There were no other statistically significant differences by municipality.



Figure 4: Percentage of mothers aged 35 or older at time of birth, Halton and Ontario, 2013 and 2023

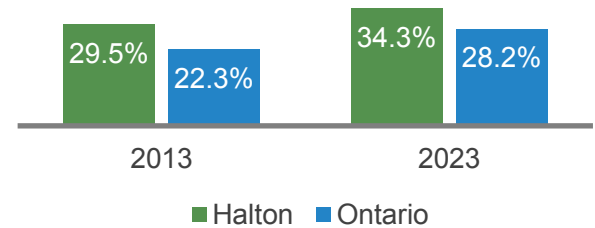


Figure 5: Percentage of first-time mothers aged 35 or older at time of first birth, Halton and Ontario, 2013 and 2023

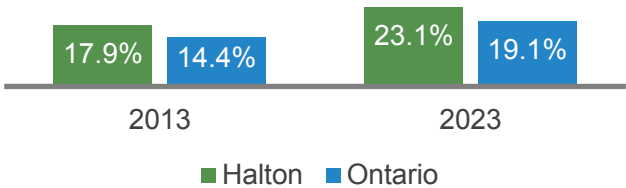
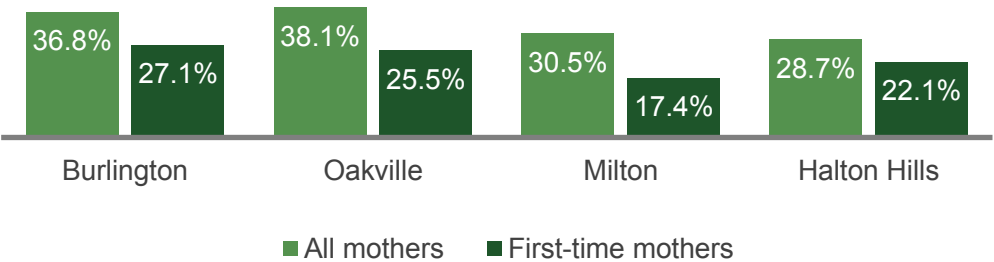


Figure 6: Percentage of mothers aged 35 or older at time of birth and percentage of first-time mothers aged 35 or older at time of birth, by municipality, Halton, 2023



Data for Figure 4 and Figure 5: Inpatient Discharges (mother's record) [2013, 2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted March 24, 2025. Data for Figure 6: Ontario Vital Statistics [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted March 24, 2025. Data for all figures shown on this page include live births only.

Social determinants of health among women of reproductive age

Socio-demographic factors shape maternal and newborn health by influencing access to resources, healthcare services, and social support systems. For example:

- Lower-income individuals may struggle to afford nutritious food, or safe housing, both of which are critical for a healthy pregnancy and infant development.
- Marital status and single parenthood can affect financial stability and emotional support, both of which are important during pregnancy and postpartum.
- Education levels can sometimes impact a person’s ability to seek, understand or follow medical advice.
- Immigrant and visible minority populations may face barriers like language difficulties, discrimination, or limited access to culturally-safe care, which can lead to disparities in health outcomes.

By understanding these factors, healthcare providers and policymakers can develop enhanced interventions to reduce health inequalities and improve outcomes for mothers and newborns across diverse communities.

Figure 7 shows the percentage of women aged 15 to 44 who had certain demographic characteristics in 2021. Halton was significantly lower compared to Ontario when looking at the percentage of women who were living in low income (based on the After-Tax Low-Income Measure) or who were single parents.

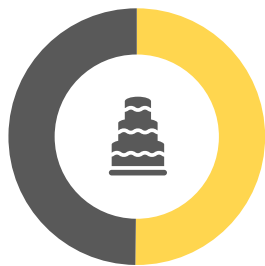
Halton was significantly higher compared to Ontario when looking at the percentage of women who were married or living in common-law relationships, had a post-secondary education or a bachelor’s degree or higher level of education, or who were immigrants or recent immigrants to Canada. The percentage of Halton women who belonged to a culturally diverse group was slightly higher compared to Ontario.

Access to prenatal care is also considered a social determinant of health and directly influences health outcomes for both mothers and infants. Data from the Better Outcomes Registry & Network (BORN) show that the percentage of women who gave birth in 2023 and did not attend a prenatal visit during their first trimester was significantly lower in Halton (4.5%; not shown) compared to Ontario (6.7%).

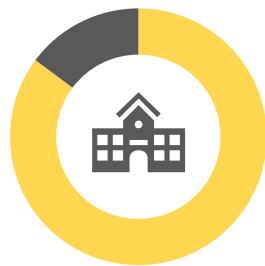
Among women aged 15 to 44 in 2021:



6.3%
in Halton were living in low income, compared to 9.4% in Ontario



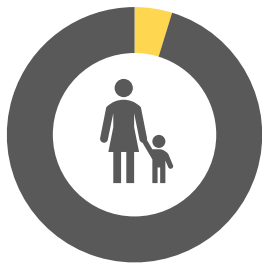
50.2%
in Halton were married or living in a common-law relationship, compared to 46.3% in Ontario



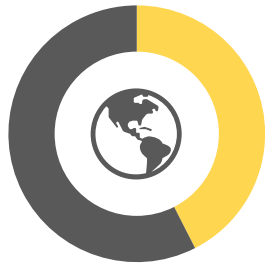
85.2%
in Halton had a post-secondary education, compared to 77.7% in Ontario



61.5%
in Halton had a bachelor's degree or higher level of education, compared to 48.3% in Ontario



4.8%
in Halton were single parents, compared to 6.9% in Ontario



42.5%
in Halton belonged to a culturally diverse group, compared to 41.7% in Ontario



35.0%
in Halton were immigrants to Canada, compared to 28.6% in Ontario



8.2%
in Halton were recent immigrants to Canada, compared to 7.4% in Ontario

Figure 7: Percentage of women aged 15 to 44 with select socio-demographic characteristics, Halton and Ontario, 2021

Data: Census profile, 2021 Census of Population [2021]. Statistics Canada, extracted March 6, 2025. Notes: Data for the percentage of women living in low income (based on the After-Tax Low-Income Measure) are from 2020. All other indicators include data from 2021. Culturally diverse refers to the category “Visible Minority” in the 2021 Census. As it was not possible to look specifically at women of reproductive age (15-49) in the Census dataset, the most similar age grouping available was used (15-44).

Pregnancies, births and fertility

This section presents key indicators related to pregnancy, births, and fertility in Halton and Ontario. It covers overall and age-specific pregnancy and fertility rates, induced abortion trends, use of assisted reproductive technology, multiple births, and stillbirths. Data are analyzed over time and by municipality to highlight patterns, emerging issues, and differences across age groups.



What the Data Tell Us

- Pregnancy rates in Halton and Ontario reached a record low in 2020, after which point they increased slightly, though not significantly. In 2023, Halton's rate was lower than Ontario's. Births in Halton remain concentrated in Milton, Oakville, and Burlington, while crude birth rates have declined across the region.
- While most pregnancies and births occur among women aged 30 to 34, birth rates have declined for younger women and increased for women aged 35 to 44. This trend reflects delayed childbearing and greater use of assisted reproductive technology, which is more common in Halton compared to Ontario.
- Induced abortion rates were highest in 2023 in both Halton and Ontario, with abortions more likely than deliveries among teens and young adults.

How This Information Can Be Used

- 1 Health providers can expect a growing share of pregnancies among older mothers. Encouraging healthy habits like folic acid supplementation, weight management, and chronic disease control is especially important for those planning pregnancy later in life. Sexual health education and access to contraception, particularly for teens and young adults who face higher social and health risks, continues to be important.
- 2 Programs and services should reduce barriers to timely prenatal care, contraception and fertility services, and tailor supports for groups at higher risk of adverse outcomes, including teenagers, those with limited resources, or residents facing access barriers.
- 3 Continued monitoring of post-pandemic trends and differences between communities, such as Milton's higher fertility rate, is essential to inform public health programs and health system planning.

Pregnancies

The **total pregnancy rate** measures the number of pregnancies per 1,000 females aged 15 to 49 in a year. Pregnancies include live births, stillbirths, and abortions (pharmacological or surgical). In 2023, Halton’s pregnancy rate was lower than Ontario’s (**Figure 8**). In Halton and Ontario, pregnancy rates decreased between 2013 and 2020, reaching their lowest points in 2020. Rates rose slightly following 2020, but these increases were not statistically significant.

Age-specific pregnancy rates show the number of pregnancies per 1,000 women within each age group. Pregnancy during adolescence is linked to adverse health and social outcomes. Babies born to adolescent mothers are at increased risk of pre-term birth and low birth weight and the risk of stillbirth is also higher during adolescent pregnancies. Becoming a parent at a young age can lead to financial stress, mental health concerns, fewer social supports, and difficulty continuing school or working (DeMarco et al., 2021). Pregnancies among older women are also linked to health risks such as gestational diabetes, high blood pressure, and a greater likelihood of having a cesarean section (Statistics Canada, 2022).

Data for 2021 to 2023 combined show that in Halton and Ontario, pregnancy rates among women aged 30 to 34 were higher compared to all other age groups, while rates among those aged 45 to 49 were the lowest (**Figure 9**). In Halton and Ontario, differences between all age groups were statistically significant.

Halton’s pregnancy rates were lower than Ontario’s for women under the age of 30, but higher than Ontario’s for women aged 30 to 34 and 35 to 39. This is consistent with earlier data showing that the average age of first-time mothers and proportion of mothers aged 35 and older are higher in Halton compared to Ontario. Halton’s rates were similar to Ontario’s for women aged 40 and older.

Figure 8: Total pregnancy rate (per 1,000 females aged 15-49), Halton and Ontario, 2013-2023

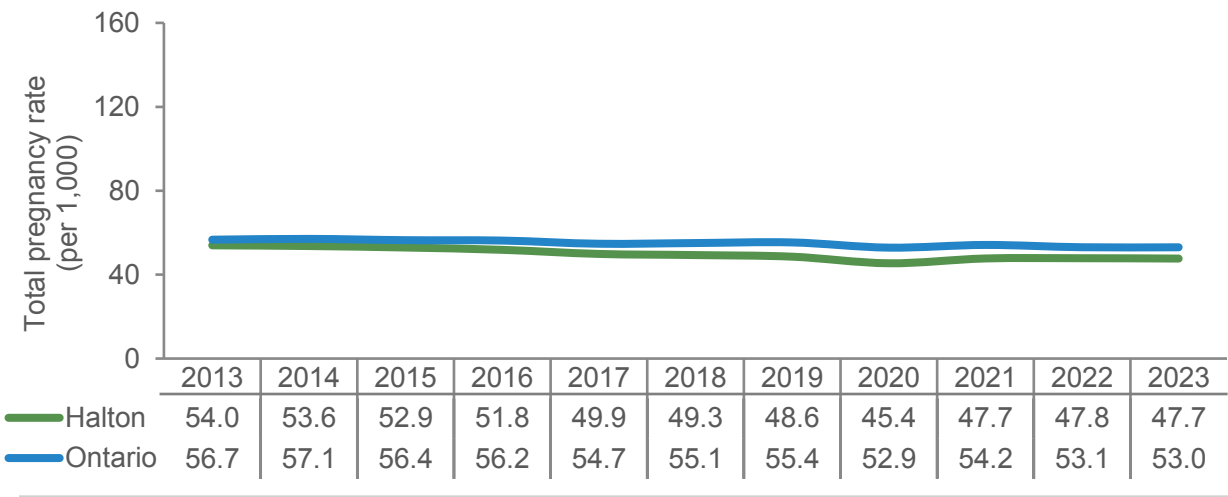
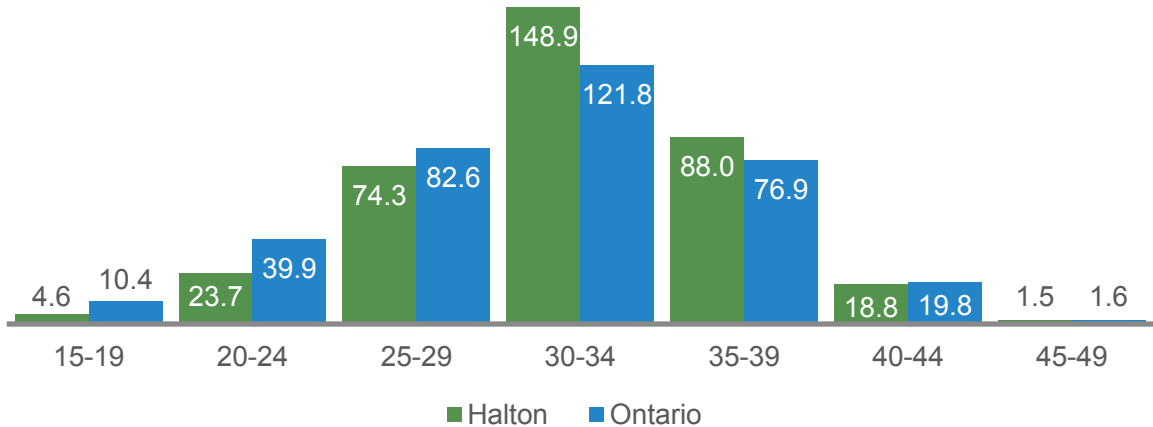


Figure 9: Age-specific pregnancy rate (per 1,000 females by age group), Halton and Ontario, 2021-2023 combined

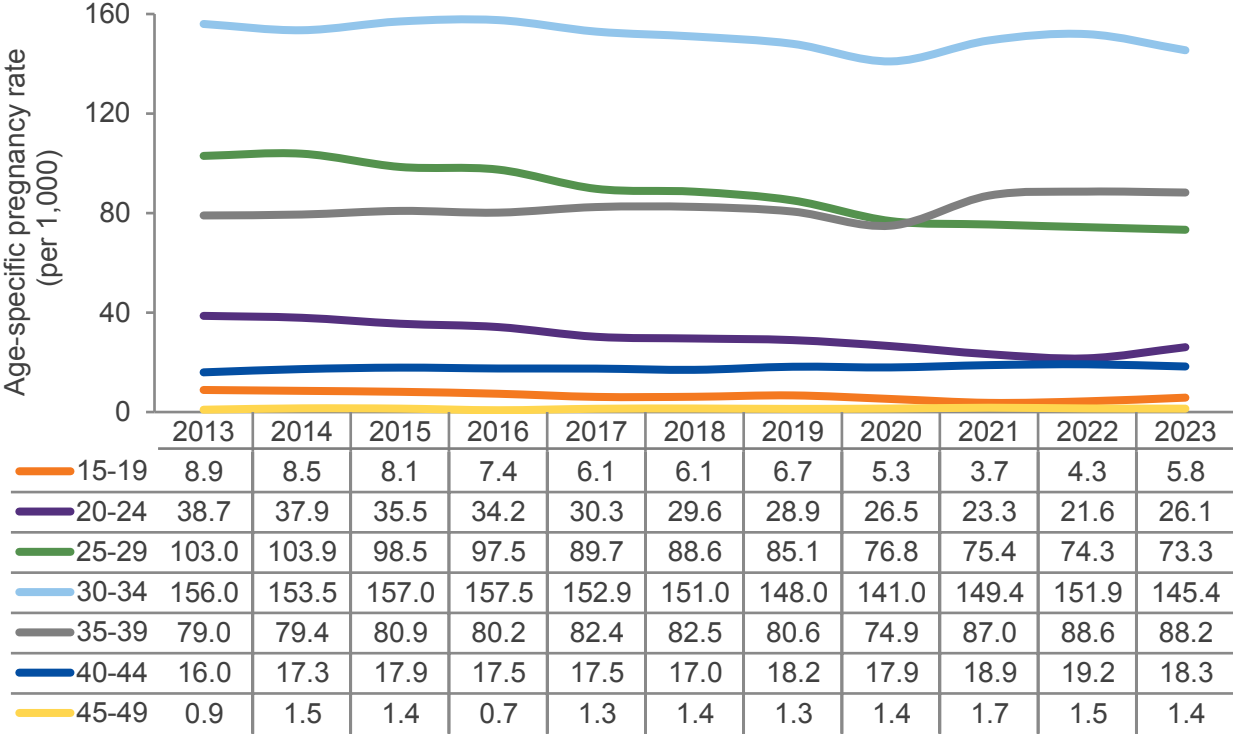


Data: Live and stillbirths [2011-2023] Vital Statistics, IntelliHEALTH Ontario, date extracted: February 24, 2025. Hospital Therapeutic Abortions [2011-2023], Hospital and Medical Services Data, IntelliHEALTH Ontario, date extracted: February 24, 2025. Pharmacological abortions [2018-2023], Ontario Drug Policy Research Network (ODPRN) and Institute for Clinical Evaluative Sciences (ICES), received July 8, 2025. IC/ES. Population Estimates [2013-2023], IntelliHEALTH, Ontario Ministry of Health and Long-Term Care, extracted February 2025.



Pregnancy rates in Halton have changed over time for certain age groups. While rates among women aged 30 to 34 and under decreased between 2013 and 2023, an increase was seen for women aged 35 to 39 and 40 to 44 (**Figure 10**). Among women aged 45 to 49, rates have remained relatively stable over time. Similar trends were seen in Ontario (not shown).

Figure 10: Age-specific pregnancy rate (per 1,000 females by age group), Halton, 2013-2023



Data: Live and stillbirths [2011-2023] Vital Statistics, IntelliHEALTH Ontario, date extracted: February 24, 2025. Hospital Therapeutic Abortions [2011-2023], Hospital and Medical Services Data, IntelliHEALTH Ontario, date extracted: February 24, 2025. Pharmacological abortions [2018-2023], Ontario Drug Policy Research Network (ODPRN) and Institute for Clinical Evaluative Sciences (ICES), received July 8, 2025. IC/ES. Population Estimates [2013-2023], IntelliHEALTH, Ontario Ministry of Health and Long-Term Care, extracted February 2025.

Pregnancies involving assisted reproductive technology

Assisted reproductive technology (ART) refers to medical treatments that help women become pregnant when they are having difficulty conceiving naturally, such as in vitro fertilization.

ART has historically been associated with a higher risk of multiple pregnancies, meaning pregnancies involving two or more babies (e.g., twins). Multiple pregnancies increase the risk of health complications for both the mother and infants during pregnancy and after birth. Advances in fertility treatment, including greater use of single-embryo transfer, have reduced the overall risk of multiple pregnancies associated with ART in recent years (Public Health Agency of Canada, 2018a). Even among singleton pregnancies, women who conceive using ART have higher rates of adverse outcomes such as preterm birth and low birth weight than those who conceive without ART (Public Health Agency of Canada, 2018a). However, it is not always possible to determine whether these increased risks are attributable to ART itself or to underlying factors associated with infertility, such as older maternal age or pre-existing health conditions, which are also more common among women who use ART.

The use of ART has been increasing over time (Canadian Fertility and Andrology Society, 2025). This trend is likely related to an increase in the proportion of births to mothers aged 35 and older, since fertility naturally declines with age, which may result in more women using ART (Public Health Agency of Canada, 2018a).

In Halton, about one in twenty (5.4%) pregnancies involved the use of ART when looking at combined data from 2019 to 2023 (Figure 11). This increased to one in four (26.7%) when looking specifically at pregnancies involving more than one baby. The percentage of pregnancies involving ART was significantly higher in Halton compared to Ontario for all pregnancies, multiple pregnancies, and singleton pregnancies.

Halton mothers who were aged 35 and older were significantly more likely to have had a pregnancy involving ART compared to those under 35 years of age (Figure 12). Halton mothers in both age categories were significantly more likely to have used ART compared to Ontario mothers.

Figure 11: Percentage of pregnancies involving assisted reproductive technology, by type of pregnancy, Halton and Ontario, 2019-2023 combined

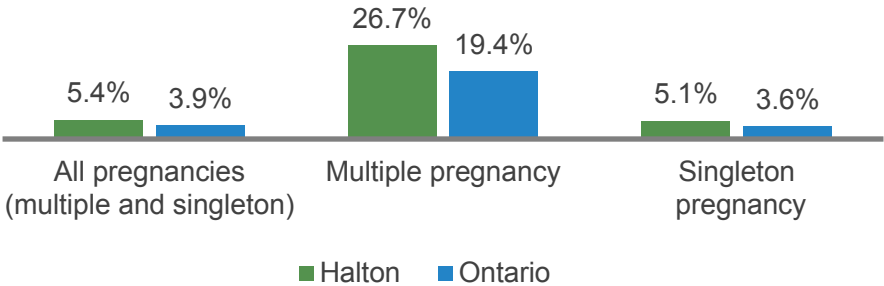
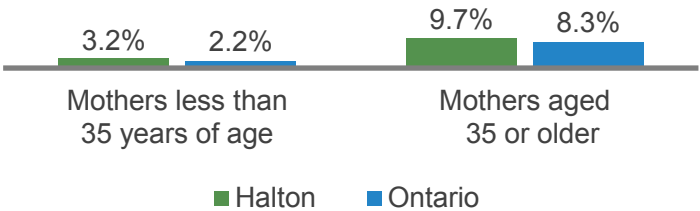


Figure 12: Percentage of pregnancies involving assisted reproductive technology, by mother's age group, Halton and Ontario, 2019-2023 combined



Data: Inpatient Discharges [2019-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025.

Induced abortions

An induced abortion refers to a pregnancy that is deliberately ended through either a surgical procedure (surgical abortion) or the use of the prescription medications mifepristone and misoprostol (medical or pharmacological abortion). Surgical abortions are usually done at a hospital, clinic, or physician's office. Medical abortions usually do not require a hospital visit. Induced abortions are sometimes referred to as therapeutic abortions.

Abortion is one of the most common medical procedures in Canada (Government of Canada, 2023). People choose abortion for different reasons. For many, it's because the pregnancy is unplanned or unwanted (Liu et al., 2019). For others, it may be for medical reasons - for example, if continuing the pregnancy would pose risks to a pregnant person's health, or if there are serious concerns about the fetus, such as structural anomalies or serious genetic disorders (Schummers & Norman, 2019). Most abortions in Canada happen within the first 12 weeks of pregnancy (Government of Canada, 2023).

Since 2017, when mifepristone and misoprostol became widely available in Canada, the percentage of induced abortions that are medical rather than surgical has increased (Schummers et al., 2022). A similar trend has been seen in Halton (**Figure 13**).

The **total induced abortion rate** refers to the number of induced abortions per 1,000 females aged 15 to 49 in a year. **Figure 14** shows rates in Halton and Ontario between 2013 and 2023. Rates for 2013 to 2017 include surgical abortions only, while rates for 2018 to 2023 include surgical and medical abortions. Although medical abortions became widely available in Canada in August 2017, they were not captured in the 2017 data. Therefore, the reported rate for 2017 likely underestimates the total induced abortion rate for that year.

In Halton and Ontario, the total induced abortion rate in 2023 was higher compared to any previous year from 2013 onwards (**Figure 14**). Halton's rate in 2023 was lower compared to Ontario's.

Figure 13: Percentage of induced abortions, by method (medical or surgical), Halton, 2018-2023

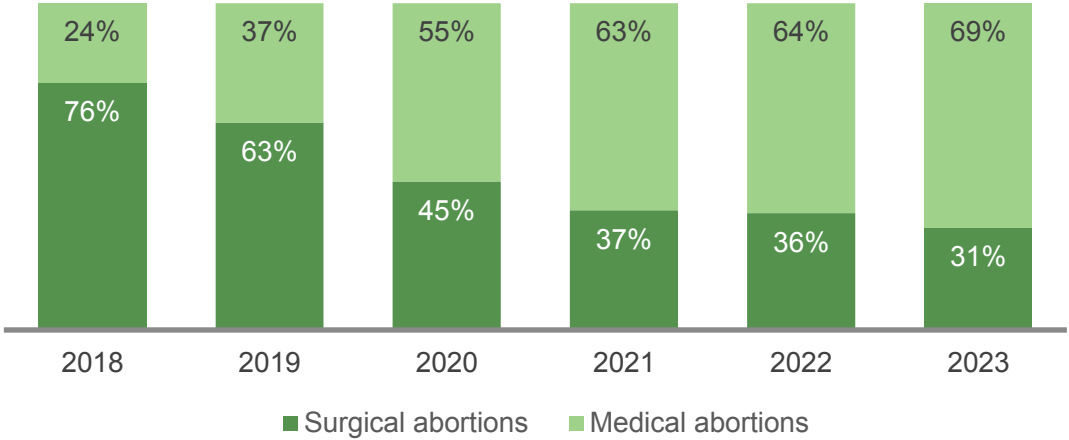
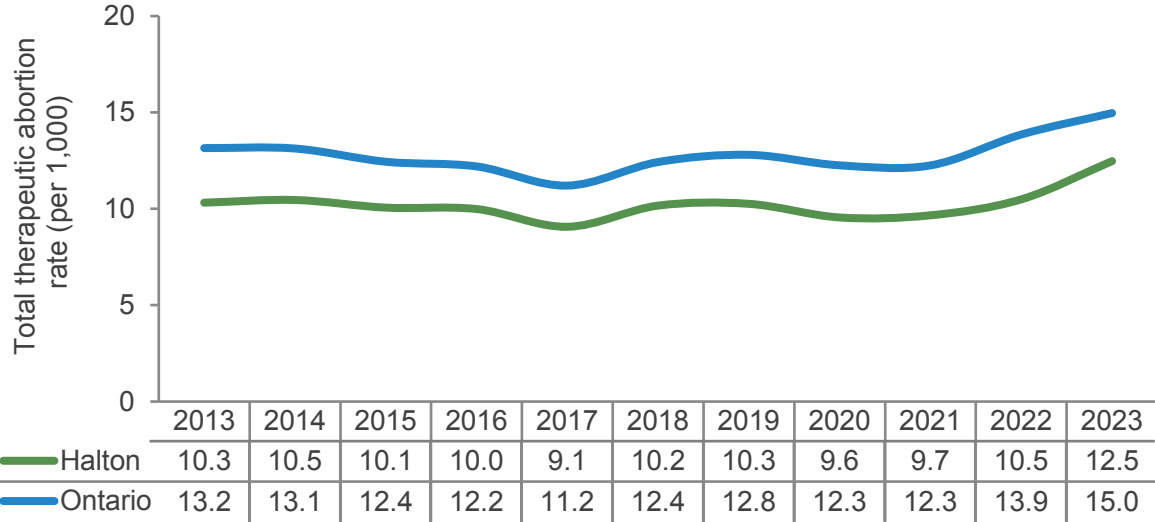


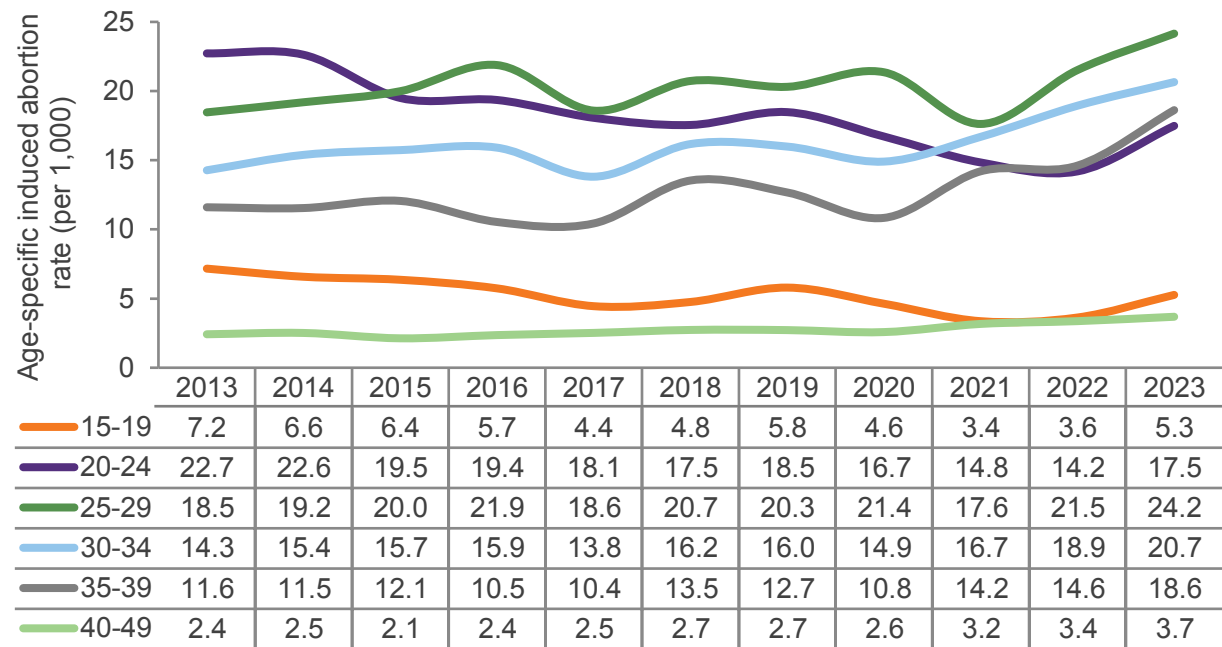
Figure 14: Total induced abortion rate (per 1,000 females aged 15-49), Halton and Ontario, 2013-2023



Data: Hospital Therapeutic Abortions [2011-2023], Hospital and Medical Services Data, IntelliHEALTH Ontario, date extracted: February 24, 2025. Pharmacological abortions [2018-2023], Ontario Drug Policy Research Network (ODPRN) and Institute for Clinical Evaluative Sciences (ICES), received July 8, 2025. IC/ES. Population Estimates [2013-2023], IntelliHEALTH, Ontario Ministry of Health and Long-Term Care, extracted February 2025.

Age-specific induced abortion rates measure the number of induced abortions for every 1,000 women in a specific age group. In Halton, the induced abortion rate among females aged 15 to 19 and 20 to 24 decreased between 2013 and 2021 (**Figure 15**). The rate then increased between 2021 and 2023, however this increase was not statistically significant. Among those aged 30 to 34, the rate increased between 2020 and 2023. The rate also increased between 2013 and 2023 among females aged 35 to 39 and 40 to 49. In 2023 among females aged 15 to 19 and 20 to 24, induced abortion rates were lower in Halton compared to Ontario (not shown). There were no differences between Halton and Ontario for other age groups.

Figure 15: Age-specific induced abortion rate (per 1,000 females by age group), Halton, 2013-2023



Data: Hospital Therapeutic Abortions [2011-2023], Hospital and Medical Services Data, IntelliHEALTH Ontario, date extracted: February 24, 2025. Pharmacological abortions [2018-2023], Ontario Drug Policy Research Network (ODPRN) and Institute for Clinical Evaluative Sciences (ICES), received July 8, 2025.IC/ES. Population Estimates [2013-2023], IntelliHEALTH, Ontario Ministry of Health and Long-Term Care, extracted February 2025. Notes: For age-specific rates, it was necessary to group ages 40-44 and 45-49 due to small numbers in the 45-49 group. Data for 2017 may be an underestimate, since medical abortions became widely available in Canada in August of 2017, while data regarding medical abortions is only available for 2018 onwards.

In 2023, pregnancies among Halton women aged 15 to 19 and 20 to 24 were more likely to result in an induced abortion than a delivery, while pregnancies among those aged 30 to 34 were the least likely to result in an induced abortion (**Figure 16**).

Table 1 shows the number of induced abortions by age group among Halton and Ontario residents between 2013 and 2023. During this time, the number of induced abortions increased among Halton and Ontario females between the ages of 25 and 49. Among women aged 15 to 24, the number of induced abortions decreased in Ontario, but remained relatively stable in Halton.

It was not possible to look at induced abortions by municipality since data regarding medical abortions were not available at this level of geography.

Figure 16: Percentage of pregnancies involving induced abortions and deliveries, by age group, Halton, 2023

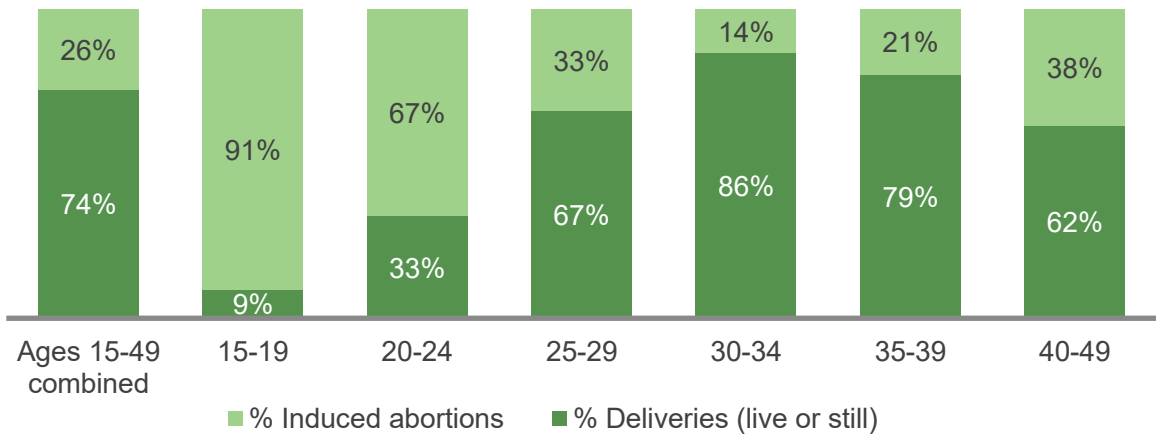


Table 1: Number of induced abortions, by age group, Halton and Ontario, 2013-2023

Year	Halton							Ontario						
	Aged 15-49	15-19	20-24	25-29	30-34	35-39	40-49	Aged 15-49	15-19	20-24	25-29	30-34	35-39	40-49
2013	1,352	125	355	263	256	245	108	42,559	4,668	12,000	10,146	7,842	5,529	2,374
2014	1,374	115	357	270	272	247	113	42,233	4,057	11,655	10,146	8,152	5,714	2,509
2015	1,327	114	307	279	275	255	97	39,781	3,489	10,640	9,935	7,949	5,439	2,329
2016	1,333	106	311	306	276	225	109	39,177	3,360	10,088	9,851	7,936	5,590	2,352
2017	1,224	84	295	267	239	221	118	36,343	2,949	9,192	9,048	7,635	5,195	2,324
2018	1,398	92	292	312	283	289	130	40,962	3,181	9,963	10,598	8,647	6,105	2,468
2019	1,449	116	320	317	290	274	132	42,849	3,270	9,973	10,909	9,468	6,657	2,572
2020	1,373	95	299	337	277	239	126	41,423	2,862	9,259	10,621	9,097	6,882	2,702
2021	1,394	70	268	276	310	315	155	41,260	2,501	8,550	10,401	9,685	7,174	2,949
2022	1,539	79	266	351	354	324	165	47,935	3,070	10,216	12,332	11,129	7,974	3,214
2023	1,881	119	346	419	402	413	182	54,142	3,489	11,384	13,818	12,790	9,075	3,586

Data: Hospital Therapeutic Abortions [2011-2023], Hospital and Medical Services Data, IntelliHEALTH Ontario, date extracted: February 24, 2025. Pharmacological abortions [2018-2023], Ontario Drug Policy Research Network (ODPRN) and Institute for Clinical Evaluative Sciences (ICES), received July 8, 2025. IC/ES. Notes: For Figure 16, it was necessary to group ages 40-44 and 45-49 due to small numbers in the 45-49 group. Data for 2017 may be an underestimate, since medical abortions became widely available in Canada in August of 2017, while data regarding medical abortions is only available for 2018 onwards.

Number of births

In 2023, there were 5,287 live births to Halton mothers. Most of these mothers lived in Milton (1,724 births), Oakville (1,535), and Burlington (1,500), while fewer lived in Halton Hills (528 births) (**Figure 17**).

In 2023, nearly half of all live births in Halton (46%, or 2,414 births) were to mothers aged 30 to 34, while 29% (1,540 births) were to mothers aged 35 to 39 (**Figure 18**). **Figure 19** shows the number of live births by parity (the number of previous live or stillbirths to a mother). In 2023, 44% of live births (2,317 births) were to first-time mothers in Halton.

Data from the Better Outcomes Registry & Network (BORN) show that between 2021 and 2023, most births to Halton mothers took place in hospitals (97.8%), while about 2.2% occurred at home (not shown).

Figure 17: Number of live births, by mother’s municipality, Halton, 2023

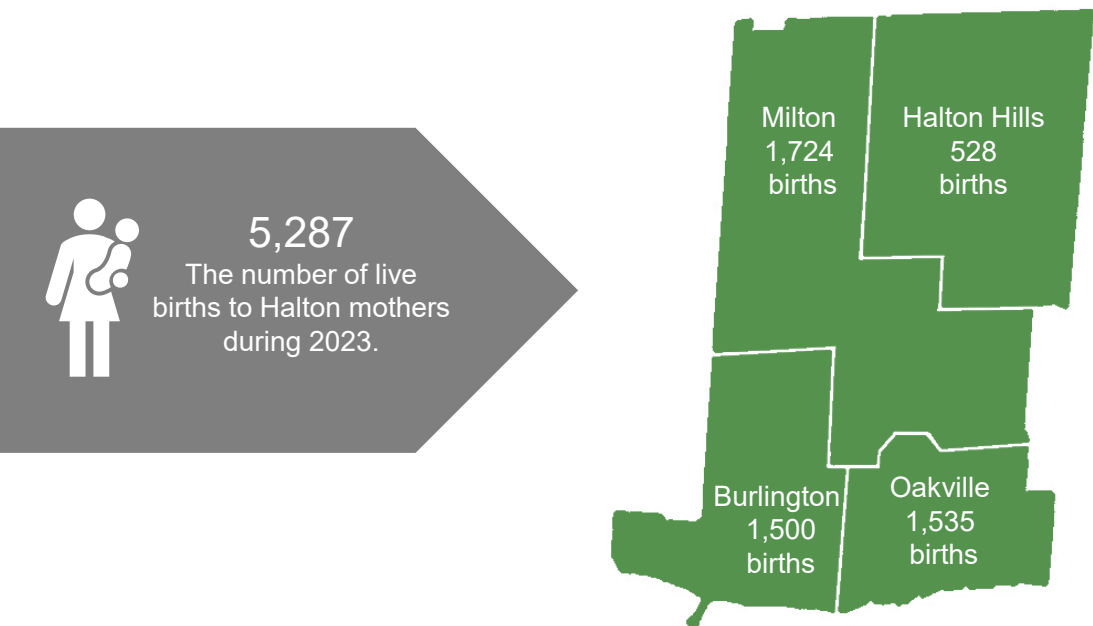


Figure 18: Number of live births, by mother's age group, Halton, 2023

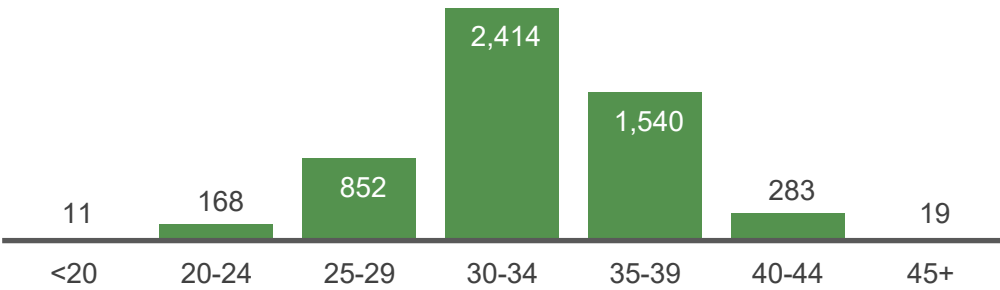
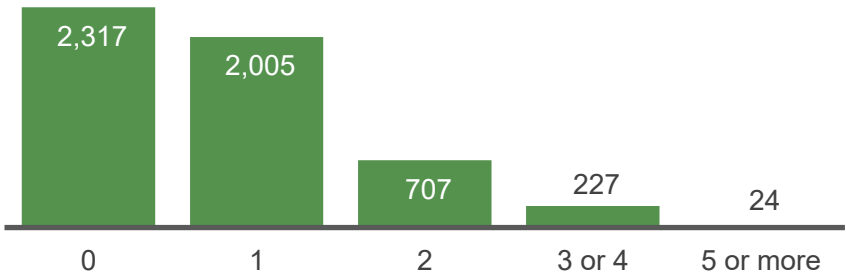


Figure 19: Number of live births, by parity, Halton, 2023



Data: Vital Statistics [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025. Notes: For the number of live births, by parity, Halton, 2023, parity was unknown for seven births.

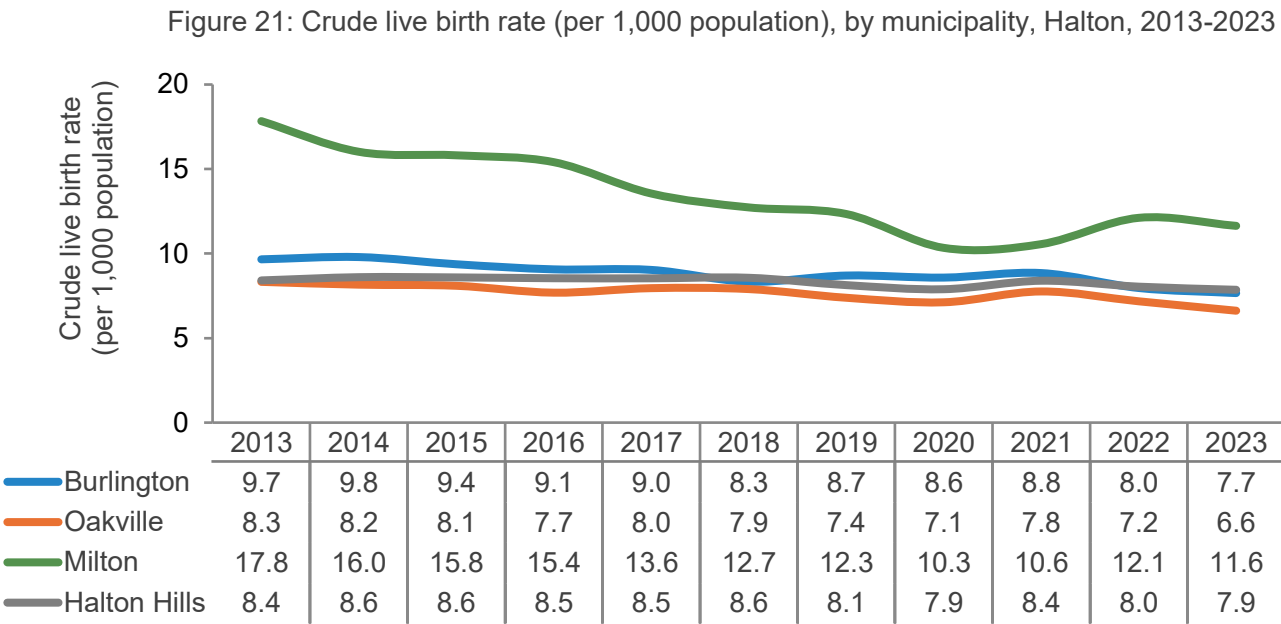
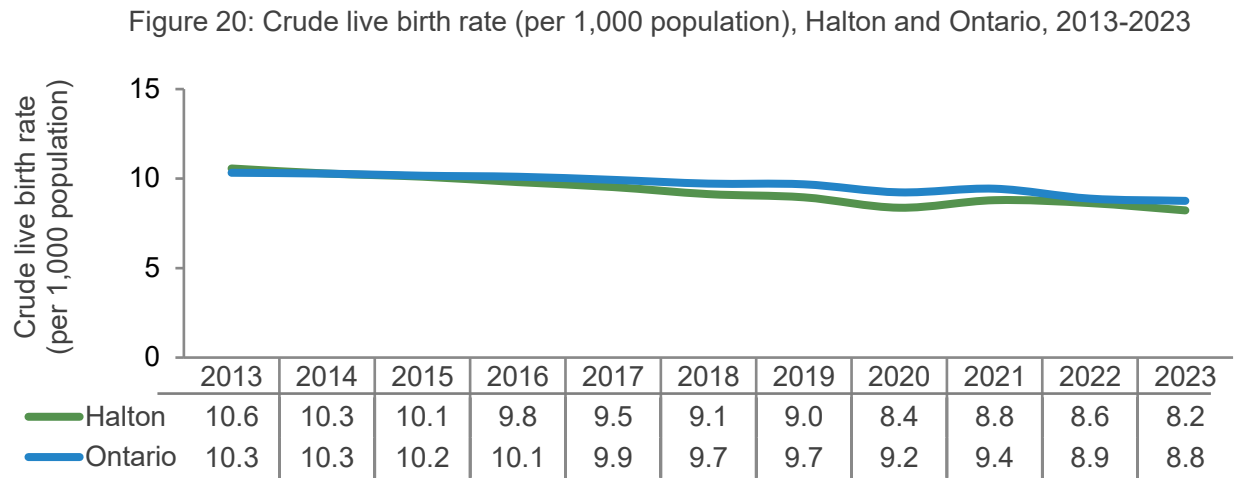
Crude live birth rate

The **crude live birth rate** shows the number of live births per 1,000 people per year. It is useful for measuring overall population growth at a broad level. In Halton and Ontario, the crude live birth rate decreased significantly between 2013 and 2023 (**Figure 20**). In 2023, Halton’s and Ontario’s crude birth rates were lower compared to any other year from 2013 onwards.

In Halton, birth rates decreased between 2013 and 2023 in Burlington, Oakville and Halton Hills (**Figure 21**). Milton had the highest rates throughout this period. Its rate dropped between 2013 to 2020, then increased slightly from 2020 to 2023, however this increase was not statistically significant.

Across Canada, the crude live birth rate has generally declined since 2017 (Statistics Canada, 2024a). Data from Statistics Canada also show that Canada’s fertility rate reached a record low as of 2023. Canada is now among the countries with the lowest fertility rates, including South Korea, Spain, Italy, and Japan (Statistics Canada, 2024a).

Reasons for declining fertility and birth rates are complex, but likely include societal and cultural shifts, increased access to contraception, and economic factors (Statistics Canada, 2024b; Vanier Institute of the Family, 2024). For example, many young Canadians have recently reported that affordability concerns and lack of access to suitable housing are significant factors influencing decisions about whether to have children (Statistics Canada, 2023a). The COVID-19 pandemic may also have impacted birth rates in Canada. According to 2021 data from Statistics Canada, nearly one in five (19%) Canadians aged 15 to 49 delayed having children or planned to have fewer children because of the COVID-19 pandemic (Statistics Canada, 2021). Financial instability, health concerns, and disruptions in access to healthcare services were some of the factors influencing these trends (Statistics Canada, 2024b). Monthly birth patterns suggest many women briefly postponed conceiving a child at the start of the COVID-19 pandemic but resumed childbearing plans fairly quickly afterward (Statistics Canada, 2024b). Despite this, birth rates have continued to decline in Canada following the pandemic.



Data: Vital Statistics [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025. Population Estimates [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted February 2, 2025.

Multiple births

Multiple births refer to the birth of more than one baby at a time, including twins, triplets, or more. The **multiple birth rate** is the total number of multiple birth deliveries per 100 deliveries. Deliveries involving both live and stillbirths are included.

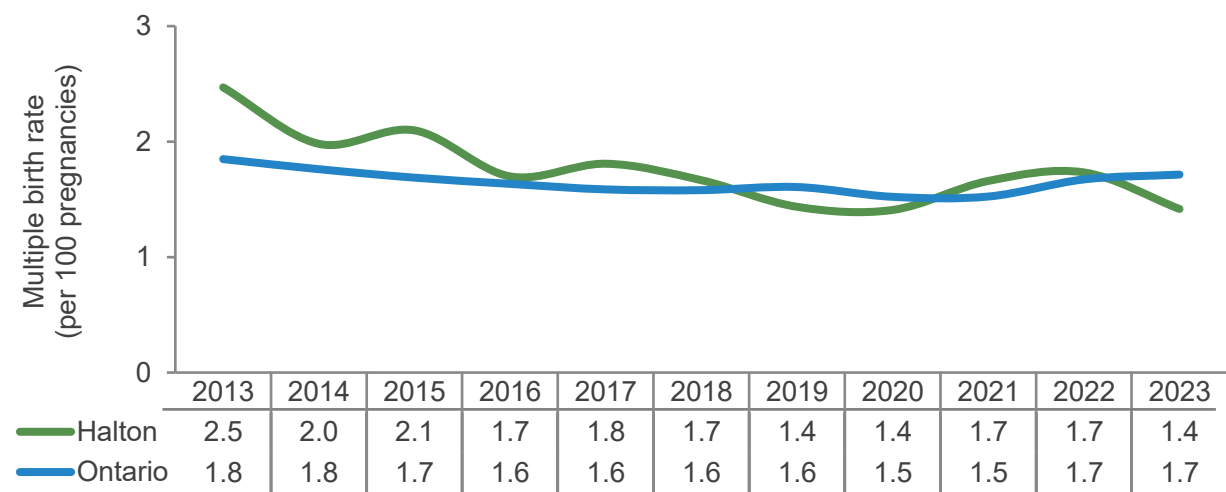
Pregnancies and births involving two or more babies can increase the risk of health complications for mothers and infants. For the mother, these risks can include a greater likelihood of gestational diabetes, high blood pressure, or cesarean section (Statistics Canada, 2023b). Infants have a higher risk of premature birth, low birth weight, neonatal death, and other complications (Public Health Agency of Canada, 2023a). As a result, families with multiple births may require more intensive support than those with single births (Public Health Agency of Canada, 2023a).

Figure 22 shows a decrease in the multiple birth rate in Halton between 2013 and 2020. Between 2020 and 2023 the rate then increased slightly, however, this change was not significant. In Ontario, the rate decreased between 2013 and 2017, then remained relatively stable from 2018 onwards.

Reasons for changes in multiple birth rates over time are complex. While the overall crude birth rate has fallen, the average age of mothers at birth and the use of assisted reproductive technology have increased over time. Women in their later reproductive years and those who use ART are more likely to have multiple births (Statistics Canada, 2023b). Older mothers - especially those aged 35 years or older - are more likely to conceive multiples, partly because age-related changes to the ovaries can increase the chances that more than one egg is released per menstrual cycle (Statistics Canada, 2024b).



Figure 22: Multiple birth rate (per 100 pregnancies), Halton and Ontario, 2013-2023



Data: Inpatient Discharges [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted May 21, 2025.

Stillbirths

A stillbirth occurs when a baby is born without any signs of life after 20 weeks of pregnancy or with a birth weight of 500 grams or more. Stillbirths can happen for many reasons. Common causes include problems with the placenta or umbilical cord, issues with the baby’s development (such as genetic or structural abnormalities) or health conditions of the pregnant female, such as high blood pressure, diabetes or infections (Merck Manual Professional Edition, 2023). However, in many cases, the cause is unknown (Merck Manual Professional Edition, 2023). In Canada, the processes that are used to track stillbirths make it difficult to determine the proportion of stillbirths by cause. For example, late-term pregnancies that are ended after a prenatal diagnosis of congenital anomalies are included in stillbirth counts (Joseph et al., 2021).

Several risk factors are associated with an increased risk of stillbirth, including higher maternal weight, smoking during pregnancy, younger maternal age (aged 19 or under), advanced maternal age (pregnancy at or after the age of 35), and pregnancies involving multiple births, such as twins or triplets (Statistics Canada, 2023b; DeMarco et al., 2021). While not all risk factors are modifiable, several can be addressed through health interventions and lifestyle changes. Addressing broader social determinants of health, including access to prenatal care, may also contribute to reducing stillbirth rates.

The **crude stillbirth rate** shows the number of stillbirths per 1,000 births (live or still) in a specific time period. Crude stillbirth rates in this report are shown as three-year moving averages to account for instability in rates due to the small number of stillbirths that typically occur. For example, the 2012 rate includes data from 2011 through 2013, while the 2013 rate includes data from 2012 through 2014, and so on.

In Halton, the crude stillbirth rate decreased between 2015 and 2022, while in Ontario, it decreased between 2017 and 2022 (**Figure 23**). Between 2013 and 2023, the greatest number of stillbirths in Halton and Ontario occurred among women aged 30 to 34. However, the highest stillbirth rates were observed among women aged 15 to 24 (**Table 2**). In Ontario, women aged 40 and older also had higher stillbirth rates compared to those aged 25 to 29, 30 to 34, or 35 to 39.

Figure 23: Crude stillbirth rate (per 1,000 births), based on three-year moving averages, Halton and Ontario, 2012-2022

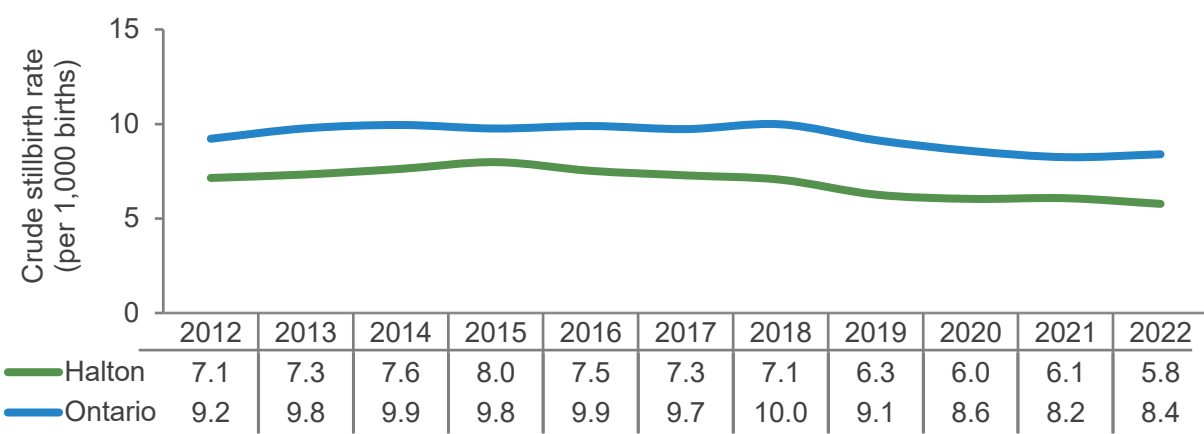


Table 2: Number and rate (per 1,000 births) of stillbirths, Halton and Ontario, 2013-2023 combined

Age group	Halton		Ontario	
	Number	Rate (per 1,000 births)	Number	Rate (per 1,000 births)
15-24	55	22.5	3,025	18.3
25-29	65	5.9	3,211	8.1
30-34	155	5.8	4,320	7.4
35-39	99	6.0	2,762	8.6
40+	32	9.0	968	13.4

Data: Vital Statistics [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025. A stillbirth is defined as a product of conception weighing 500 grams or more, or with a gestational age of 20 weeks or more, that shows no signs of life after complete delivery. In Ontario, therapeutic abortions meeting these same criteria (≥500 grams or ≥20 weeks' gestation) are also classified as stillbirths. Consequently, stillbirth data may include a small number of fetal deaths resulting from pregnancy termination.

Fertility rates

- In this section of the report, fertility is described using several complementary indicators:
- The **total fertility rate** estimates the average number of children a woman would have over her lifetime if current birth rates stayed the same
 - The **general fertility rate** measures the number of live births per 1,000 females of reproductive age
 - **Age-specific fertility rates** describe births within specific age groups

Fertility rates provide important information about birth patterns and population trends, including whether a population is expected to increase or decrease over time.

When total fertility rates are less than 2.1 children per woman, a population does not naturally replace itself and will decrease over time without immigration (Statistics Canada, 2024b). Between 2013 and 2023, Halton’s total fertility rate decreased from 1.6 to 1.3 (**Figure 24**). Similarly, the total fertility rate in Ontario decreased from 1.5 in 2013 to 1.2 in 2023.

Total fertility differs by municipality in Halton (**Figure 25**). In 2023, Milton had the highest rate at 1.6, followed by Halton Hills at 1.4. The total fertility rate in Burlington and Oakville was 1.2.



The dashed grey lines in **Figure 24** and **Figure 25** show a total fertility rate of 2.1. This is the average number of children a woman would need to have over her lifetime to keep a population stable, without accounting for immigration.

Figure 24: Total fertility rate, Halton and Ontario, 2023

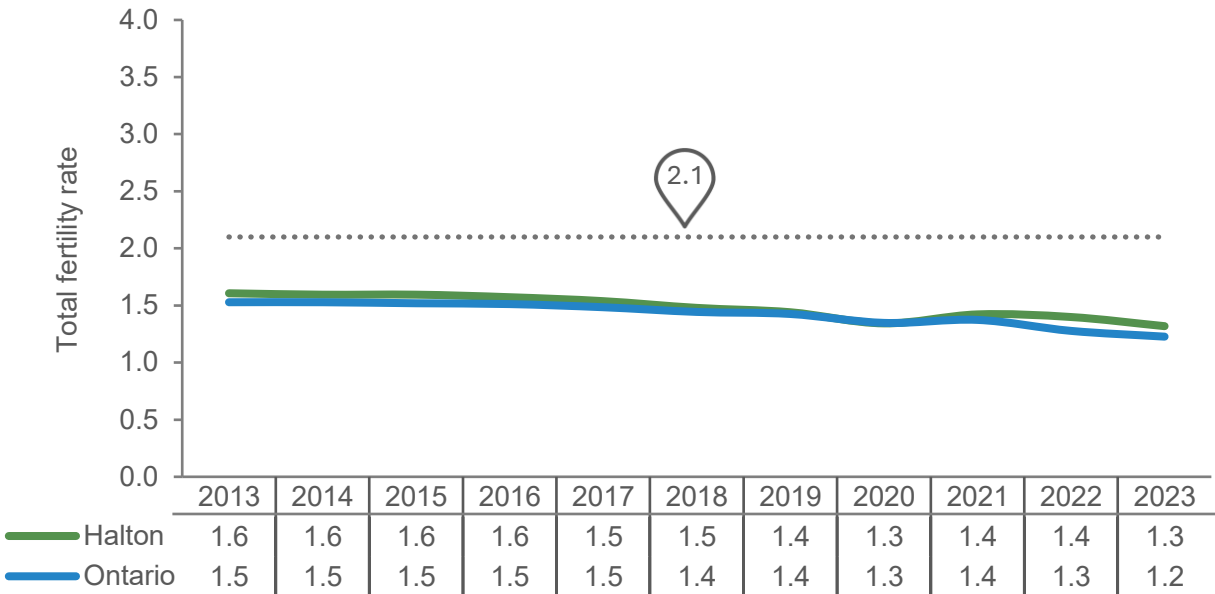
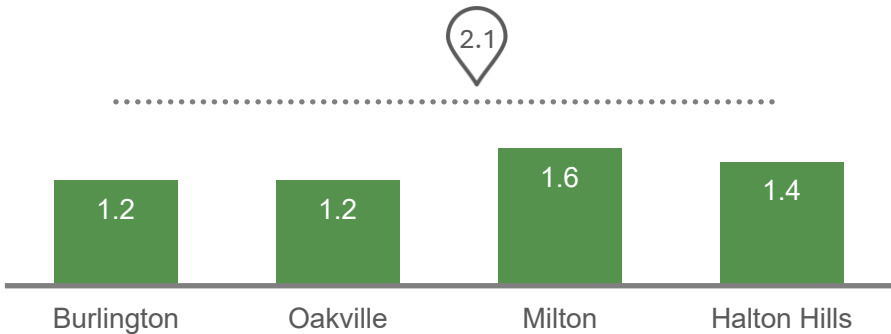


Figure 25: Total fertility rate, by municipality, Halton, 2023



Data: Vital Statistics [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025. Population Estimates [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted February 2, 2025.

The **general fertility rate** measures how many infants are born per 1,000 women of reproductive age in a year. It provides a more precise estimate of fertility than the crude birth rate because it only focuses on women of reproductive age (i.e., aged 15 to 49).

Between 2013 and 2023, the general fertility rate in Halton decreased (**Figure 26**). In Ontario, the rate remained relatively stable between 2013 and 2017, before decreasing between 2017 and 2023. Halton's general fertility rate was significantly lower than Ontario's as of 2023.

Figure 27 shows that between 2013 and 2023, the general fertility rate decreased in Burlington and Oakville but remained relatively stable in Halton Hills. In Milton, the rate decreased between 2013 and 2020. It then increased between 2020 and 2023 however this change was not statistically significant.

In 2023, Milton had the highest fertility rate, while Oakville had the lowest. Differences were statistically significant, except when comparing Burlington and Halton Hills.



Figure 26: General fertility rate (per 1,000 females aged 15-49), Halton and Ontario, 2013-2023

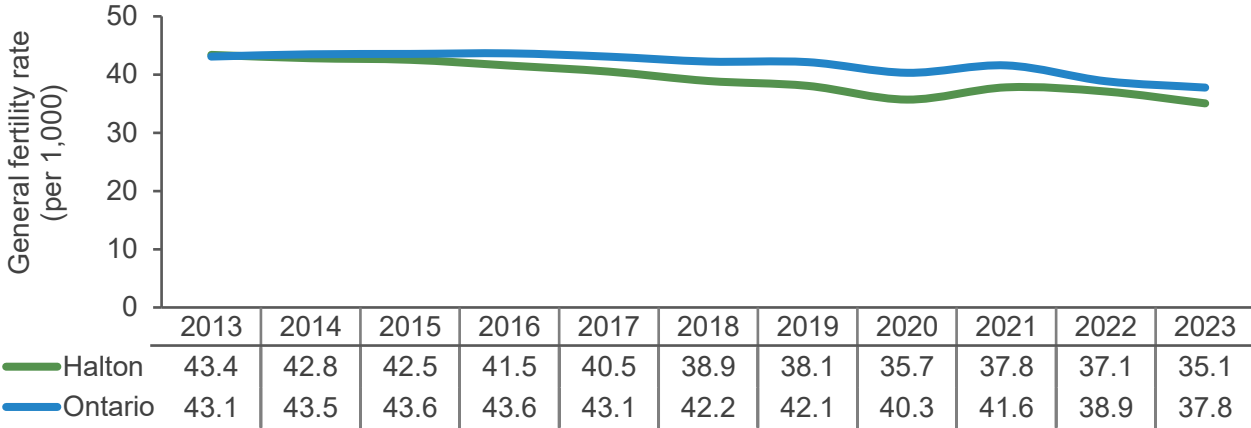
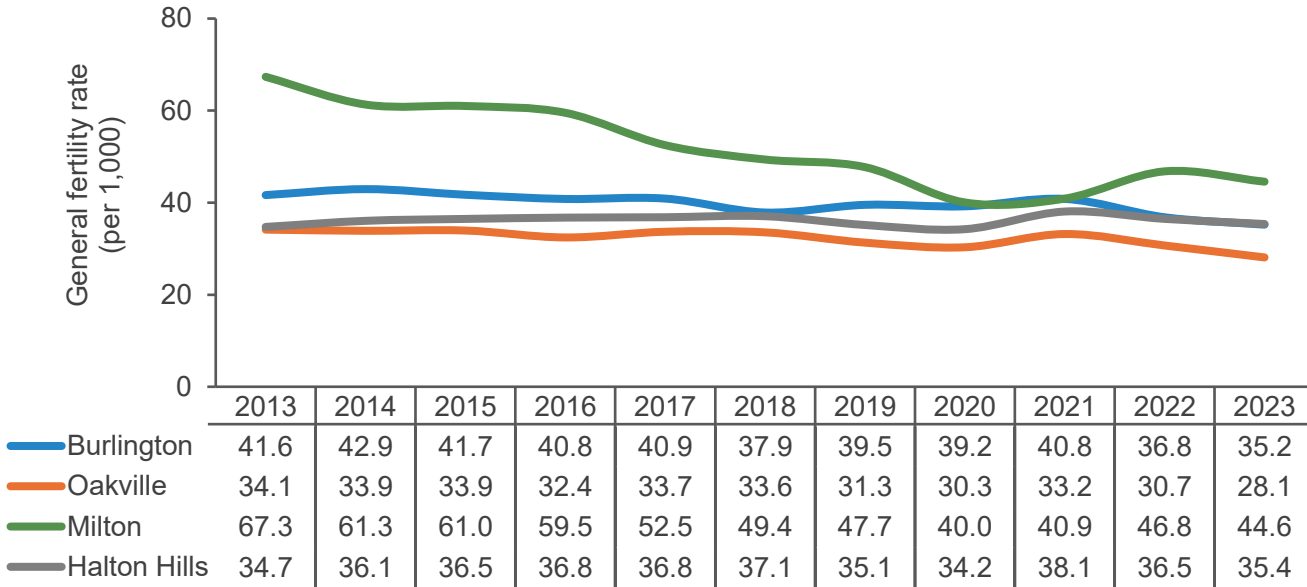


Figure 27: General fertility rates (per 1,000 females aged 15-49), by municipality, Halton, 2013-2023

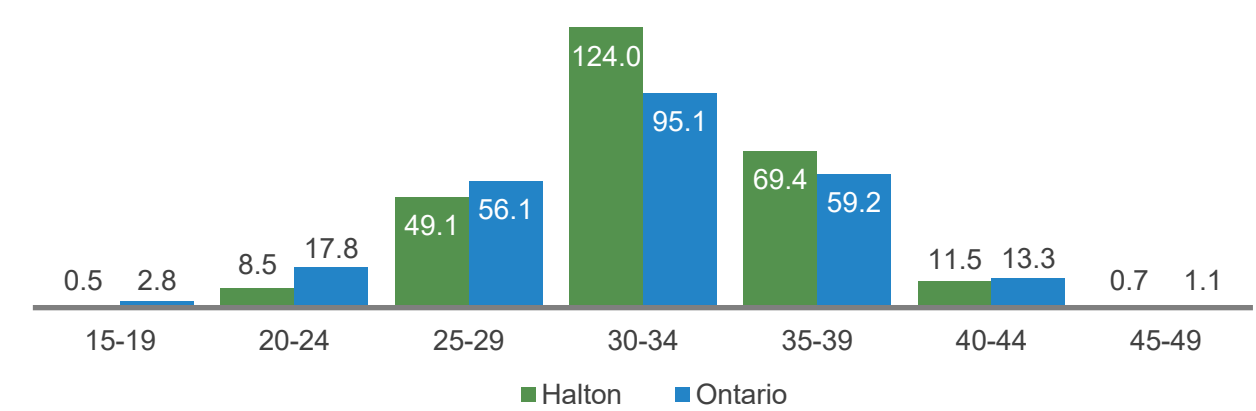


Data: Vital Statistics [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025. Population Estimates [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted February 2, 2025.

Age-specific fertility rates measure the number of live infants born for every 1,000 women in a specific age group. They show how fertility rates differ by age, and which age groups are having the most children.

In 2023, women aged 30 to 34 had the highest fertility rates in Halton and Ontario, followed by women aged 35 to 39 (**Figure 28**). Compared to Ontario, rates in Halton were generally lower among younger women but higher among women in their mid-reproductive years - this is consistent with earlier data showing that Halton mothers tend to be older compared to the provincial average. All differences were statistically significant except when comparing Halton and Ontario women aged 45 to 49, or when comparing Halton women aged 15 to 19 to those aged 45 to 49.

Figure 28: Age-specific fertility rate (per 1,000 females), by age group, Halton and Ontario, 2023



Data: Vital Statistics [2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025. Population Estimates [2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted February 2, 2025.



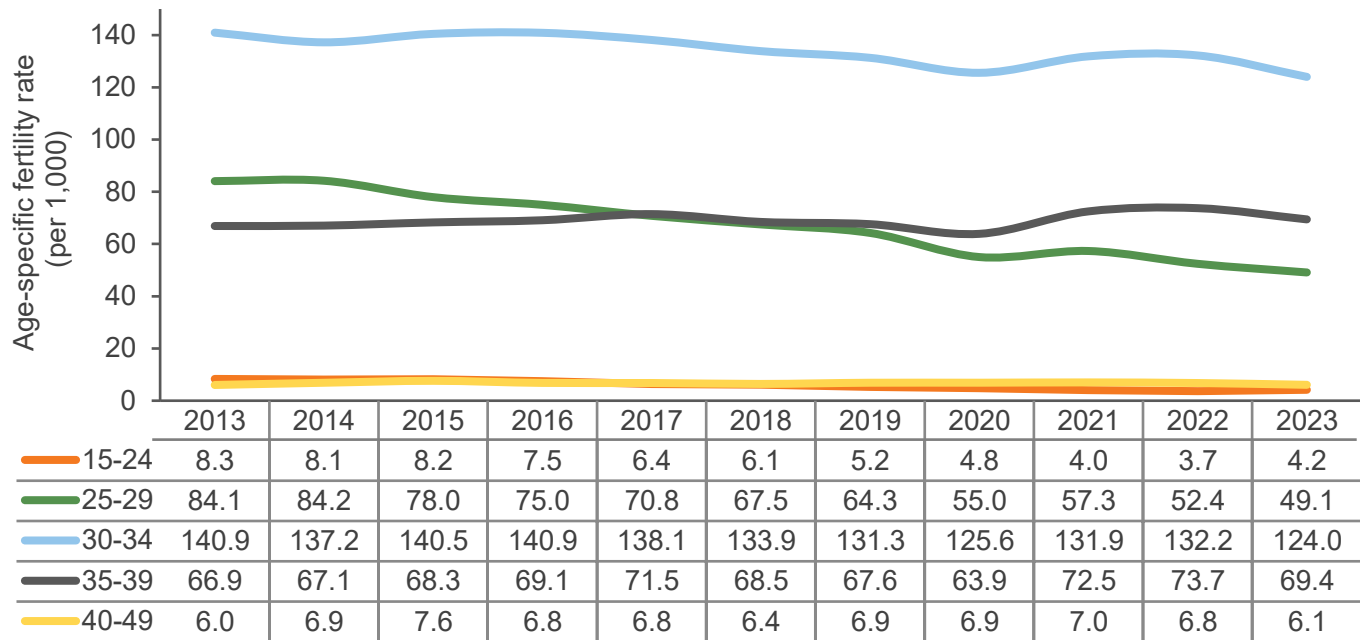
Figure 29 shows age-specific fertility rates in Halton between 2013 and 2023. For this analysis, age groups 15 to 24 and 40 to 49 were collapsed to ensure reportable estimates, as the youngest (15 to 19) and oldest (45 to 49) groups had small numbers.

Across all years shown, rates were highest for women aged 30 to 34. Between 2013 and 2023, rates among women aged 15 to 24, 25 to 29 and 30 to 34 decreased. Although the rate among those aged 35 to 39 generally increased, this change was not statistically significant. Rates for women aged 40 to 49 remained relatively stable.

The decrease in fertility rates among women under the age of 35 reflects an overall decline in general fertility rates over time, while the slight increase among those aged 35 to 39 suggests a trend of delayed childbearing and is consistent with other data in this report showing that the average age of mothers and first-time mothers has increased.



Figure 29: Age-specific fertility rate (per 1,000 females by age group), Halton, 2013-2023



Data: Vital Statistics [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025. Population Estimates [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted February 2, 2025.

Healthy pregnancies

This section highlights factors related to healthy pregnancies in Halton and Ontario, including folic acid supplementation, pre-pregnancy body mass index (BMI), gestational weight gain, gestational diabetes, maternal mental health, substance use during pregnancy, and prenatal class attendance. Data are analyzed over time and by age group to identify patterns and areas for improvement.



What the Data Tell Us

- Most women in Halton and Ontario report healthy behaviours during pregnancy, though there continue to be challenges related to weight management, gestational diabetes, and mental health.
- Substance use during pregnancy is less common in Halton than in Ontario, and smoking rates have declined. Prenatal class attendance and folic acid use are common in Halton and higher than the provincial average, particularly among first-time mothers in Milton.
- Over time, an increasing proportion of women in Halton and Ontario have entered pregnancy overweight or obese and nearly half gained more weight than recommended during pregnancy. Rates of gestational diabetes and mental health concerns - particularly anxiety - have also increased.
- Women who are younger tend to face greater challenges during pregnancy. They are less likely to use folic acid or attend prenatal classes, more likely to experience mental health concerns, and at increased risk of substance use or exposure.

How This Information Can Be Used

- 1 Health providers should be aware of the increasing prevalence of pre-pregnancy overweight and obesity, excess gestational weight gain, gestational diabetes, and mental health concerns when supporting women before and during pregnancy. Promoting evidence-informed guidance on nutrition, physical activity, mental well-being, and recommended weight gain may be particularly relevant for women planning or experiencing pregnancy.
- 2 Programs and services can use these findings to identify opportunities to strengthen prenatal education, as well as early-pregnancy support related to folic acid use, prenatal class participation, and screening for mental health concerns and gestational diabetes. Tailoring approaches for populations experiencing greater challenges, such as younger mothers, may help address disparities.
- 3 Ongoing monitoring of maternal health behaviours and outcomes over time, as well as differences across communities and age groups, can support planning and evaluation of public health programs and inform collaboration with health system and community partners.

Supplementing with folic acid

Folic acid is a type of B vitamin found in foods, such as dark green leafy vegetables, legumes, citrus fruit, or whole grains, and can also be taken as a supplement (e.g., in a prenatal multi-vitamin). Taking a folic acid supplement before and during early pregnancy helps prevent serious birth defects of the baby’s brain and spine, known as neural tube defects. Because these defects can happen very early in pregnancy, often before a woman even knows she is pregnant, it is important to start taking folic acid before getting pregnant.

Health Canada recommends that women who could become pregnant take 0.4 mg of folic acid every day, in addition to eating a healthy, balanced diet. Women should begin folic acid supplementation at least three months prior to pregnancy and continue with folic acid supplementation throughout pregnancy (Public Health Agency of Canada, 2023b).

Figure 30 shows that just over half of women who gave birth in Halton between 2021 and 2023 took a folic acid supplement both before and during pregnancy. Women in Halton were more likely than those in Ontario to take folic acid before and during pregnancy.

In Halton, the percentage of women who reported taking a folic acid supplement before and during pregnancy increased significantly from 44.9% in 2013 to 54.6% in 2021, then declined to 50.1% in 2023 (not shown).

Halton women aged 20 to 24 were less likely than women in any other age group to report that they supplemented with folic acid both before and during pregnancy (**Figure 31**). Those aged 25 to 29 were less likely than those aged 30 to 34, 35 to 39, or 40-44 to have supplemented with folic acid.

Figure 30: Percentage of women who gave birth (live or still) who reported folic acid supplementation, Halton and Ontario, 2021-2023 combined

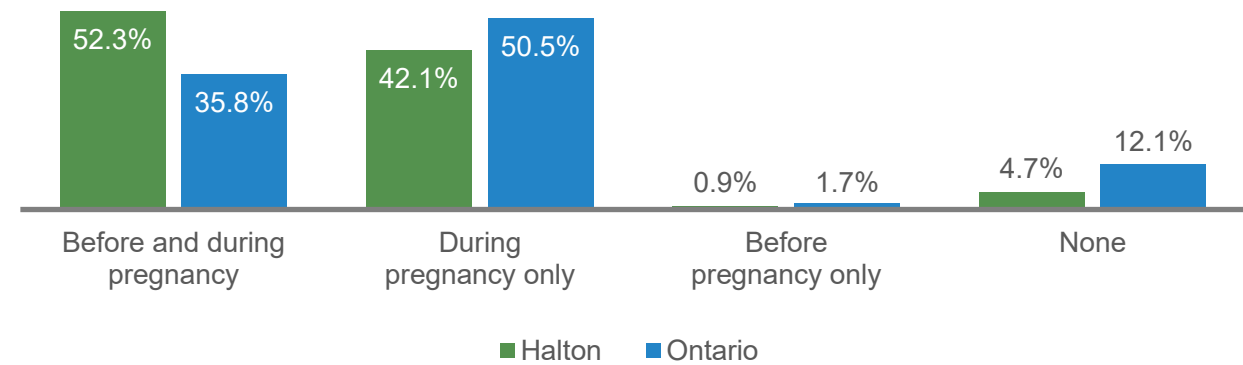
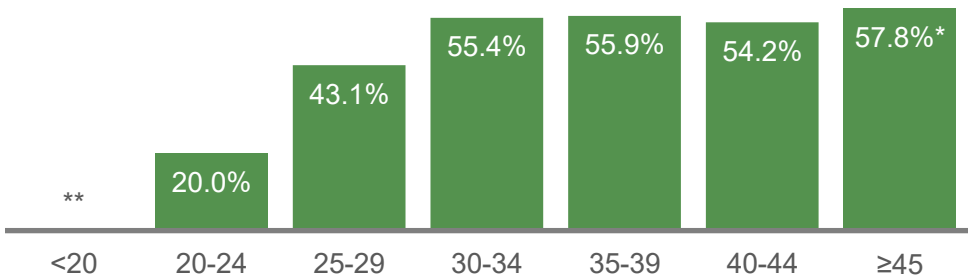


Figure 31: Percentage of women who gave birth (live or still) who reported folic acid supplementation both before and during pregnancy, by age group, Halton, 2021-2023 combined



Data: BORN Information System [2013-2023], extracted June 5, 2025: Notes: Records with missing data were not included. A single asterisk (*) indicates the result should be interpreted with caution due to high variability. A double-asterisk (**) indicates that the result is not reportable due to small numbers (<6 individuals in a category) or a high proportion of missing data (30% or more).

Body mass index (BMI) before pregnancy

Body mass index, or BMI, can be used to assess a woman’s weight status before pregnancy. BMI measures a person’s body weight using a weight-to-height ratio, where weight is measured in kilograms (kg) and height is measured in square meters (m²). **Table 3** shows BMI categories and the range of weight-to-height ratios associated with each category (World Health Organization, 2000). A woman’s pre-pregnancy BMI is used to set recommendations for healthy weight gain while she is pregnant. Women who begin pregnancy with a BMI in the “normal” range are less likely to experience negative health outcomes for herself or her newborn.

Figure 32 shows the percentage of women who gave birth between 2021 and 2023, by their pre-pregnancy BMI. Caution should be taken when interpreting these results since more than 5% of records were missing data. In Halton, just over half of women had a BMI in the normal range and more than one quarter were considered overweight. About 17% were considered obese (class I, II or III).

Halton women were more likely to have a normal BMI and less likely to be obese (class I, II or III) compared to Ontario women. In both Halton and Ontario, the percentage of women who were overweight or obese before they became pregnant increased between 2015 and 2023 (not shown).

The percentage of women who were overweight or obese before pregnancy generally increased with age, though not all differences were statistically significant (**Figure 33**). Women aged 45 or older were more likely than any other age group to have been overweight or obese before pregnancy.

Table 3: BMI categories and ranges

BMI Category	BMI range
Underweight	<18.5
Normal weight	18.5 to 24.9
Overweight	25.0 to 29.9
Obese class I	30.0 to 34.9
Obese class II	35.0 to 39.9
Obese class III	≥ 40.0

Figure 32: Percentage of women who gave birth (live or still), by pre-pregnancy body mass index, Halton and Ontario, 2021-2023 combined

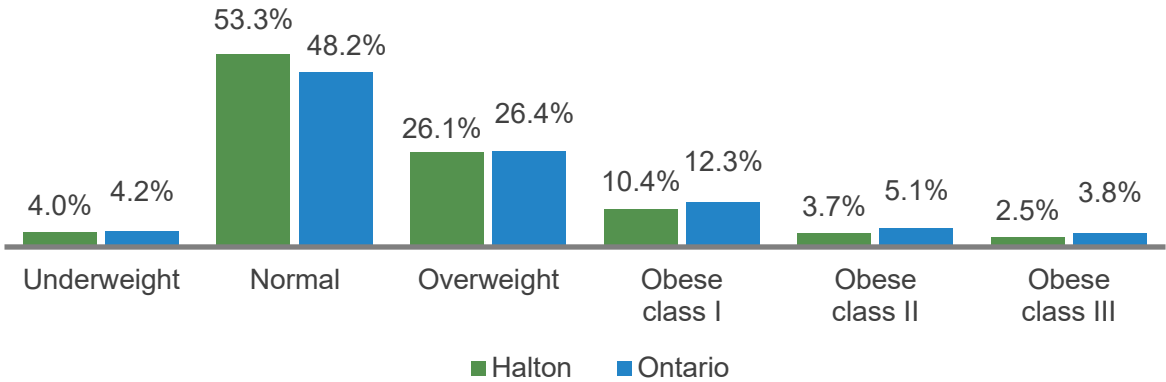
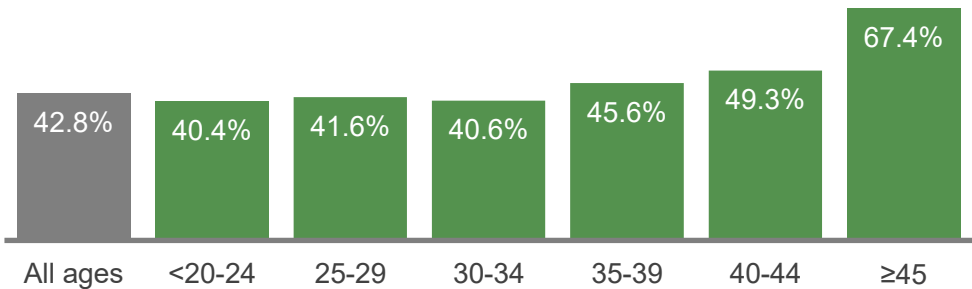


Figure 33: Percentage of women who gave birth (live or still) who were overweight or obese prior to pregnancy, Halton, by age group, 2021-2023 combined



Data: BORN Information System [2013-2023], extracted June 11, 2025. Notes: Records with missing data were not included. Caution should be taken when interpreting the results shown in both figures since >5% of records were missing data.

Weight gain during pregnancy

Gestational weight gain is the amount of weight gained during pregnancy, measured in pounds (lbs) or kilograms (kg). Health Canada provides recommended weight gain ranges based on a woman’s pre-pregnancy body mass index (BMI) (**Table 4**; Health Canada, 2020). Weight gain should be gradual, with most occurring in the second and third trimesters.

Gaining more or less weight than recommended can affect the health of the mother and baby. Gaining too much weight increases the risk of gestational diabetes and high blood pressure during pregnancy. Gaining too little weight is linked to poorer nutrition, worse immune health, and, for the baby, a higher chance of low birth weight and pre-term birth.

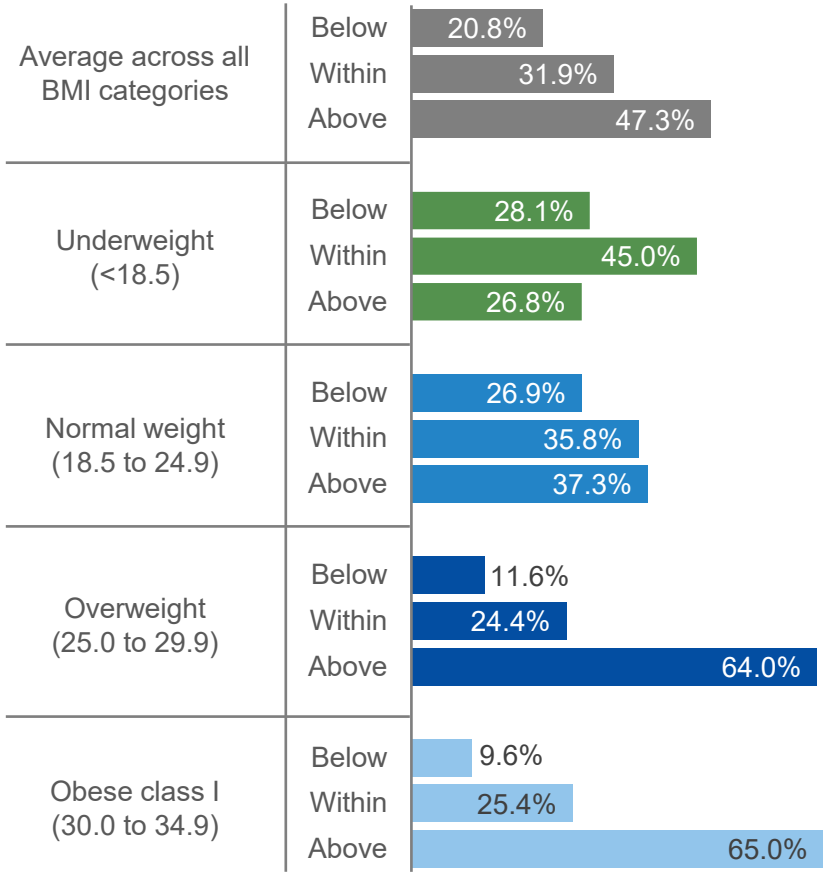
Combined data from 2021 to 2023 show that more than one in five (21%) women who gave birth in Halton gained less than the recommended amount of weight, while about one-third (32%) gained within the recommended range, and nearly half (47%) gained more than recommended (not shown).

Weight gain differed by pre-pregnancy BMI (**Figure 34**). Women who were overweight or obese before pregnancy were most likely to gain more than recommended. Those who were underweight were most likely to gain within the recommend range, followed by those in the normal BMI range. Women who were underweight and those within the normal BMI range were about equally likely to gain less than the recommended amount of weight.

Table 4: Recommended weight-gain during pregnancy, based on pre-pregnancy BMI

Pre-pregnancy BMI category	Recommended weight gain during singleton pregnancies	Recommended weight gain during twin pregnancies
Underweight (<18.5)	28 to 40 lbs (12.5 to 18 kg)	There is insufficient information to develop guidelines for underweight women carrying twins.
Normal weight (18.5 to 24.9)	25 to 35 lbs (11.5 to 16 kg)	37 to 54 lbs (17 to 25 kg)
Overweight (25.0 to 29.9)	15-25 lbs (7-11.5 kg)	31 to 50 lbs (14 to 23 kg)
Obese class I, II or III (30.0+)	11-20 lbs (5-9 kg)	25 to 42 lbs (11 to 19 kg)

Figure 34: Percentage of women who gave birth (live or still) who gained below, within, or above the recommended amount of weight during pregnancy, by pre-pregnancy body mass index, Halton, 2021-2023 combined



Data: BORN Information System [2013-2023], extracted June 11, 2025. Notes: Records with missing data were not included. Caution should be taken when interpreting the results shown in this figure since >5% of records were missing data. Gestational weight gain calculations exclude women with missing BMI information, who had pre-pregnancy BMI above 34.9, or whose pregnancy involved three or more fetuses (i.e., triplets or higher order pregnancies).

Gestational diabetes mellitus

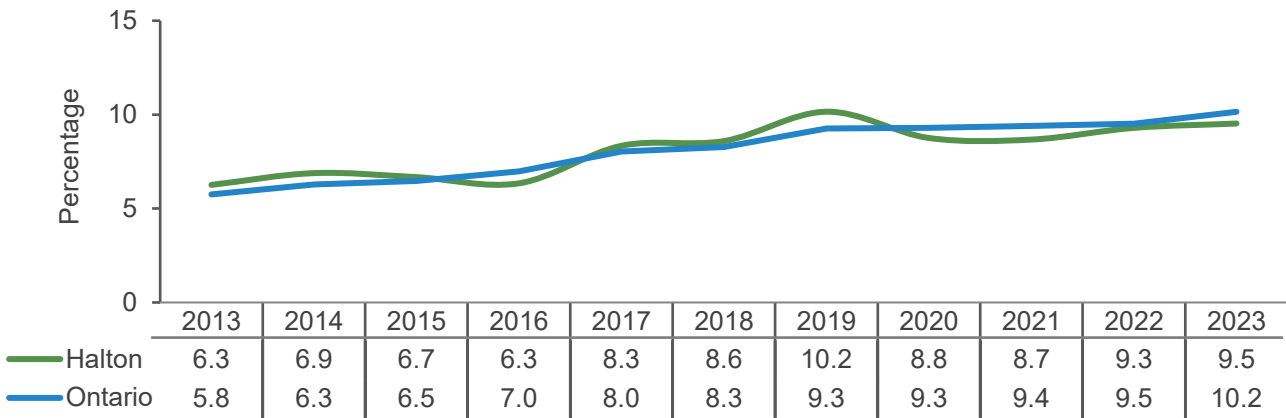
Gestational diabetes mellitus (GDM) is a condition where high blood sugar levels develop during pregnancy. It typically happens in the second or third trimester and is diagnosed through medical screening. Certain risk factors like advanced maternal age, obesity, being prediabetic, or having a history of gestational diabetes in previous pregnancies can increase a woman’s chances of developing GDM (Diabetes Canada Clinical Practice Guidelines Expert Committee, 2018).

Although GDM usually resolves after delivery, it increases the risk of developing type 2 diabetes in the future for both the mother and child (Public Health Agency of Canada, 2023c). It also increases the risk of complications during pregnancy and delivery.

By maintaining a healthy weight before and during pregnancy, being physically active, and eating a balanced diet, women can reduce their chances of developing GDM (Public Health Agency of Canada, 2019). If GDM does develop, it can often be managed through diet, exercise, and regularly checking blood sugar levels, however some women may require insulin (Public Health Agency of Canada, 2023c).

In Halton and Ontario, the percentage of women who developed gestational diabetes while pregnant increased significantly between 2013 and 2023 (**Figure 35**). In 2023, nearly one in ten (9.5%) Halton women who gave birth developed gestational diabetes. This was similar to Ontario (10.2%).

Figure 35: Percentage of women who gave birth (live or still) who developed gestational diabetes mellitus (GDM) while pregnant, Halton and Ontario, 2013-2023



Data: BORN Information System [2013-2023], extracted June 5, 2025. Notes: Records with missing data were not included. Caution should be taken when interpreting results where >5% of records were missing data for this variable; this includes 2013, 2014, 2015 and 2022 for Halton and 2013 and 2014 for Ontario.



Mental health during pregnancy

Poor maternal mental health is linked to negative health impacts for the mother and infant (Public Health Agency of Canada, 2022). Women with mental health concerns during or after pregnancy may be at increased risk of poor physical health, pregnancy complications, substance use, and difficulties caring for herself and her baby. Risks for the infant include pre-term birth, low birth weight, and long-term developmental challenges. Poor maternal mental health can also disrupt mother-infant bonding and in extreme cases, can result in maternal suicide or infanticide.

Figure 36 shows the percentage of women who gave birth between 2021 and 2023 and who self-reported:

- Any mental health concern during pregnancy, including anxiety, depression, history of postpartum depression, addiction, bipolar, schizophrenia, or other mental health concerns
- Anxiety
- Depression
- A history of postpartum depression

Data from 2021 to 2023 combined show that during pregnancy, nearly one-quarter of women (23%) who gave birth in Halton experienced some type of mental health concern, while nearly one in five (18.4%) experienced anxiety. Halton women were less likely to experience depression during pregnancy than Ontario women. There were no other significant differences between Halton and Ontario.

In Halton, between 2021 and 2023, women under the age of 20 (60.6%) and between 20 and 24 (34.8%) were more likely than those in older age groups to report experiencing any mental health concern during pregnancy (not shown).

The percentage of women who gave birth and experienced any mental health concern increased in Halton between 2018 and 2023, and in Ontario between 2013 and 2021 (**Figure 37**). In Halton, the largest increase was seen for anxiety, with rates more than doubling between 2013 (7.6%) and 2023 (18.7%; not shown).

Figure 36: Percentage of women who gave birth (live or still) who experienced any mental health concern, depression, or anxiety during pregnancy, or who had a history of postpartum depression, Halton and Ontario, 2021-2023 combined

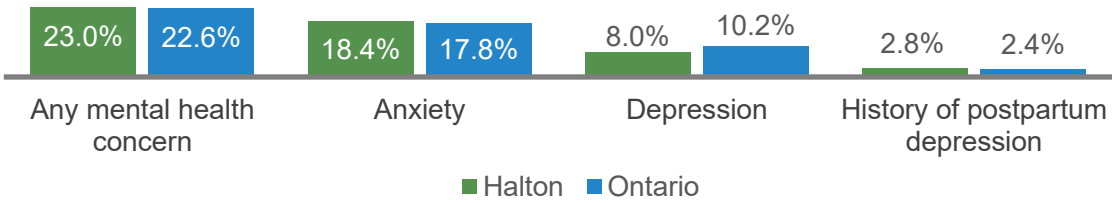
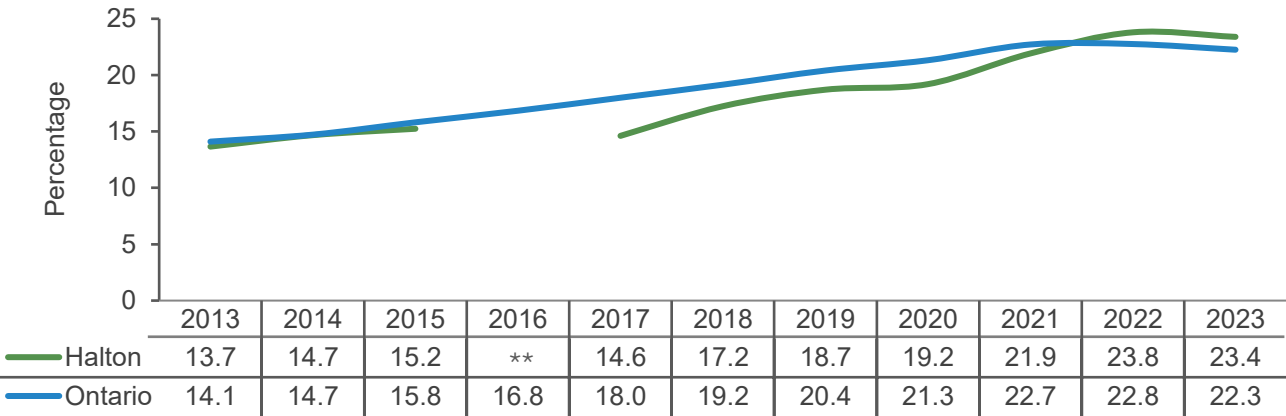


Figure 37: Percentage of women who gave birth (live or still) who experienced any mental health concern, Halton Region and Ontario, 2013-2023



Data: BORN Information System [2013-2023], extracted June 5, 2025. Notes: Records with missing data were not included. Caution should be taken when interpreting results where >5% of records were missing data; this includes data for 2022 for Halton and data for 2013 to 2020 for Ontario. A double-asterisk (**) indicates that the result is not reportable due to small numbers (<6 individuals in a category) or a high proportion of missing data (30% or more).

Substance use during pregnancy

Substance use during pregnancy - including tobacco, alcohol, cannabis, opioids, and other drugs - can pose serious health risks to a pregnant woman and their developing fetus, such as preterm birth, low birth weight, and stillbirth. Infants exposed to substances in utero may also be at increased risk of birth defects, neurodevelopmental disorders, and behavioural problems. Cannabis use during pregnancy has been associated with an increased risk of low birth weight and small-for-gestational-age infants, although evidence for other neonatal and longer-term developmental outcomes is still emerging (Marchand et al., 2025).

The risks of second-hand smoke exposure are similar to those of smoking during pregnancy (Health Canada, 2022). Drinking alcohol during pregnancy can lead to Fetal Alcohol Spectrum Disorder (FASD), a lifelong condition characterized by physical, mental, behavioural, and learning disabilities (Health Canada, 2023a). Opioid exposure during pregnancy often causes neonatal abstinence syndrome (NAS), which causes withdrawal symptoms such as tremors, irritability, and feeding difficulties (Zipursky & Juurlink, 2021). NAS can also affect infant bonding, feeding, and sleep. No amount of alcohol, cannabis, tobacco, or non-medical drug use, including exposure to second-hand smoke, has been proven safe during pregnancy (Health Canada, 2023a).

Figure 38 shows the percentage of women who gave birth between 2021 and 2023 and self-reported smoking, living with a smoker at the time of birth, cannabis use, alcohol use, or other drug use during pregnancy (including cocaine, amphetamines, hallucinogens, opioids, methadone, narcotics, gas/glue, and other drugs).

Women in Halton who gave birth between 2021 and 2023 were less likely than those in Ontario to have smoked, lived with a smoker, or used cannabis, alcohol, or other drugs during pregnancy (**Figure 38**). The percentage who smoked or lived with a smoker during pregnancy decreased between 2015 and 2023 (**Figure 39**).

In Halton, women under age 25 were at least twice as likely as older women to report smoking at the time of birth (5.5%*; not shown), living with a smoker at birth (19.2%), or using cannabis during pregnancy (7.7%). The smoking estimate should be interpreted with caution because of high variability. Women aged 25 to 29 were three times as likely to report cannabis use during pregnancy (3.1%) as older women.

Figure 38: Percentage of women who gave birth (live or still), who reported smoking or residing with a smoker at the time of the newborn’s birth, or reported any alcohol, cannabis, or drug exposure during pregnancy, Halton and Ontario, 2021-2023 combined

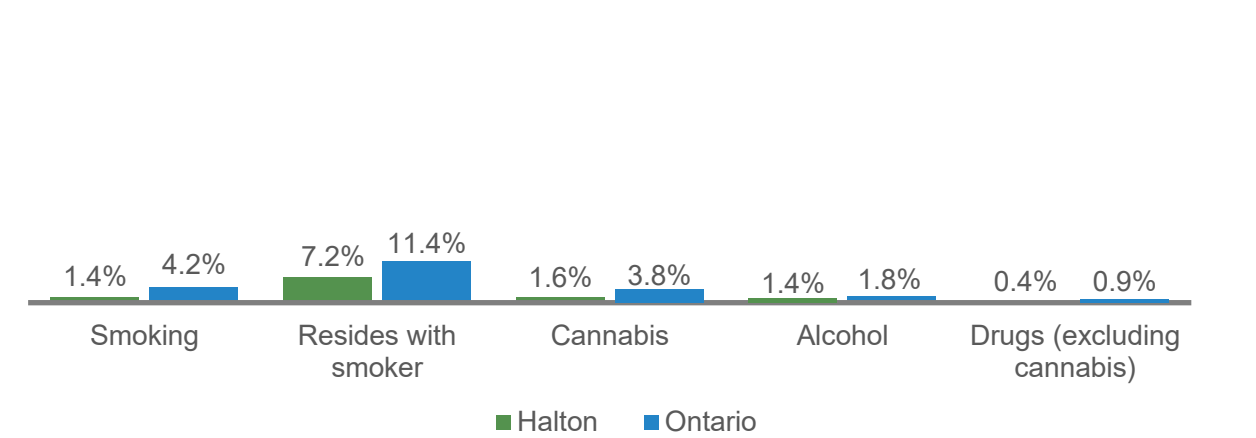
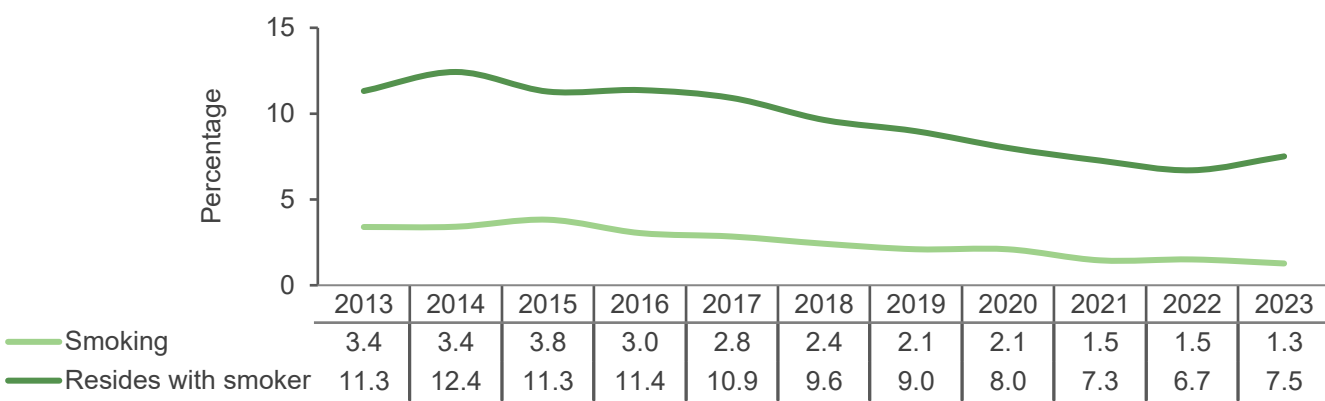


Figure 39: Percentage of women who gave birth (live or still), who reported smoking or residing with a smoker at the time of the newborn’s birth, Halton, 2013-2023 combined



Data: BORN Information System [2013-2023], extracted June 5, 2025. Notes: Records with missing data were not included. Caution should be taken when interpreting results where >5% of records were missing data. For Figure 38, this includes all years of data for 'Resides with Smoker' for Halton and Ontario, and all years of data for 'Cannabis' for Halton. For Figure 39, this includes 2016 and 2022 data for 'Smoking' for Halton, and 2015, 2016, 2021, 2022 and 2023 data for 'Resides with Smoker' for Halton.

Prenatal class attendance

Prenatal classes provide pregnant women and their partners with information on a range of topics about pregnancy, birth, and parenting. Prenatal education programs can be delivered in-person or online. **Figure 40** shows the percentage of all mothers and first-time mothers who gave birth and attended prenatal classes. Data for 2021 to 2023 combined show that Halton mothers were more likely than Ontario mothers to attend prenatal classes during pregnancy. This was true of all mothers and first-time mothers.

In Halton, the percentage of first-time mothers who attended prenatal classes decreased significantly between 2013 and 2017, before increasing again between 2017 and 2023 (**Figure 41**). A similar trend was seen in Ontario. These increases may be partly due to the greater availability of online formats, which have improved accessibility for many women.



Figure 40: Percentage of women who gave birth (live or still) who reported attending prenatal classes, all mothers and first-time mothers, Halton and Ontario, 2021-2023 combined

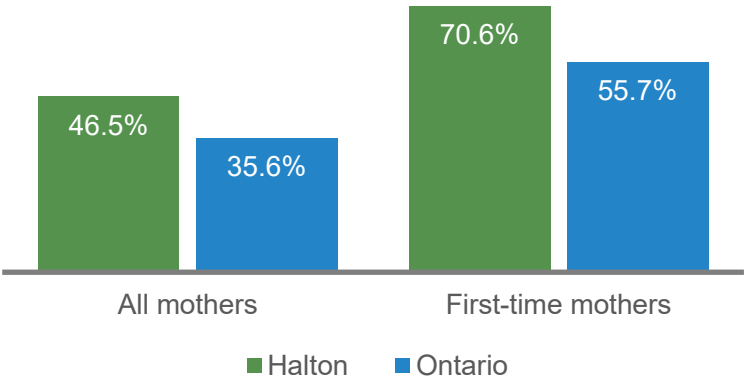
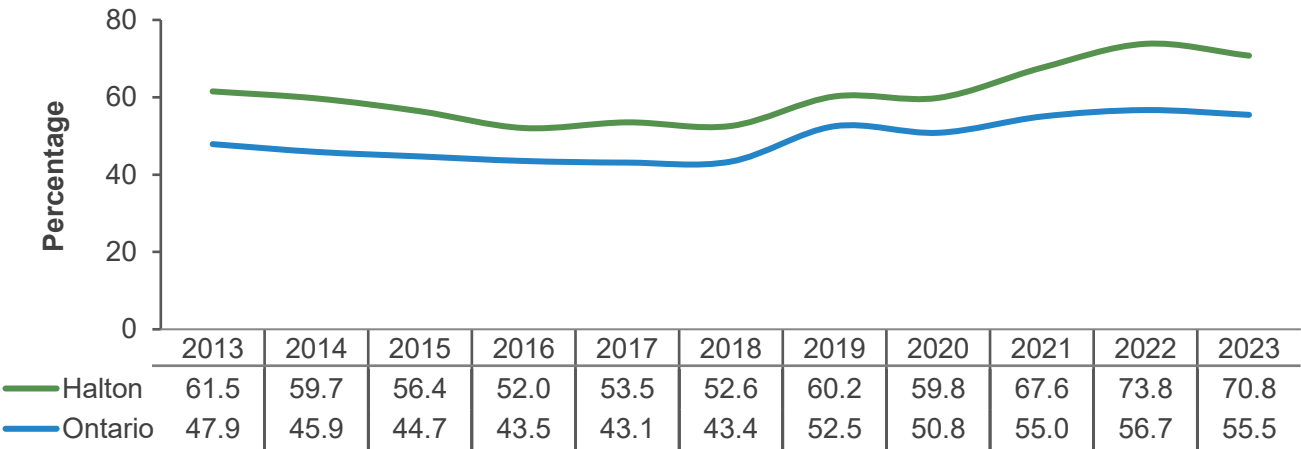


Figure 41: Percentage of first-time mothers who gave birth (live or still) who reported attending prenatal classes, Halton and Ontario, 2013-2023



Data: BORN Information System [2013-2023], extracted June 5, 2025. Notes: Records with missing data were not included. Caution should be taken when interpreting results where >5% of records were missing data; this includes all years of data shown for Halton and Ontario. All mothers include first-time mothers and mothers with one or more children.

Data for 2021 to 2023 combined show that first-time mothers aged 24 and under were the least likely to have attended prenatal classes (**Figure 42**). This difference was statistically significant when compared to mothers aged 30 to 34 or 35 to 39. Mothers aged 30 to 34 were the most likely to have attended and this difference was statistically significant compared to those under the age of 24 or between the ages of 25 and 29.

First-time mothers from Milton were much more likely to have attended prenatal classes compared to mothers from any other municipality in Halton (**Figure 43**). First-time mothers from Halton Hills were also more likely to attend prenatal classes compared to those from Burlington.



Figure 42: Percentage of first-time mothers who gave birth (live or still) who reported attending prenatal classes, by age, Halton, 2021-2023 combined

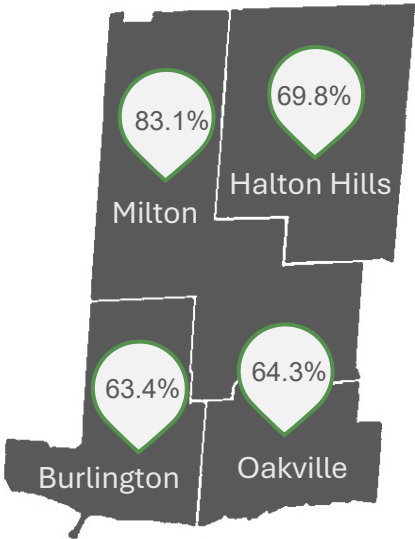
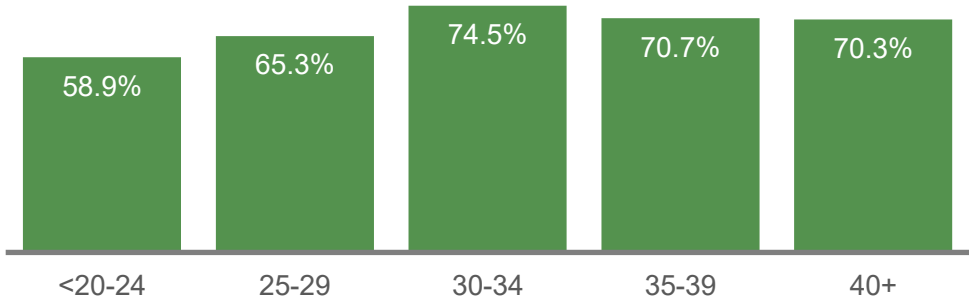


Figure 43: Percentage of first-time mothers who gave birth (live or still) who reported attending prenatal classes, by municipality, Halton, 2021-2023 combined

Data: BORN Information System [2013-2023], extracted June 5, 2025. Notes: Records with missing data were not included. Caution should be taken when interpreting results where >5% of records were missing data; this includes all years of data shown.

Health of newborns

This section describes key indicators related to the health of newborns in Halton and Ontario. It includes measures of breastfeeding exclusivity, breastfeeding intention, gestational age at birth, birth weight, small- and large-for-gestational-age births, congenital anomalies, congenital infections, and infant mortality. Data are examined over time and, where appropriate, by municipality and maternal age to highlight trends, differences between Halton and Ontario, and areas that may benefit from continued monitoring and support.



What the Data Tell Us

- Breastfeeding patterns at hospital discharge have shifted over time in both Halton and Ontario, with declines in exclusive breastfeeding and increases in mixed feeding. Overall, breastfeeding patterns in Halton are now similar to the provincial average.
- Most infants in Halton are born full-term and at a healthy birth weight; however, pre-term birth and small-for-gestational-age births have increased over time. These outcomes vary by maternal age, with higher rates observed among younger (under 20) and older (age 45+) mothers.
- More serious newborn health outcomes, including congenital anomalies and infant mortality, remain relatively uncommon in Halton. While congenital anomaly-related hospitalizations have increased in some municipalities, infant mortality rates have remained low and stable overall.

How This Information Can Be Used

- 1 Health providers may consider these findings when supporting families during pregnancy and the early postnatal period, particularly in relation to monitoring fetal growth, identifying infants at higher risk due to pre-term birth, and breastfeeding support. Awareness of age-related patterns and regional trends may help inform conversations and care planning with pregnant women.
- 2 Programs and services can use this information to identify opportunities to strengthen early-life supports, including breastfeeding education, prenatal and postnatal follow-up, and targeted supports for populations or communities experiencing higher rates of adverse newborn outcomes. This includes promoting early identification and referrals to developmental supports to optimize child development outcomes.
- 3 Ongoing monitoring of newborn health indicators can support local planning, evaluation of public health initiatives, and collaboration with healthcare and community partners to promote healthy beginnings for infants across Halton.

Breastfeeding

The World Health Organization, Health Canada, Canadian Pediatric Society, and other health organizations recommend breastfeeding exclusively for the first six months of an infant’s life, followed by continued breastfeeding for two years or more, with the introduction of solid foods (World Health Organization, 2023a; Health Canada, 2023b; Canadian Paediatric Society, 2023). **Exclusive breastfeeding** means giving babies only breast milk, with no other food or drink. Breastfeeding helps infants build a strong immune system, supports brain development, and strengthens the bond between the mother and her baby (Canadian Paediatric Society, 2023). Halton Region Public Health offers a wide range of breastfeeding supports to assist new and expecting parents. These services provide guidance, education, and community connections throughout the breastfeeding journey.

Figure 44 and **Figure 45** show data related to breastfeeding exclusivity, which is measured at the time the infant is discharged from hospital following birth, or on the third day post-partum for home births. Between 2013 and 2023, the breastfeeding exclusivity rate decreased by 15% in Halton and Ontario (**Figure 44**). Halton’s rate was similar to Ontario’s in 2023.

Halton’s declining exclusivity rate has corresponded to an increase in the percentage of births where the infant was being fed a combination of breastmilk and formula (**Figure 45**). As of 2023, the proportion of births where infants were fed breastmilk only, or a combination of breastmilk and formula, were nearly equal. The proportion of births where the infant was fed formula (only) decreased significantly between 2013 and 2023. Further qualitative research is needed to better understand why breastfeeding exclusivity has declined while combination feeding has become more common.

Figure 44: Percentage of births where mother was breastfeeding exclusively at discharge from hospital/birth centre, or home births three days post-partum, Halton and Ontario, 2013-2023

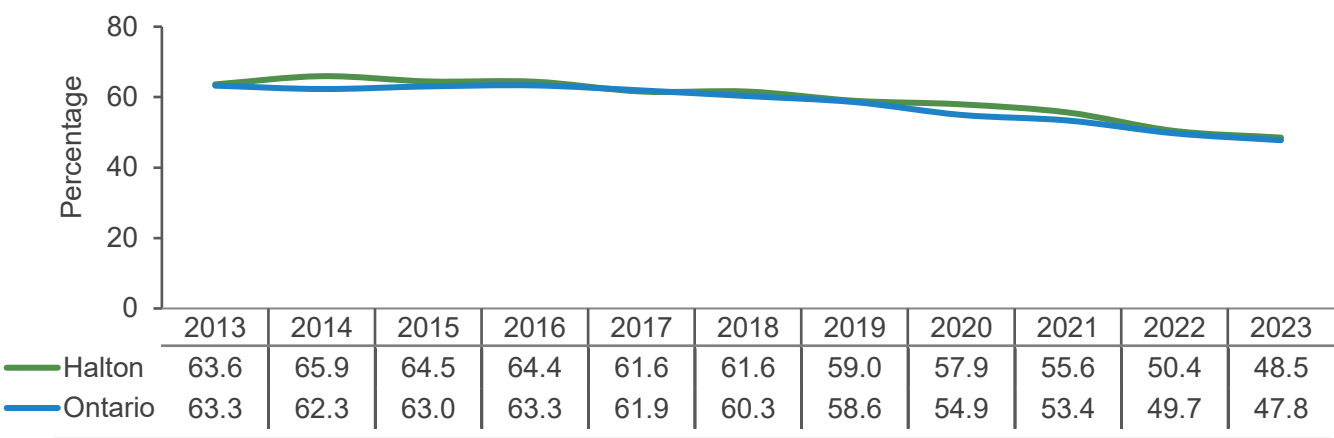
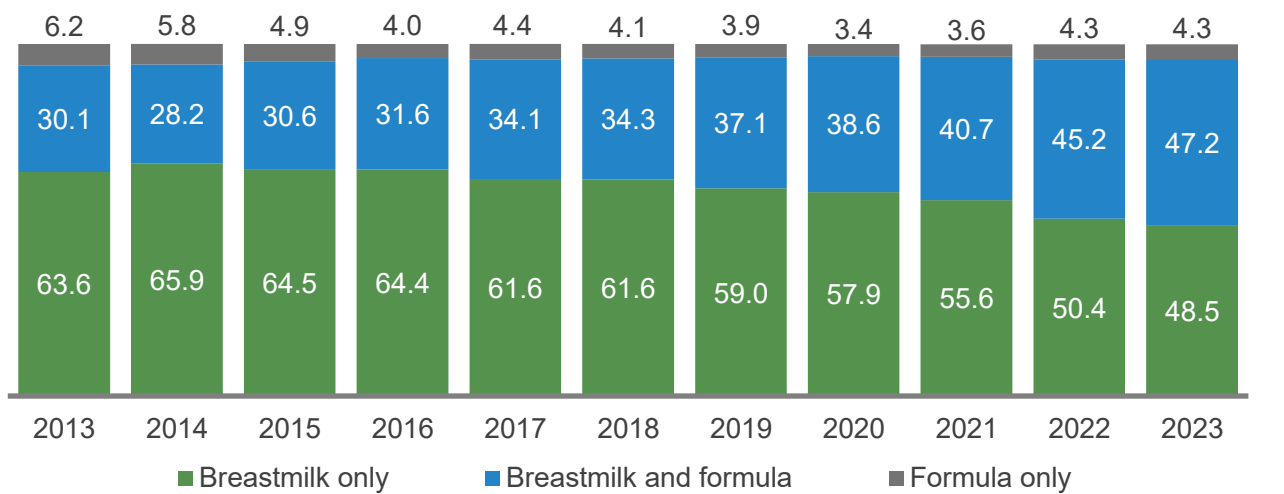


Figure 45: Percentage of births by infant feeding method at discharge from hospital/birth centre, or home births three days post-partum, Halton, 2013-2023



Data: BORN Information System [2013-2023], date extracted: June 11, 2025. Notes: Records with missing data were not included. Caution should be taken when interpreting results from years of data where >5% of records were missing data related to this variable. This includes data for 2013 and 2014 for Halton and 2013 to 2020 for Ontario. The category ‘Formula’ includes formula and other breastmilk substitutes (animal milk, donor human milk, etc.).

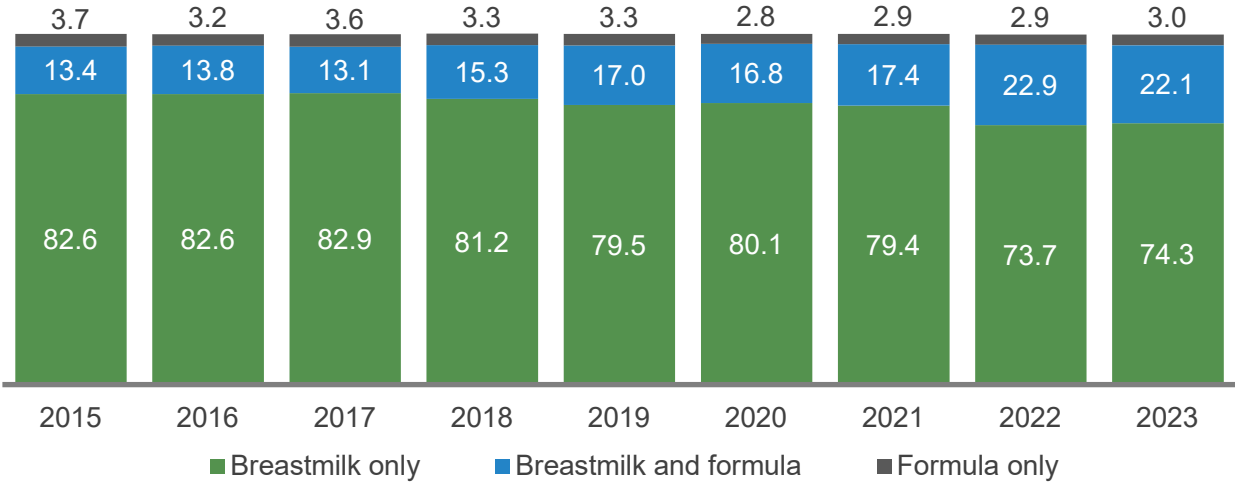
Intention to breastfeed

Changes in breastfeeding exclusivity rates over time may be due in part to shifts in infant feeding intentions among women who gave birth. Data from the Better Outcomes Registry & Network (BORN) show that in Halton, the percentage of women who intended to breastfeed exclusively declined from 82.6% in 2015 to 74.3% in 2023 (**Figure 46**). Over the same period, the percentage who planned to feed their newborn a combination of breastmilk and formula nearly doubled, from 13.4% to 22.1%. Similar trends were observed across Ontario (not shown).

Although nearly three-quarters of pregnant women in Halton planned to breastfeed exclusively in 2023, data regarding breastfeeding exclusivity suggest that fewer than half went on to do so. This gap between intention and practice highlights opportunities to strengthen education and supports for expectant mothers to help them meet their breastfeeding goals and support optimal health outcomes for infants.



Figure 46: Percentage of women who were pregnant or gave birth, by breastfeeding intention (breastmilk only, breastmilk and formula, or formula only), Halton Region, 2015-2023



Data: BORN Information System [2015-2023], date extracted: June 5, 2025. Notes: Data prior to 2015 are not shown due to changes over time to data collection methods. Records with missing data were not included. Caution should be taken when interpreting results from years of data where >5% of records were missing data related to this variable. This includes data for all years except 2016 and 2022. The category 'Formula' includes formula and other breastmilk substitutes (animal milk, donor human milk, etc.).

Pre-term births

Gestational age refers to the age of a pregnancy in completed weeks. An infant is considered premature (or pre-term) if it is born at fewer than 37 weeks of gestational age, full-term (or term) if it is born between 37 and 41 weeks of gestational age, and post-term, if it is born at 42 or more weeks of gestational age.

Pre-term or post-term birth can increase health risks for babies and mothers. Babies born too early may face challenges such as breathing problems, difficulty feeding, and developmental delays. They are also more likely to experience long-term health issues, including problems with vision and hearing (Canadian Institutes of Health Research, 2017). Post-term births can also lead to complications including larger birth weight, which increases the risk of injury during delivery. In addition, the placenta may not function as effectively, which could reduce the baby’s supply of oxygen and nutrients (Public Health Agency of Canada, 2018b). Regular prenatal care is important for detecting and managing risks associated with pre-term or post-term birth.

In Halton, data from 2021 to 2023 combined show that most live-born infants in Halton (92.7%) were full-term at the time they were born, while 7.2% were pre-term, and 0.1% were born post-term (not shown).

The pre-term birth rate is the number of live-born infants who were born pre-term per 1,000 live births. In Ontario, the pre-term birth rate increased between 2013 and 2023 (**Figure 47**). The increase in Halton during this period was not statistically significant. In Halton, the percentage of infants born pre-term did not differ significantly by maternal age group (**Figure 48**).



Data for 2021 to 2023 combined show that **93%** of live-born infants in Halton were born at full term (between 37 and 41 weeks of pregnancy).

Figure 47: Crude pre-term birth rate (per 1,000 births), Halton and Ontario, 2013-2023

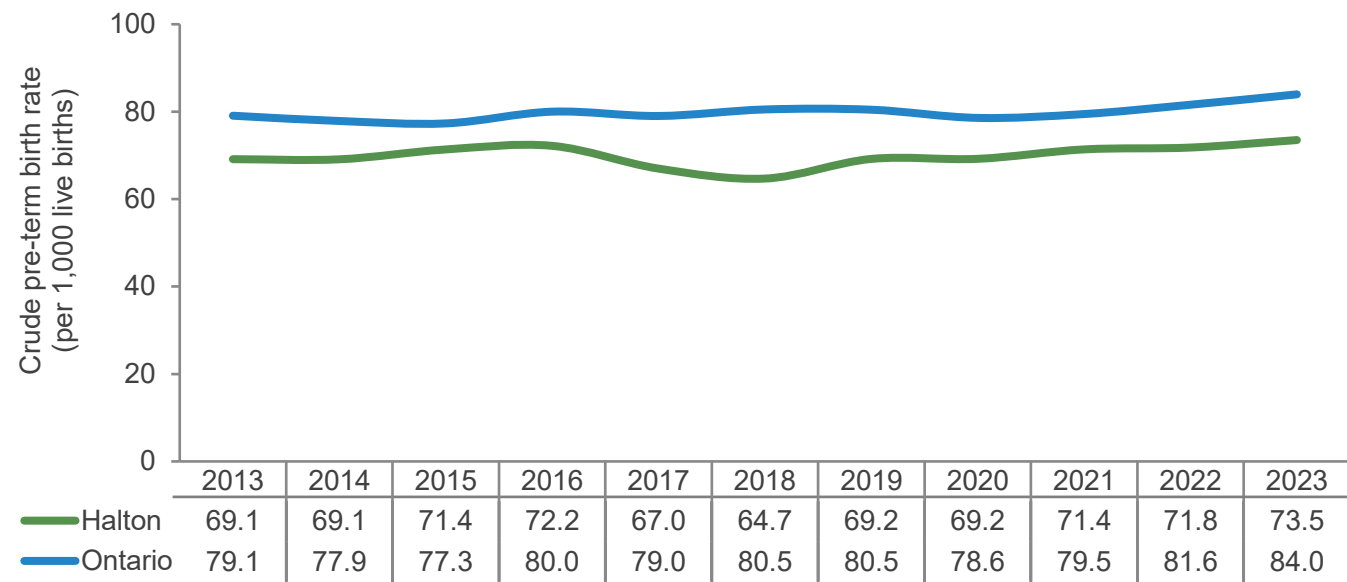
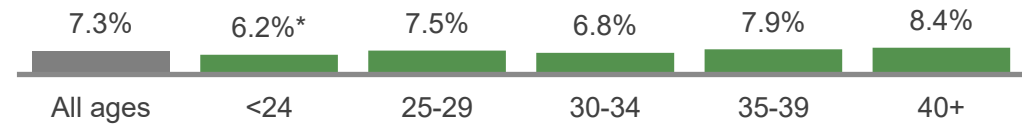


Figure 48: Percentage of live-born infants who were born pre-term (37 to 41 weeks), by mother’s age group, Halton, 2021-2023 combined



Data: BORN Information System [2013-2023], date extracted: June 11, 2025. Records with missing data were not included. A single asterisk (*) indicates the result should be interpreted with caution due to high variability.

Newborn birth weights

Low birth weight (LBW), defined as a birth weight of less than 2,500 grams, poses significant health risks for infants. Babies born with LBW are more likely to experience immediate complications such as breathing difficulties, infections, and problems maintaining body temperature. Over the long term, they may be at increased risk for developmental delays, chronic diseases, and poor growth outcomes (World Health Organization, 2023b).

Table 5 shows the average number and percentage of births between 2021 and 2023, by birth weight category. Most infants (92.5%) had a normal birth weight, while 6.4% had a low birth weight (extremely, very, or moderately low) and just over 1% had a high birth weight. Infants who were multiples (e.g., twins, triplets) or who were born pre-term were more likely to be born with LBW (**Figure 49** and **Figure 50**). There were no statistically significant differences by mother’s age (not shown).

Table 5: Average number and percentage of births per year, by birth weight, Halton, 2021-2023 combined

Birth weight category	Average number of births per year	Percentage of births per year
Extremely low (500 to 999 grams)	13 births	0.2%
Very low (1,000 to 1,499 grams)	28 births	0.5%
Moderately low (1,500 to 2,499 grams)	308 births	5.7%
Normal (2,500 to 4,499 grams)	5,017 births	92.5%
High (4,500 or more grams)	57 births	1.1%

Figure 49: Percentage of live births with low birth weight, by singleton or multiple birth, Halton, 2021-2023 combined

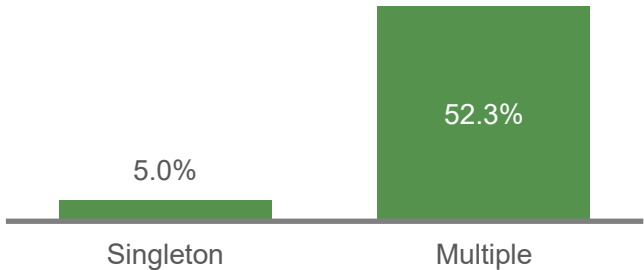
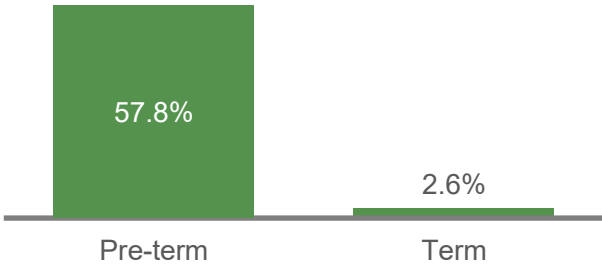


Figure 50: Percentage of live births with low birth weight, by gestational age (pre-term or term), Halton, 2021-2023 combined



Data: BORN Information System [2013-2023], date extracted: July 4, 2025. Notes: Records with missing data were not included. Pre-term refers to a birth that occurs at less than 37 weeks of gestational age. Term refers to a birth that occurs at a gestational age of 37 weeks or more.

Small-for-gestational age and large-for-gestational age

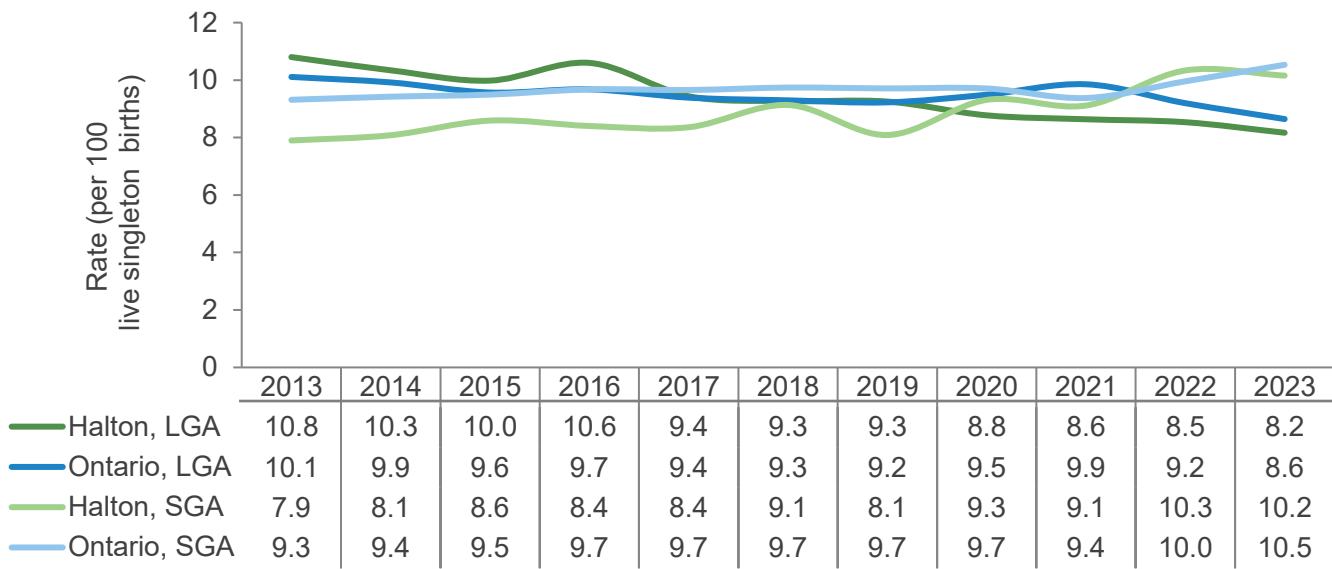
Small-for-gestational age (SGA) infants are those whose birth weight is below the 10th percentile for their gestational age and sex. SGA babies may have trouble keeping warm (hypothermia), feeding properly, and maintaining normal blood sugar levels after birth. They can also be at higher risk for slower growth and learning delays as they grow older. Later in life, they may be more likely to develop chronic conditions like heart disease or diabetes. Risk factors associated with SGA births can include poor nutrition during pregnancy, smoking, and chronic illnesses (World Health Organization, 2023c). In Halton and Ontario, rates of SGA births increased slightly but significantly between 2013 and 2023 (**Figure 51**).

Large-for-gestational age (LGA) infants have a birth weight above the 90th percentile for their gestational age and sex. LGA babies are more likely to have a difficult delivery, which can lead to injuries, and may be more likely to require a cesarean section. As LGA infants grow older, they are more likely to become overweight or develop health problems like diabetes. LGA births are more common when the mother has gestational diabetes, gains more than the recommended amount of weight during pregnancy, or starts pregnancy at a higher weight. Managing weight and blood sugar during pregnancy are important to lower these risks (Public Health Agency of Canada, 2013).

In Halton and Ontario, rates of LGA births decreased slightly but significantly between 2013 and 2023 (**Figure 51**). This decline occurred despite an increase in the proportion of women who were overweight or obese prior to pregnancy, which may reflect the effects of universal gestational diabetes screening and the resulting opportunities for earlier intervention and management.

Regular prenatal care is essential in identifying and managing the risks associated with LBW, SGA, or LGA births. Healthcare providers can offer guidance on nutrition, monitor fetal growth, and provide appropriate care to promote optimal outcomes for both the mother and child.

Figure 51: Small-for-gestational age and large-for-gestational age rates (per 100 live singleton births), Halton and Ontario, 2013-2023



Data: BORN Information System [2013-2023], date extracted: July 4, 2025. Notes: Records with missing data were not included. Excludes births under 500 grams.



Congenital anomalies

A **congenital anomaly** is a structural or functional abnormality of the fetus that develops during pregnancy, is present at birth, and may affect physical development, organ function, or overall health. Congenital anomalies include malformations, deformations, and chromosomal abnormalities. Congenital anomalies are the leading cause of infant mortality in Canada (Statistics Canada, 2024c). Congenital anomalies can be identified during pregnancy, at birth, or later in life. Some types of anomalies can have long-term health impacts, while others may cause no significant impact on health. Causes include genetic factors, environmental exposures such as radiation or pollutants, maternal infections, or poor nutrition during pregnancy. However, about half of all congenital anomalies have no known cause.

Figure 52 shows the rate per 1,000 infants (live or stillborn) who were hospitalized and diagnosed with any congenital anomaly within the first 365 days of life. Infants with more than one congenital anomaly are counted only once. This analysis only captures anomalies that required hospitalization and may therefore underestimate the actual rate of congenital anomalies. For example, less serious congenital anomalies identified by healthcare providers outside of the hospital setting, or pregnancies that were terminated due to anomalies detected prior to birth, would not be included. Between 2013 and 2024, Halton’s rate increased, while Ontario’s rate remained relatively stable.

Figure 53 shows the rate of infants hospitalized and diagnosed with any congenital anomaly within a year of birth, by municipality. Three-year moving averages were used to reduce year-to-year variation and produce more stable estimates when analyzing small numbers at the municipal level. For example, the 2014 rate includes data from 2013 through 2015, while the 2015 rate includes data from 2014 through 2016, and so on. Statistically significant increases were seen in Milton and Burlington from 2014 to 2023.

The observed differences over time and between municipalities likely reflect a combination of factors rather than a single underlying cause. Possible explanations include changes in population growth and composition, including differences in genetic risk or family patterns; cultural beliefs and practices related to pregnancy and prenatal screening; access to comprehensive primary care; changes in healthcare use; and broader maternal health trends such as increasing maternal age and chronic health conditions during pregnancy. It is not yet clear how significantly each of these factors may be influencing the observed trends, and further analyses are underway to better understand these findings. A clearer understanding of the factors contributing to these trends could help inform upstream interventions to improve access to care and provide relevant education and resources. Prioritizing prevention and early intervention, where opportunities exist, has the potential to improve newborn and longer-term pediatric health outcomes across Halton.

Figure 52: Rate (per 1,000) of infants who were hospitalized and diagnosed with any congenital anomaly within the first year of life, Halton and Ontario, 2013-2024

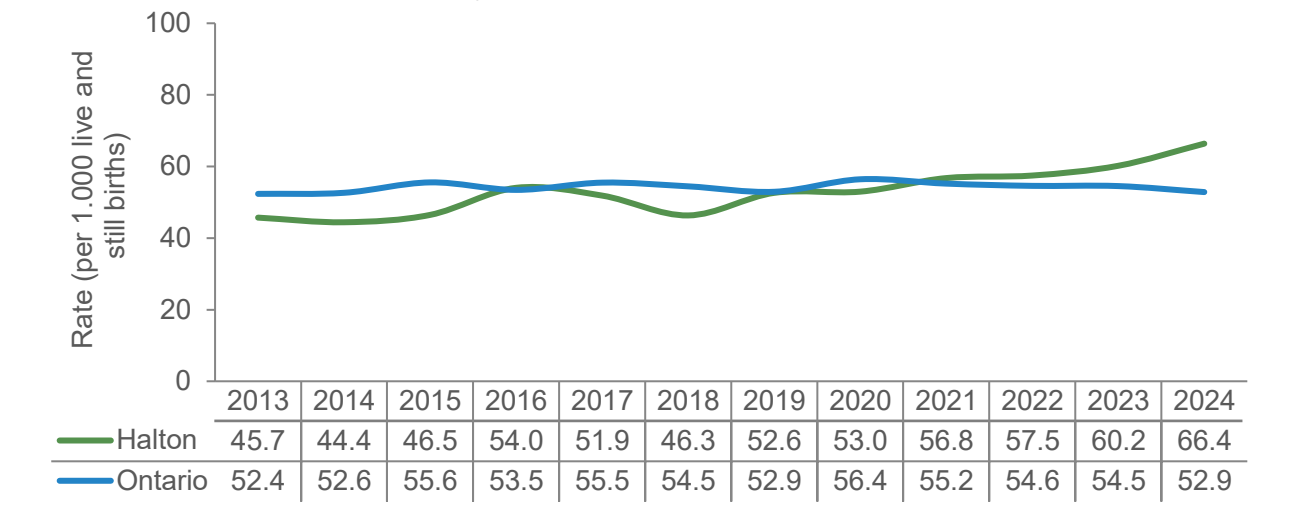
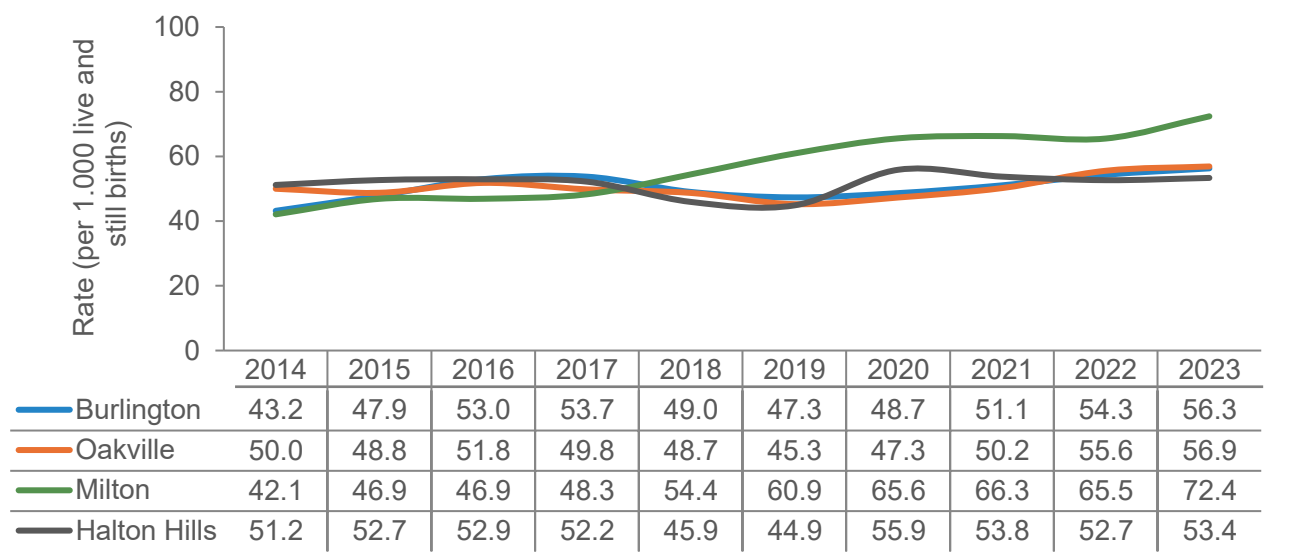


Figure 53: Rate (per 1,000) of infants who were hospitalized and diagnosed with any congenital anomaly within the first year of life, based on three-year moving averages, by municipality, Halton, 2014-2023



Data: Inpatient Discharges [2013-2024]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted May 20, 2026.

Congenital infections

Congenital infections are infections that are transmitted from a mother to her infant during pregnancy or delivery. They include group B streptococcal disease, ophthalmia neonatorum (a bacterial eye infection), early congenital syphilis, and rubella (a viral infection). The congenital infection rate is the number of congenital infections per 10,000 live births. **Figure 54** shows the rate of congenital infections in Halton and Ontario for 2014 to 2023 combined. A combined rate was used to account for unstable rates due to small numbers. Halton’s rate was low and similar to Ontario’s. Between 2014 and 2023, a total of 19 congenital infections were reported in Halton. Group B streptococcal infection was the most common type of infection reported, accounting for 83% of congenital infections in Ontario.

Infant mortality

Infant mortalities are deaths within the first year of birth. When deaths happen within 27 days of birth, they are called neonatal mortalities. Deaths between 28 and 364 days of birth are called post-neonatal mortalities. The infant mortality rate is the number of infant deaths within one year of birth per 1,000 live births.

The most common causes of neonatal mortality are congenital anomalies; disorders related to short gestation and low birth weight; complications of pregnancy; complications of the placenta, cord, and membrane; and complications of labour and delivery. Common causes of post-neonatal mortality include structural or functional birth defects, infections, immaturity (meaning the infant is not fully grown), or sudden infant death syndrome (Statistics Canada, 2023b).

Infant mortality in Canada has declined over time but remains higher compared to many similar countries, including the United Kingdom, France and Ireland (Statistics Canada, 2023b). Certain socio-demographic factors such as lower maternal education, inadequate housing, lack of access to health care, food insecurity, poverty, and unemployment may be linked to an increased risk of infant mortality (Statistics Canada, 2023b).

Figure 55 shows the infant mortality rate in Halton and Ontario. Three-year moving averages were used to account for unstable rates due to small numbers. Between 2012 and 2022, Halton’s rate of infant mortality remained relatively stable and low. In Ontario, the rate declined slightly between 2012 and 2022.

In Halton, data for 2019 to 2023 combined show that there were an average of 17.4 deaths per year among infants under one year of age (not shown). Most of these deaths (85%) happened within 27 days of birth.

Figure 54: Congenital infection rate (per 10,000 live births), Halton Region and Ontario, 2014-2023 combined

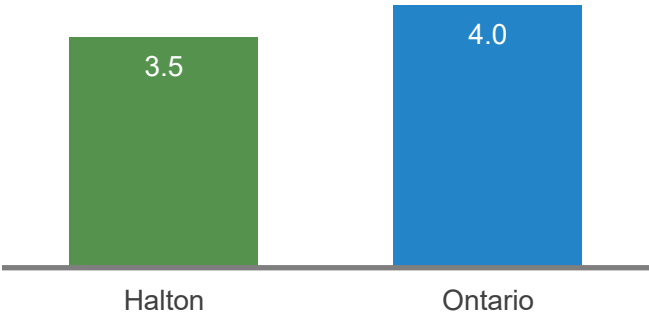
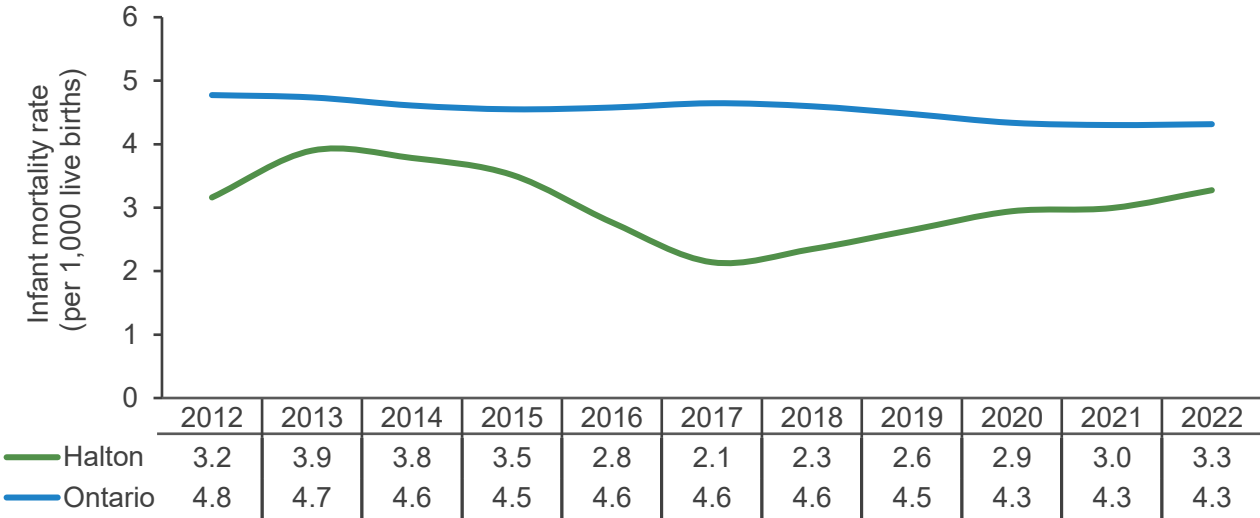


Figure 55: Infant mortality rate (per 1,000 live births) based on three-year moving averages, Halton and Ontario, 2012-2022



Data for Figure 53: Public Health Ontario ID Query [2014-2023], extracted December 5, 2024. Vital Statistics [2011-2023], IntelliHEALTH Ontario, date extracted: March 6, 2025. Data for Figure 54: Vital Statistics [2013-2023]. Ontario Ministry of Health: IntelliHEALTH Ontario, extracted November 4, 2025. Three-year moving averages were used to reduce year-to-year variation and produce more stable estimates that can occur due to small numbers. For example, the 2012 rate includes data from 2011 through 2013, while the 2013 rate includes data from 2012 through 2014, and so on.

Appendix – Data Sources & Limitations

Three major reproductive health data sources were used for this report: Vital Statistics data and hospital discharge data (from IntelliHEALTH Ontario), and the Better Outcomes Registry Network (BORN). This section describes these data sources, including key information and limitations.

Data source: Vital Statistics

About this data source

- Original source: Vital Statistics, Ontario Office of Registrar General (ORG), ServiceOntario
- Data are available for download through IntelliHEALTH for the year 1986 onward.
- Where possible, indicators in the report that use this data source are based on the established guidelines as set out in Association of Public Health Epidemiologists in Ontario (APHEO) core indicators repository.
- Live birth and stillbirth registration is required by law. All live and stillbirths in Ontario must be registered with the Office of the Registrar General (ORG) within 30 days of birth, as per the Vital Statistics Act (1990). The ORG supplies the birth registration data to Statistics Canada for national reporting. With the ORG's approval, Statistics Canada provides the Ontario Ministry of Health with an edited and standardized dataset, which is uploaded to IntelliHEALTH.
- Information on stillbirths is collected by the Office of the Registrar General and is based on three forms: 1) the Notice of Stillbirth completed by the birth attendant; 2) Statement of Stillbirth completed by parents; and 3) the more detailed Medical Certificate of Stillbirth completed by the birth attendant. The ORG supplies the stillbirth registration data to Statistics Canada for national reporting. With the ORG's approval, Statistics Canada provides the Ontario Ministry of Health with an edited and standardized dataset, which is uploaded to IntelliHEALTH.
- The Office of the Registrar General (ORG) obtains information about mortality from death certificates which are completed by physicians. All deaths within Ontario are registered in the office of the division registrar within which the death occurs. The ORG provides death data to Statistics Canada for national reporting.
- Data are analyzed by the residence of the mother, not by where the birth, stillbirth or death occurred. Births or stillbirths to out-of-province mothers and are not included in analyses in this report. Births or stillbirths to Ontario residents that occur outside the province, as well as deaths of Ontario residents (including infants) occurring outside Ontario, are not included in IntelliHEALTH.
- Statistics Canada derives the municipality of residence from the postal code using the Postal Code Conversion File Plus (PCCF+) programs where there is a valid postal code. If no valid postal code is available, manual coding of residence municipality is done from any available address information on the record.
- A stillbirth is defined as a product of conception weighing 500 grams or more, or with a gestational age of 20 weeks or more, that shows no signs of life after complete delivery. In Ontario, therapeutic abortions meeting these same criteria (≥ 500 grams or ≥ 20 weeks' gestation) are also classified as stillbirths. Consequently, stillbirth data may include a small number of fetal deaths resulting from pregnancy termination. As a result, estimates of the total number of pregnancies based on the sum of live births, stillbirths, and abortions may slightly overestimate the true number of pregnancies.
- The rate of stillbirth may be affected by temporal and regional variations in the definition of stillbirth and birth registration practices, especially for stillbirths and live births at the low end of birth weight or gestational age range.

Limitations

- Not all births are registered, and under-registration varies by geography and other characteristics. Under-registration also appears more common for teen mothers and infants that die soon after birth.
- Data linking live birth registrations and infant death registrations is not available. Therefore it is not possible to examine infant mortality by certain factors, like gestational age or birth weight.
- Vital Statistics does not collect information about maternal health behaviours or breastfeeding practices.

Additional information about this data source can be found in the Association of Public Health Epidemiologists in Ontario Core Indicators Index under [Data Sources and Resources](#).

Appendix – Data Sources & Limitations

Data source: Inpatient Discharges (Hospitalization Data)

About this data source

- Original source: Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI)
- Data are available for download through IntelliHEALTH for the year 1997 onward.
- Where possible, indicators in the report that use this data source are based on the established guidelines as set out in Association of Public Health Epidemiologists in Ontario (APHEO) core indicators repository.
- Hospitalization data include in-patient discharges resulting from a hospital admission for delivery of a live birth or stillbirth. Live and stillbirths are both captured. Multiple births are counted as one delivery. Each delivery admission generates a maternal record (for delivery of a live birth or stillbirth) and an infant record (for live births and stillbirths).
- Day procedures and emergency department visits are available through the National Ambulatory Care Reporting System (NACRS); however, births not admitted overnight are still captured in the DAD database.
- Ontario residents treated outside of the province are excluded.
- Births outside of hospital - including home births, which account for up to 3.5% of births each year in Ontario - are not included in the calculation of births using DAD data.
- The congenital anomalies indicator presented in this report follows the same methodology used by Durham Region Public Health in the [Infant Health Data Tracker](#) dashboard. Congenital anomalies are classified using the Congenital malformations, deformations, and chromosomal abnormalities chapter of ICD-10 ([Chapter XVII](#)). The analysis includes both live-born and stillborn infants aged 365 days or less. The numerator includes infants diagnosed with at least one congenital anomaly (ICD-10 codes beginning with “Q”), based on the year of hospital admission. Infants with multiple congenital anomalies are counted only once. Infants born outside of hospital are not counted in the denominator, however these account for a relatively small proportion of births (<4% per year). Differences in screening and reporting across public health units and hospitals can impact rates. Some congenital anomalies may be under-reported due to no hospitalization for or diagnosis of the condition at birth or within the first year of life, or termination of pregnancy due to screening for these conditions (e.g., certain chromosomal anomalies). Therapeutic terminations performed due to screening and spontaneous abortion (e.g., resulting from a congenital anomaly) would not be captured. Underreporting may vary over place and time and by type of anomaly.
- Congenital anomaly rates were calculated using a period-based approach. Numerators represent the number of unique infants hospitalized with a congenital anomaly in a given calendar year, based on the year of first hospitalization. Denominators represent the number of infants born in the same calendar year. As a result, numerator cases may include infants born in the preceding year, and the resulting rates should be interpreted as period-based rather than birth cohort-based estimates.

Limitations

- Data are influenced by factors such as availability and accessibility of care, and administrative policies and procedures. This may influence comparisons between areas and over time.
- Hospital records for newborns and mothers are separate. As a result, it is not possible to do a cross-tabulation of information such as birth weight (from the newborn record) with other factors, like mother's age (from the maternal record).
- Does not collect information about maternal health behaviours.

Additional information about this data source can be found in the Association of Public Health Epidemiologists in Ontario Core Indicators Index under [Data Sources and Resources](#).

Appendix – Data Sources & Limitations

Data source: Better Outcomes Registry & Network (BORN)

About this data source

- Original source: Better Outcomes Registry & Network (BORN) Ontario.
- Data are available for download through BORN Ontario via Public Health Reports of the Public Health Data Cube for the year 2013 onward and partial data for 2012.
- Where possible, indicators in the report that use this data source are based on the established guidelines as set out in Association of Public Health Epidemiologists in Ontario (APHEO) core indicators repository.
- BORN Ontario is a provincially funded program, established in 2009, that provides leadership, data, and expertise to support, monitor, and improve maternal, child, and youth health care across Ontario through integrated information, research, and system planning. It provides access to real-time population-based mother and child health data to organizations and practice groups providing health care to mothers and children in Ontario, including hospitals, midwives, labs, public health units, and fertility clinics.
- BORN includes data from a number of sources including fertility clinics, prenatal screening laboratories, specialized antenatal clinics, hospitals, midwifery groups, newborn screening laboratories and prenatal screening and newborn screening follow-up clinics. Specific information is collected for each patient encounter, which is integrated across the continuum of care for the mother and infant. Maternal encounters include: assisted reproduction, prenatal screening, prenatal screening follow-up, antenatal care (antenatal general and antenatal specialty), labour, birth mother and postpartum mother. Infant encounters include: birth child, postpartum child, newborn screening, NICU/SCN (Neonatal ICU/Special Care Nursery), and NICU follow-up.
- Information collected for the birth mother encounter includes maternal demographics and health behaviors; pre-existing maternal health problems; obstetric complications; intrapartum interventions; and birth outcomes. When a woman is admitted to hospital to give birth, data are collected by health care providers and hospital staff from charts, clinical forms and patient interview, and then entered in the database either through a secure website by hospital staff or uploaded directly from hospitals that have electronic record capability. An ongoing program of data verifications, quality checks, and formal training sessions for individuals collecting and entering data assures a high level of data quality is maintained.
- Data are analyzed by maternal residence rather than place of infant's birth.
- The BIS is a live database. Hospitals and midwifery clinics are required to acknowledge their data.
- Records with missing data are excluded from all BORN analyses in this report. Caution should be taken when interpreting data if the percentage of "missing data" is greater than 5%. Throughout this report, data notes have been used to identify estimates or time periods where missing data is greater than 5% for a given indicator. Data are not reported if the percentage of missing data is 30% or greater.
- Some indicators, including those related to mental health and substance use during pregnancy, rely on self-reported data and are therefore subject to reporting biases. For example, social desirability bias may lead some individuals to underreport behaviours that are perceived as stigmatized, resulting in potential underestimation of true prevalence.

Limitations

- Due to disruptions associated with the COVID-19 pandemic and the transition to a new electronic medical record (EMR) system at Oakville Trafalgar Memorial Hospital (OTMH), a data backlog occurred that affected births taking place between April 1, 2022 and March 31, 2023. This may impact BORN data for the calendar year 2022 presented in this report, and - to a lesser extent - data for 2023 as well. Although all births during this period were captured in the BORN system, data entry for certain variables and indicators was incomplete for a large proportion of records. Since that time, significant efforts have been made to enter and update missing information; however, a higher level of missing data persists for this time period compared to other periods referenced in this report. Although data for this report include births to Halton women occurring at all Ontario hospitals, many births to Halton women take place at OTMH. Therefore, incomplete data from OTMH may have a disproportionate impact on overall Halton-level estimates for this period. Where noted throughout this report, estimates where missing data is greater than 5% should be interpreted with caution.

Additional information about this data source can be found in the Association of Public Health Epidemiologists in Ontario Core Indicators Index under [Data Sources and Resources](#).

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