

Smoking and Pregnancy in Tasmania 2006

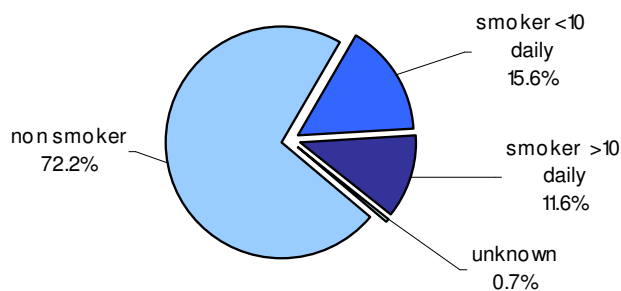
Fact Sheet – October 2008

The Perinatal Data Collection is a state-wide collection of obstetric and perinatal information for all births reported in Tasmania, including live births and stillbirths of at least 400 grams or 20 weeks gestation. The data on smoking prevalence during pregnancy are derived from self-reported information obtained by clinicians from the mother and reported to the Perinatal Data Collection.

Smoking during pregnancy is regarded as one of the key preventable causes of low birth weight and pre-term birth. Low birth weight babies (less than 2500 grams) are more likely to die in the first year of life and are more susceptible to chronic illness later in life, such as heart and kidney disease and diabetes.

In 2006, some **27.2%** of Tasmanian women smoked while pregnant, with 15.6% reporting to smoke less than 10 cigarettes per day and 11.6% reporting to smoke more than 10 cigarettes daily.

Self-Reported Tobacco Smoking Status During Pregnancy, Tasmania 2006



Data available for other jurisdictions show that in 2005 Tasmania had the second highest proportion of women who smoked during pregnancy.

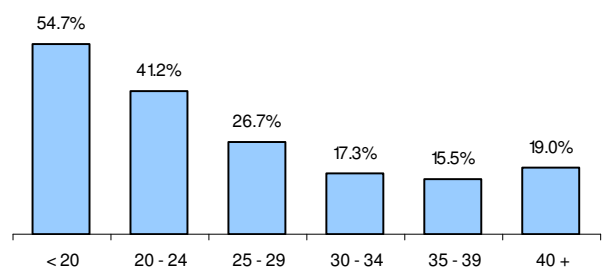
Smoking During Pregnancy by State and Territory, 2005

Northern Territory	31.1%
Tasmania	27.6%
South Australia	23.6%
Queensland	20.4%
Western Australia	17.1%
Australian Capital Territory	14.5%
New South Wales	14.3%

AIHW, National Perinatal Statistics Unit, Australia's Mothers and Babies 2005, Sydney, 2007, Table 3.10; data not available for Victoria

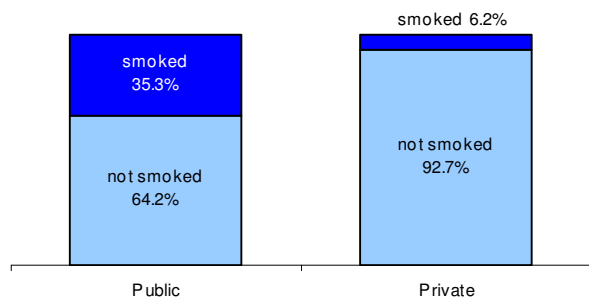
Maternal smoking is more prevalent among younger women, particularly those aged less than 24 years. Smoking while pregnant declines significantly for women aged 30 years and over.

Self-Reported Tobacco Smoking During Pregnancy by Age, Tasmania 2006



There has been a statistically significant decline in self-reported smoking during pregnancy by private patients, from 8.3% in 2005 to 6.2%. Smoking continues to be more prevalent for public patients (35.3%) compared to private patients (6.2%). This reflects the higher prevalence of smoking among lower socio-economic groups.

Self-Reported Smoking Status During Pregnancy by Public and Private Patients, Tasmania 2006



Note: a) multiple births are excluded; b) smoking status unknown for 1.3% private and 0.5% public patients; DHHS, Perinatal Database

For public hospitals, smoking during pregnancy was reported most frequently by patients of the RHH at 36.6%, down from 38.2% the previous year, and the least frequently by patients of the LGH at 27.0%. A key factor in these variations is differences in the patient mix at the three hospitals.

Self-Reported Tobacco Smoking Status During Pregnancy by Hospital, Tasmania 2006

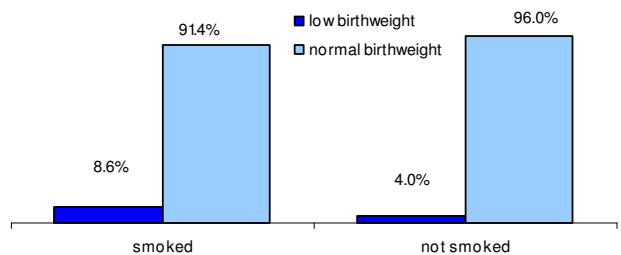
	Not Smoked	Smoked
RHH	63.4%	36.6%
LGH	72.7%	27.0%
NWRH Mersey	68.9%	31.1%

DHHS, Perinatal Database

Low birth weight is defined as a weight of less than 2500 grams and includes babies that are small for gestational age as well as premature. Excluding multiple births, a total of 319 babies were born who had a birthweight of less than 2500 grams. Of these, 16.9% (54) had a weight of less than 1500 grams (very low birth weight).

In 2006, 8.6% of all women who had smoked in pregnancy had a low birth weight baby, compared to 4.0% of women who reported not to have smoked. The relative risk of having a low birth weight baby in 2006 was 2.17 (95% 1.75–2.70) in women who smoked in pregnancy compared with those who reported not to smoke.

Self Reported Tobacco Smoking Status During Pregnancy by Birthweight, Tasmania 2006



Note: multiple births are excluded; DHHS, Perinatal Database

A number of sources of error may influence the strength of this association. Women may report they had not smoked in pregnancy when, in fact, they had but were uncomfortable disclosing their smoking. Also, maternal smokers may have other risk factors associated with low birth weight babies including younger age, poorer prenatal care, inadequate maternal weight gain or other substance use.

These factors were not adjusted for in the analyses. If one or more of these factors is positively associated with low birth weight, they may be responsible for some of the excess risk that is attributed to maternal smoking. In other words, the relative risk estimate of $RR = 2.17$ may be an overestimate due to confounding.