

Smoking and Pregnancy in Tasmania 2005

Fact Sheet

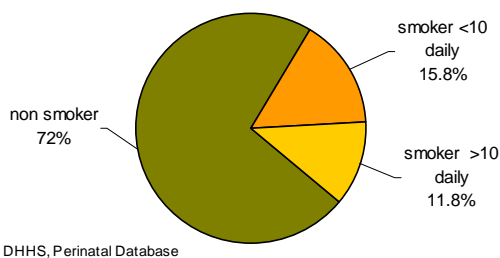
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For the first time, detailed data are available on the smoking status of Tasmanian women during pregnancy. The data are based on information obtained from the mother by her clinician and reported to the Perinatal Data Collection. The Perinatal Data 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 birthweight or at least 20 weeks gestation.

Smoking during pregnancy is one of the major 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 2005, some 27.6% of Tasmanian women smoked while pregnant, with 15.8% reporting to smoke less than 10 cigarettes per day and 11.8% reporting to smoke more than 10 cigarettes per day.

Self-Reported Tobacco Smoking Status During Pregnancy, Tasmania 2005



Data available for other jurisdictions show that in 2004 the Northern Territory and South Australia had high proportions of women who smoked tobacco during pregnancy.

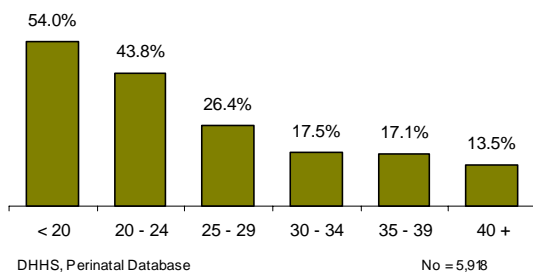
Proportion of Women Smoking Tobacco during Pregnancy by State and Territory, 2004

NT	28.6%
SA	23.6%
WA	17.2%
ACT	15.6%
NSW	14.8%

AIHW, National Perinatal Statistics Unit, Australia's Mothers and Babies 2004, Sydney, 2006, Table 3.10; data not available for other jurisdictions

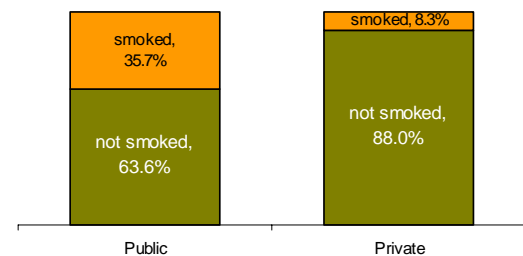
Maternal smoking is more prevalent among younger women, particularly those aged less than 24 years. The proportion of women smoking during pregnancy declines significantly for women aged 30 years and over.

Self-Reported Tobacco Smoking Status During Pregnancy by Age, Tasmania 2005



Smoking during pregnancy was more prevalent for public patients (35.7%) compared to private patients (8.3%). This is to be expected, as the prevalence of smoking is higher among lower socio-economic groups.

Self-Reported Smoking Status During Pregnancy by Public and Private Patients, Tasmania 2005



Note: a) multiple births are excluded; b) smoking status unknown for 3.7% private and 0.7% public patients; DHHS, Perinatal Database

For public hospitals, smoking during pregnancy was reported most frequently by patients of the RHH (38.2%), and the least by patients of the LGH at 26.2%. A key factor in these variations is differences in the patient mix at the three hospitals.

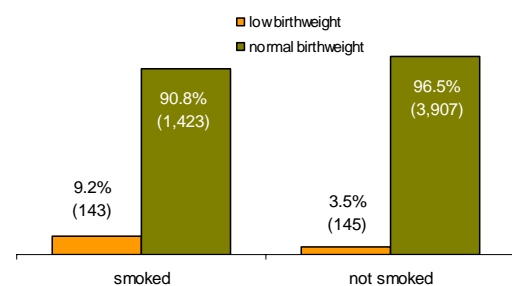
Self-Reported Tobacco Smoking Status during Pregnancy by Hospital, Tasmania 2005

Hospital	Not Smoked	Smoked
RHH	61.8	38.2
LGH	73.8	26.2
NWRH Mersey	69.1	30.9

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 293 babies were born who had a birthweight of less than 2500 grams. Of these, 17.1% had a birthweight of less than 1500 grams (very low birth weight). A total of 9.2% of women who smoked in pregnancy had a low birth weight baby, compared to 3.5% of women who reported not to have smoked.

Self Reported Smoking Status During Pregnancy by Birthweight, Tasmania 2005



Note: a) multiple births are excluded; b) smoking status unknown for 94 births (9.6%); DHHS, Perinatal Database

The relative risk of having a low birth weight baby was 2.55 (95% 2.02-3.19) in women who smoked in pregnancy compared with those who did not smoke.

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 status. Also, maternal smokers may have other risk factors associated with low birth weight babies including younger maternal 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 them is positively associated with low birth weight, they would be responsible for some of the excess risk that is attributed to maternal smoking. In other words, the relative risk estimate of RR = 2.55 may be an overestimate due to confounding.