Smoking: Pregnancy

- Smoking in pregnancy causes significant harm to both mother and baby and is the single most important modifiable risk factor during pregnancy.
- It is more common in disadvantaged groups and younger mothers.
- Smoking in pregnancy can reinforce cycles of inequality across generations.
- For more information, take a look at ASH's Smoking and Reproduction fact sheet

The case for action

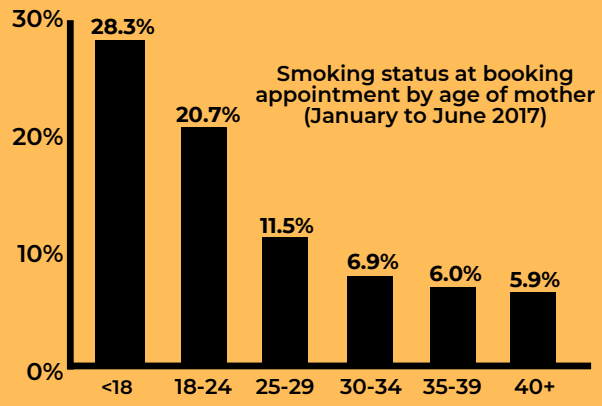
	Maternal smoking	Secondhand smoke exposure
Low birth weight	Average 250g lighter	Average 30-40g lighter
Stillbirth	Double the likelihood	Increased risk
Miscarriage	24-32% more likely	Possible increase
Preterm birth	27% more likely	Increased risk
Heart defects	50% more likely	Increased risk
Sudden Infant Death	3 times more likely	45% more likely

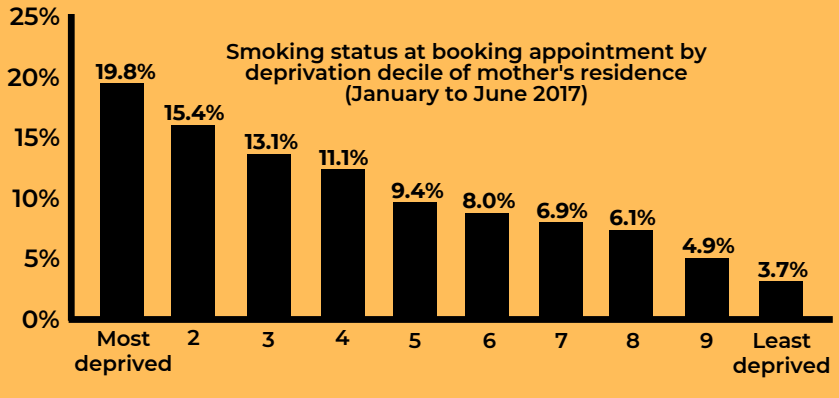
Source: Passive Smoking and Children, Royal College of Physicians and Royal College of Paediatrics and Child Health, 2010.

Disproportionate impact on younger and poorer women

There is a **significant age gradient to smoking in pregnancy,** with younger mothers being much more likely to smoke, especially those aged under 18.

There is a **strong association between smoking prevalence and socio-economic status.** Older and more affluent women are less likely to be smokers when they become pregnant and are more likely to quit during pregnancy.





Smoking during pregnancy exacerbates health inequalities. **Children growing up in a household where their mother smokes are over 2 times more likely to smoke in later life,** reinforcing existing inequalities and cycles of disadvantage (Leonardi-Bee et al, 2011).

Both graphs taken from PHE. Health of women before and during pregnancy: health behaviours, risk factors and inequalities. 2018

Regional variation

2018/19 marked the fourth consecutive year where the rate of smoking at time of delivery (SATOD) in England **remained at 11% or just below** (now 10.6%) (NHS, 2019).

Furthermore, **wide variations exist between areas, with more affluent areas having far lower rates than less advantaged areas.** These variations correlate strongly with deprivation – NHS West London CCG recorded a SATOD rate of 1.6% in 2018/19, whilst NHS Blackpool CCG recorded a rate of 25.7% (NHS, 2019).

Smoking rates among pregnant women are higher in the Midlands, East and North of England compared with London and the South.

Reaching women at the earliest opportunity

It is vital that women who smoke are identified early in pregnancy. The sooner a woman quits the less harm will come to her baby.

Carbon Monoxide (CO) is a poisonous gas found in tobacco smoke which causes significant harm to the mother and baby. Women can be exposed through their own smoking, secondhand smoke or from other sources such as a faulty boiler.

To ensure all women are offered appropriate advice and support, CO screening, measuring the level of CO the mother has been exposed to, should be carried out by midwives at the first booking visit, subsequent antenatal appointments where appropriate and at the 36 week antenatal appointment. All smokers should be referred on an opt out basis to specialist quit support. See the Smoking in Pregnancy Challenge Group's resources on CO screening.

Role for Local Authorities

1. Implement robust strategies that will help drive down smoking rates across the whole community.
2. Local authorities, CCGs and Trusts should explore ways to work collaboratively across LMS footprint to realise economies of scales in implementing NICE guidance on smoking in pregnancy

Role for NHS

1. Commission services to ensure all pregnant women are CO screened at first booking appointment, at subsequent appointments where appropriate and at 36 weeks.
2. Ensure that all women who smoke are referred to specialist stop smoking support on an opt-out basis.
3. Ensure all relevant maternity staff receive training on the use of CO monitors and having brief, meaningful conversations with women about smoking.

For more information, visit the Smoking in Pregnancy Challenge Group website.