Stop smoking in its tracks: understanding smoking by rural Aboriginal women

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Background

In Australia, the prevalence of smoking has fallen to 20% for non-Indigenous people aged 14 years or over, while rates for Indigenous Australians remain alarmingly high at 39%. 1 Tobacco smoking is the single largest preventable cause of morbidity and mortality for Aboriginal and Torres Strait Islander people. It causes or exacerbates lung cancer, chronic obstructive pulmonary disease, asthma, cardiovascular disease, pregnancy complications and low birth weight as well as numerous other conditions. 2 Passive smoking is associated with higher rates of lung cancer and heart disease in adults and sudden infant death syndrome, asthma and respiratory tract illness in children. 3

Smoking is a risk factor for premature birth, low birth weight and perinatal death including stillbirth and SIDS. 4 Aboriginal births in Australia are characterised by a higher proportion of premature births, small for gestational age babies and low birthweight babies compared to births to non-Aboriginal women 5,6, and smoking has been identified as an independent predictor of these outcomes among Aboriginal women 6,7,8. Following the birth, continued smoking by the mother exposes the infant and other children to environmental tobacco smoke (ETS). In 2004 the prevalence of smoking among pregnant Aboriginal women was 56.6% in NSW compared to 13.6% in non-Indigenous women. 9 In the same year, 12.9% of Aboriginal births in NSW were low birthweight, and 11.7% were premature, compared with 6.2% and 7.2% respectively for non-Indigenous births. 1

Despite the high prevalence and considerable health risks, there are no published intervention studies targeting this group. However, two qualitative studies have recently been published which shed light on some of the factors contributing to the high prevalence of smoking among Indigenous Australians. 10,11 One of these studies was set in Perth and looked specifically at smoking in pregnancy. 11 The authors emphasised the importance of understanding the contextual factors associated with smoking, in particular the social and economic pressures women faced causing them to experience considerable stress. As a result, smoking cessation was given a relatively low priority by women, and smoking reduction was considered an acceptable and positive change. Johnston and Thomas, in their work in a remote Northern Territory community again emphasised the importance of contextual factors in both initiation and continuation of smoking in this remote Aboriginal community. They identified historical, social, cultural, physiological and psychological factors which contributed to the high prevalence of smoking among community members. In particular they emphasised the importance of family in influencing smoking behaviour. 10

The current study aims to develop a better understanding of the meaning and significance of smoking for rural Aboriginal women in NSW and to explore barriers and enhancers to successful quitting. The results will be used to develop a program to support women to quit smoking. Some of the preliminary results are presented here.
Methods

A community reference group comprising community women, Aboriginal Health Workers (AHWs) and a community midwife is guiding the project. Three focus groups were held: one with AHWs and two with community women; 22 pregnant women were interviewed individually by an Aboriginal woman, using a semi-structured interview format. Participants were drawn from 5 different rural locations in northern NSW. Interview themes explored participants’ views on smoking and cessation; knowledge of smoking risks; barriers and enhancers to quitting; and the role of individual and community influences on smoking behaviour including use of other substances.

The focus groups and interviews were digitally recorded and transcribed verbatim. After accuracy checks by the researchers, the transcripts were offered to participants for checking and for further comment. Initial codes were identified from further review of the transcripts and identification of themes. Transcripts were coded using N-Vivo with development of further codes as additional themes and patterns emerged from the data. The results of the analysis have been fed back to the community reference group at intervals throughout the analysis, for confirmation of interpretation and further elaboration of issues.

Results

Twenty two women were interviewed individually and 14 participated in the focus groups. Characteristics of the women interviewed individually are summarised in Table 1.

Views of smoking

Everyone reported a very high prevalence of smoking among the local Aboriginal community and believed that smoking was generally considered acceptable. On the whole, women were very negative about smoking—they thought it was “a filthy habit”, was “smelly” and was bad for people’s health. However, they also reported some good things about smoking—that it was great for stress relief, good for sitting down and having a yarn, and for rewarding yourself when you’d worked hard at something. The majority of the women who smoked did not particularly want to keep smoking, but having started had become addicted and found quitting very difficult. Most of the women interviewed had cut down or quit during their pregnancy, although most started smoking again once the baby was born.

Influences on smoking

Influences on smoking occurred at a number of different levels. It was generally reported that Aboriginal people’s lives were very stressful. The poor health of many people in the community and the high number of deaths also increased stress levels.
Smoking was one way of dealing with this stress.

Women reported that the fact that smoking is so common and acceptable in the community makes it seem 'normal' to smoke, and thus there is not much pressure on people to quit smoking and not much support for people who try. There was also recognition that some communities had a greater problem with smoking than others. They thought this was due to more limited opportunities in these places.

Quite a number of women felt that smoking was not seen as a particular problem as there were so many other issues to deal with, and the harms of smoking were not immediately obvious. They compared this with the visible harms of getting drunk and using other drugs, where a person often behaved very differently to normal. They also discussed the many other issues faced by Aboriginal people on a daily basis, and that against this background, smoking was given low priority.

Smoking triggers and addiction

While many of the women were strongly addicted to nicotine and smoking, others described smoking as a social activity which they only did when socialising and particularly drinking. The women who had managed to quit during pregnancy were all either social or light smokers (less than 10 per day). The most common triggers to having a cigarette were seeing others having one, stress, after a meal or with a cup of tea, and when drinking. Several women smoked as a reward for completing some chore, or to have a break by themselves.

Perception of harm

Everyone agreed that in general people were well aware that smoking was bad for their health. However, few women were able to name many diseases caused by smoking. In particular, most women were very vague about the health effects in pregnancy and the impact on the baby. The most commonly named diseases were lung cancer, heart disease, emphysema and asthma. Other harms mentioned were that it made you look older, smell bad and generally feel not as healthy as previously.

Many women mentioned the TV advertisements and how these were quite disturbing. However, they also said that people will channel surf or go out of the room when they are on, to avoid facing them. They also talked about ways people try to avoid seeing the packet warnings by putting the cigarettes into another box, or asking for the packet that doesn’t immediately relate to them eg men asking for the pregnancy packet.

Quitting and what would help

One third of the women reported quitting during their pregnancy and many others had cut down. In general women were trying to do the best for their baby and this was the main motivation behind their attempts to quit and reduce. They were motivated to quit for their baby's well-being, but not for themselves. Thus many started again once the baby was born.

Most women also knew other people who had quit smoking permanently, although some couldn’t think of anyone. Most of the people mentioned were older people who had quit due to health problems such as cancer, diabetes and heart disease. Most women also knew people who had tried to quit using nicotine patches, with mixed results. The women emphasised that the decision to quit had to be the person’s own, and that they should not be forced into it.

There were many barriers to women quitting smoking when they got pregnant. Most relate to the broader influences on smoking, such as the high rate of smoking in the community, smoking by household members, and high levels of stress which may actually increase with pregnancy. Addiction to smoking combined with frequently being exposed to other people smoking make quitting very hard.
There were quite a few suggestions for ways to support women to reduce their smoking or quit. Everyone emphasised that it needed to be a personal choice, but that it was okay for others, particularly the health worker, midwife and doctor, to encourage women to make that choice. Other people who could also help influence women were young children, and older women who had quit. They also emphasised that women would need a lot of support to quit and that it was essential to help sort out other needs in their lives as well.

There was a lot of support for the idea of running groups to support women trying to quit. These should be focused on quitting and include stress management techniques; activities like arts and crafts to keep hands busy; education about the benefits of quitting and strategies to help; as well as motivation and social activities. These groups would also link women together to support each other and continue once the baby was born.

It will also be important to look at the household environment where the woman lives. Other people in the household should also be supported to try to quit if they want. They should also be asked to help the woman quit by not smoking near her, not offering her cigarettes and generally recognising the importance and difficulty of what she is trying to do.

Conclusions

Exploration of women’s views on smoking allows a greater understanding of both the reasons for continued smoking and the complex array of factors affecting behaviour. This information will be combined with other evidence on smoking cessation to develop a program aimed at addressing the specific cultural and contextual needs of Aboriginal women in rural NSW.

Presenter

Megan Passey is a medically trained epidemiologist with an interest in addressing disparities in health. Her research focuses on health services approaches to prevention of chronic disease. She is currently collaborating with service providers and community members on a project to try to support Indigenous women to reduce their substance use during pregnancy.

References


