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Letter
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Guidance for Culturally Competent Approaches to Smoking Cessation for Aboriginal and Torres Strait Islander Pregnant Women

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We read with interest Passey and Sanson-Fisher's findings from their survey with pregnant Aboriginal and Torres Strait Islander women.[1] We agree entirely with their points in the Discussion that health providers lack the skill and confidence to help Aboriginal and Torres Strait Islander women tackle smoking during their pregnancy, and the need for culturally sensitive guidelines to address the barriers to cessation specific to this context.

While there are no "official guidelines" of that nature in Australia, there appears to be a lack of awareness of the clinical guidelines we published in March 2014, to provide assistance to health providers in evidence-based translational approaches that are culturally competent for this target group.[2] This "pragmatic guide" was developed after a systematic review of the literature,[3] empirical research with Aboriginal mothers,[4] and resource development with extensive engagement with Aboriginal Community Controlled Health Services and other relevant stakeholders in New South Wales, Australia.[5] We took into account other published research in the area.[6–8]

In the development of this guide, coauthors Clarke provided a unique perspective as an Aboriginal Obstetrician, Bittoun as an internationally recognized expert in smoking cessation and health professional training, and Gould as a Tobacco Treatment Specialist, general practitioner and Indigenous health researcher. The "pragmatic guide" was presented at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' Indigenous Women's meeting in May 2014. This clinical guide will become the basis of a randomized controlled trial involving webinar training for general practitioners and health providers in culturally competent approaches for the target group at Aboriginal Community Controlled Health Services in 2016. It is also contributing to other e-learning packages for antenatal care providers in New South Wales.

We summarize the salient points of the guide for your readers. The guide is structured according to an ABCD framework. ABC has been used in New Zealand to provide a more dynamic approach to the use of behavioral counseling and cessation assistance. A—ask; B—brief advice; C—cessation. To this we have added D—discuss the psychosocial context of smoking.[2] Step D is important in this target population but could relate to any vulnerable population where smoking is highly prevalent or a social norm. However cultural competence is a key to our whole ABCD approach. ABCD includes the following evidence-based features:

A—ask the woman to tell of her smoking journey using a non-confrontational conversational approach. A multi-choice format may elicit a more accurate response to the reporting of smoking.[9] We recommend using the Heaviness of Smoking Index, the strength of urges to smoke,[10] and a carbon monoxide meter to assess dependence and monitor treatment response. Asking about exposure to environment tobacco smoke is important as 49% of Indigenous Australians smoke.

B—brief advice: this includes the use of a visual guide to prompt discussion and educate about the stress-inducing effects of nicotine withdrawal, as an overlap between the two are reported in the target group. Pregnant Aboriginal and Torres Strait Islander women are more likely to try to "cut down" than quit, but quitting needs to be unambiguously yet sensitively encouraged.

C—cessation: the "pragmatic guide" includes a nicotine replacement therapy (NRT) treatment algorithm to guide initiation in a step-wise fashion from oral NRT (safest in pregnancy), to transdermal NRT, then combination NRT (oral plus patch) if required, consistent with the Royal Australian College of General Practice updated guidelines.[11] Our view is that if a woman cannot manage 1–3 days abstinence then she should be offered NRT in an expedited manner. We provide a quit plan template to help the provider work through the steps required in assisting the client to plan her quit attempt. Features of the quit plan include goal setting, problem solving, self-incentives, and social support.

D—discuss the psychosocial context: this overlaps with discussion initiated for the quit plan. D acts as a reminder for the importance of the pregnant woman's context and unique circumstances relating to smoking. The amount of family and social support can

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vary. The provider has a role to help the client navigate problems that can impact on smoking in pregnancy, such as financial or housing issues, and screen for domestic violence and mental health concerns, thus refer on to other services if required.

We propose the ABCD approach outlined in our pragmatic guide could help standardize approaches in Australia for management of smoking in Aboriginal and Torres Strait Islander women in pregnancy. We are currently refining the guidelines with further input from Aboriginal Community Controlled Health Services and antenatal services, and developing webinar training that will potentially have geographical reach nationally.

Declaration of Interests

None declared.

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