Ngaaminya (find, be able to see): summary of key findings from the Which Way? project

Michelle Kennedy[1,*], Raglan Maddox[2,†]

The cross-sectional results from the Which Way? project are outlined in this supplement[1,2] and summarised in the Box. This project has provided the first Indigenous-led primary evidence on smoking and cessation behaviour of Aboriginal and Torres Strait Islander women of reproductive age. It was developed for and by Aboriginal and Torres Strait Islander women, with the aim of guiding policy and practice to improve smoking cessation care provided to Aboriginal and Torres Strait Islander women during pregnancy and beyond. The novel findings highlight the importance of using a client-centred, culturally responsive approach to inform meaningful smoking cessation support strategies, clinical practice, and health care delivery.

Despite Australia being seen as a world leader in tobacco control,[3,4] smoking is the single biggest contributor to the burden of disease.[5] Over one-third (37%) of Aboriginal and Torres Strait Islander deaths are attributable to tobacco use, and this increases to 50% of deaths when considering only those aged 45 years or older.[6] This reflects the systematic embedding of tobacco use by colonisers as an addictive commodity[7] — for example, by using tobacco rations while Aboriginal and Torres Strait Islander peoples were actively excluded from both the cash economy and the education system. Consequences of this have been long and enduring, such as the low socio-economic status which is strongly associated with smoking. The overall lower socio-economic status of Australia's Aboriginal and Torres Strait Islander population is an outcome that was manufactured by colonisation, which eroded power, social structures and Indigenous community resources,[7-9] and has led to disproportionately high risk of tobacco use and rates of tobacco-related morbidity and mortality.[10] However, the vast majority of Aboriginal and Torres Strait Islander people who smoke want to quit, or wish they never took up smoking.[11]

The results from Which Way? indicate that work is urgently required to support the development and implementation of meaningful cessation support services to accelerate reductions in tobacco use and tobacco-related morbidity and mortality among Aboriginal and Torres Strait Islander people.

Multifaceted, comprehensive and holistic approaches

The findings of the project are consistent with evidence that Aboriginal and Torres Strait Islander people want to quit smoking. They also call for strategies that are community-led, multifaceted and comprehensive, and which incorporate holistic approaches to addressing the complexities of tobacco use.[7] There is no one-size-fits-all approach. Different strategies, and combinations of strategies, are needed to reflect community needs and supports to quit smoking. This highlights the importance of flexible program delivery that acknowledges sovereignty and principles of self-determination to empower Aboriginal and Torres Strait Islander women to be smoke-free. It also aligns with overseas evidence which suggests that Indigenous community investment, ownership and activation are important pathways for success and sustainability — programs perceived as community owned have been linked with positive change across a diverse range of outcomes.[12]

One of the findings of the Which Way? project was that group-based and holistic supports were preferred by most women. In 2019, the Medicare Benefits Schedule Review Taskforce recommended that allied health services provide group services.[13] The Taskforce indicated that group therapy services offer a unique opportunity to deliver preventive care more effectively to Aboriginal and Torres Strait Islander people,[13] and thereby reduce the burden and costs of chronic disease — increasingly important benefits in the context of reduced health care capacity owing to the coronavirus disease 2019 (COVID-19) pandemic. In the United States, group-based smoking cessation supports are reimbursable in clinical settings,[14] but this evidence-based practice is not incorporated in Medicare item rebates or block funding models that are necessary to integrate this type of support into current health services in Australia.

Another finding from Which Way? was that women expressed a preference to have smoking cessation care provided by Aboriginal health workers. The key role of Aboriginal health workers and practitioners in providing culturally safe care goes beyond Aboriginal health services, as these positions are included in a range of mainstream, hospital and community-controlled settings. However, not all Aboriginal and Torres Strait Islander women want face-to-face support, which highlights the need for a range of cessation supports to be available. Mobile phone apps to support cessation, developed specifically for and with Aboriginal and Torres Strait Islander people, are in trial phases.[15,16] Preliminary evidence suggests that these apps require strong integration with currently used mobile apps and platforms, including social media, to be relevant and meaningful to Aboriginal and Torres Strait Islander people. Ensuring culturally safe, supportive, and appealing alternatives — including online and phone-based support — is important in terms of complementing face-to-face counselling services. Such alternatives would be particularly relevant for women who may not feel safe or comfortable discussing smoking during pregnancy with their health care provider.

Funding and embedding smoking cessation support in health services

Six temporary Medicare items for nicotine and cessation counselling provided by general practitioners were introduced in July 2021,[17] including face-to-face, telehealth and telephone services. These provided unique opportunities to offer

* Wiradjuri; † Modewa.

[1] University of Newcastle, Newcastle, NSW. [2] National Centre for Epidemiology and Population Health, Australian National University, Canberra, ACT.
michelle.bovill@newcastle.edu.au • doi: 10.5694/mja2.51622

Key findings from the Which Way? project

We surveyed 428 Aboriginal and Torres Strait Islander women of reproductive age. They were smokers (269, 62.9%) and ex-smokers (159, 37.1%), and lived in urban (212, 49.5%), regional (187, 43.7%) and remote (29, 6.8%) settings.

Smoking behaviour (current smokers)

- 32.3% of the women we surveyed smoked < 5 CPD, and 33.5% smoked ≥ 11 CPD
- 66.2% had low nicotine dependence (based on Heaviness of Smoking Index scores)
- 32.7% of those with low dependence had high strength and/or high frequency of urges to smoke

Quitting behaviour

- 90.2% had ever tried to quit smoking
- 65.4% reported attempting to cut down smoking in the past month
- 35.7% had ever tried NRT and/or SSM
- 80.0% reported barriers of attitudes and beliefs to not using NRT or SSM
- Quitting suddenly, rather than gradually, was significantly associated with sustained abstinence (prevalence ratio, 1.27; 95% CI, 1.10–1.48)

Differences between younger and older women

- Younger women tended to smoke fewer cigarettes per day (57.1% smoking 0–5 CPD) than older women (48.2% smoking ≥ 11 CPD)
- Older women were significantly more likely to have tried NRT and/or SSM than younger women (52.4% for those aged 35–49 years *v* 11.5% of those aged 16–20 years; 35–49 years: odds ratio, 8.47 [3.62–19.84])
- Older women were more likely to have sustained a quit attempt for years (45.6%) compared to younger women (< 5.0%)

Difference between women in urban and regional/remote areas

- Women living in regional and remote areas were less likely to have ever used NRT and/or SSM compared with women living in urban areas (30.1% *v* 41.5%; odds ratio, 0.50 [95% CI, 0.27–0.94])

Preferred strategies to support smoking cessation

- Group-based and holistic support were the most preferred strategies to empower women to quit smoking (31.8% and 22.2%, respectively)
- Women with higher nicotine dependency were more likely to consider group-based supports helpful (prevalence ratio, 1.13; 95% CI, ≥ 1.00–1.27) than those with low nicotine dependency
- Aboriginal health workers were the most preferred providers for smoking cessation support (64.3%)
- Most women preferred face-to-face support at an Aboriginal health service (73.4%)
- One-third of women reported phone support (34.8%) and online support (38.8%) to be of interest

CPD = cigarettes per day. NRT = nicotine replacement therapy. SSM = stop-smoking medication. ◆

appropriate supports to Aboriginal and Torres Strait Islander women. Due to the high preference for Aboriginal health services and the continuity-of-care model recommended in maternity care,[18] having a known health provider offer cessation support to Aboriginal and Torres Strait Islander women is recommended. This includes systematically embedding cessation supports into services with GPs using this option. As these Medicare items were aimed specifically at GPs, there is a need for block and/or Medicare funding to also support Aboriginal health workers and practitioners and Aboriginal health services to deliver smoking cessation care. Embedding smoking cessation care in health services is cost-effective,[19] and has the potential to provide large cost savings and substantial health gains. This approach should be explored, implemented and evaluated, with appropriate data collection and continuous quality improvement mechanisms that facilitate better recognition of and responses to smoking behaviour. Dedicated funding to resource such work could help provide smoking cessation supports in a culturally safe and familiar environment, including by Aboriginal health workers and practitioners at Aboriginal health services. This would integrate important services as part of routine pre-natal and maternity care without the need for referrals to other services.

While the development of relevant, appealing and targeted interventions to support attempts to quit smoking is urgently required, it is important to recognise, address and mitigate factors in the broader context of Aboriginal and Torres Strait Islander health and wellbeing. This includes racism and other social determinants of health, which underpin the basic drivers of smoking prevalence. Although addressing these broader socio-structural factors is largely beyond the scope of any health program, these should be recognised and mitigated in policy to help ensure access to culturally safe smoking cessation supports. At a broader system-wide level, tobacco control through cross-sector and cross-jurisdictional collaborations is critical to supporting women to quit. Listening to the preferences of Aboriginal and Torres Strait Islander women is an important component of meaningful co-design processes, upholding Indigenous agency, self-determination and sovereignty to be free from nicotine and tobacco.

As the National Preventive Health Strategy, the imminent new Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan, and jurisdictional tobacco programs and strategies are developed, implemented, monitored and evaluated, it is fundamentally important that they are informed by the strongest available evidence developed for and by Aboriginal and Torres Strait Islander people to urgently address the tobacco epidemic. This will help ensure that policies capture the needs of all Aboriginal and Torres Strait Islander people across this diverse country, that there is equitable access to smoking cessation support strategies, and that improvements in health outcomes are accelerated.

Acknowledgements: Michelle Kennedy is funded by an NHMRC Early Career Fellowship, grant number 1158670. This study was funded by the National Heart Foundation Aboriginal and Torres Strait Islander Award, grant number 102458. The funding bodies were not involved in the conduct of this research. We acknowledge the partnering services and staff for their time and commitment to this long term project, including the Dhanggan Gudjagang team, Yerin Eleanor Duncan Aboriginal Health Centre, Tamworth Aboriginal Medical Service, Nunyara Aboriginal Health Clinics, and Waminda South Coast Women's Health and Welfare Aboriginal Corporation. We also acknowledge all the Aboriginal and Torres Strait Islander women who contributed to this research project — thank you for sharing your experiences with us, it is our honour to privilege your voices.

Open access: Open access publishing facilitated by The University of Newcastle, as part of the Wiley – The University of Newcastle agreement via the Council of Australian University Librarians.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed.

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