Australian Government
Department of Health

Indigenous Smoking and Pregnancy Roundtable – Summary Report

20 February 2020

Sirius Building, cnr Furzer and Worgan Sts., Woden ACT
Function room 1.N.2 Nguru
Roundtable Chair: Professor Tom Calma AO

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Welcome — Trudy McInnis (Department of Health)

Trudy introduced herself as the Manager of the Tackling Indigenous Smoking (TIS) program. She welcomed participants and thanked them for attending.

Acknowledgement of Country — Josh Kelly (Chair, National Aboriginal and Torres Strait Islander Staff Network, Department of Health)

Josh introduced himself as a Worimi man of Biripi country and gave the Acknowledgement of Country, recognising the traditional owners, past, present and emerging.

Introduction and Overview — Professor Tom Calma AO (National Coordinator – Tackling Indigenous Smoking)

In his introduction and overview, Professor Calma said that policies are often developed without good input from practitioners, so he was very pleased to see so many practitioners and researchers sharing their expertise and their thoughts about best practice. He also noted that, because he is a contractor to the Australian Department of Health and not a departmental officer, he does not have the same restrictions as a departmental officer. He welcomed participants to talk to him privately if they wished.

Professor Calma explained that the TIS program is a significant federal government contribution, running since 2010, with several iterations. The program now has a population health focus and includes 37 TIS teams, 31 of which are located within an Aboriginal Community Controlled Health Service (ACCHS).[1] The teams work across regions in an outreach role and deal with people in those regions, regardless of whether or not they are clients of ACCHSs.

The program aims to get good messaging out to the people. There had been a considerable amount of research on the topic of Indigenous women smoking during pregnancy, but this was not always well coordinated and shared. Professor Calma said that he hoped that this Roundtable would enable people to share best practice and also to recognise that it is not just people who are part of the TIS program who are working to tackle Indigenous smoking -- everyone working in a health delivery service has a responsibility for this.

He explained that Trudy and the department's TIS team work with state and territory counterparts, and that he is a member of the National Expert Reference Group on Tobacco, which means that the output of the Roundtable would be shared.

Professor Calma noted that one of his frustrations is that good research is not always able to be implemented, is not taken up, or does not get funding. This Roundtable provides an opportunity for good research to influence

[1] The number of TIS teams has increased since February 2020 with funding provided for TIS activities in four remote regions.

practice.

In 2018, just over 15,000 Aboriginal babies were born across Australia. If we estimate that roughly 45% of pregnant women smoke, that means there is a group of about 7,000 Aboriginal women each year who are our target group. This is not insurmountable, Professor Calma said.

Professor Calma said that Associate Professor Gillian Gould would talk about the iSISTAQUIT program, which the Australian Department of Health funds, and participants would also hear about Nicotine Replacement Therapy (NRT). He noted that other researchers are doing good work in epigenetics and genomics with regard to Aboriginal people, but that it is difficult to influence the mainstream, which is where significant funding is going.

Professor Calma outlined the structure of the Roundtable proceedings and noted that the department had been overwhelmed at the level of interest from potential presenters. He apologised to those who were not selected and to those whose time was restricted, and urged presenters to maintain discipline on their times so that all could be heard over the day.

Overview of health provider, family and patient approaches to address smoking cessation in pregnancy — Associate Professor Gillian Gould (Univ of Newcastle)

Associate Professor Gould referred to a project called 'Our Stories', which she managed. The project involved talking with Aboriginal women about their journey of smoking, from when they first came across smoking up to and including pregnancy. The project found that there were multiple opportunities to intervene to help women over that period (see Gould, Bovill, Clarke, et al., 2017; Bovill, Gruppetta, Cadet- James, et al., 2018).

While the focus was on the period of pregnancy, women often started smoking at a very early age. It is therefore necessary to look at the different points and services where interventions can be made over that trajectory.

It is also necessary to focus on what works now. Associate Professor Gould explained that she would talk about health messaging, counselling, incentives, NRT, and some of the research the team is doing.

She explained that health messaging is good and effective if it is positively framed. Her PhD research had shown that, while fear-based messaging may be helpful with Aboriginal people with a high efficacy to quit, it is not helpful for recipients with low efficacy to quit, as they tend to deny, avoid, or find it all "way too hard". Pregnant women are vulnerable in this regard. (The consideration of efficacy should include both self-efficacy and response efficacy -- whether people feel capable of quitting and think that quitting is a worthwhile thing to do.). So it is important to support women's efficacy to quit using positive messages. However, the messaging is seldom about the chronic health story. People need to know that the harmful outcomes of

smoking during pregnancy are not only short-term, such as low birthweight, but that the effects can continue for a lifetime.

Counselling is one effective strategy. There are 44 behaviour change techniques for smoking cessation, some more effective in pregnancy (Lorencatto, West and Michie, 2012).

Counselling can double the quit rates, but health education and brief risk advice are not sufficient on their own. Most of what health providers are actually doing is giving the advice – that smoking is bad for you – but not much more.

NRT is another effective strategy, but there is something of a disconnect because studies show that health providers are not always sure how to use it in pregnancy, with regard to safety and efficacy. We have also done a good job of persuading women not to take anything during pregnancy, but now we are saying "take this". There is also a faster metabolism of nicotine in pregnancy, so you have to use more NRT, which is counter-intuitive. But it does result in a modest 40% increase in quit rates.[2]

Incentives are probably the biggest influence, in that they can triple quit rates and cessation can last up to three months post-partum. Some trials have shown promise with Indigenous women, but Indigenous women can be reluctant to be recruited to an incentives trial. Associate Professor Gould is leading a trial on smoking cessation with women who use other substances and she can share information about this (Jackson, Brown, Baker et al, 2019).

Turning now to what health providers are actually doing, Associate Professor Gould noted that there has been a survey of 378 GPs and obstetricians in Australia, and a review over 10 countries looked much the same (Bar-Zeev, Bonevski, Twyman et al., 2017; Gould, Twyman, Stevenson et al., 2019; Gould, Bar-Zeev, Twyman et al., 2017).

The Australian survey showed that the health providers were good at asking about tobacco but were poor at getting detail – for example, on e-cigarettes, chewing tobacco and second-hand smoke. We are particularly reluctant, Associate Professor Gould said, to assist people by prescribing NRT, and follow-up is low, at around 30%.

So, she concluded, we are not really helping. Why is this? The reasons health providers give are: they do not have the communication skills; they do not want to interfere with the women's relationships; and reasons relating to resources and cultural competency. Training the health workforce is therefore a particularly important focus. This training can help increase quit rates in the general population.

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[2] A 'modest 40%' is in the context of a low baseline -- eg., if the baseline is 5%, then a 40% increase would increase that to 7%.

As for other approaches, involving partners and families can certainly help, with other women being particularly relevant; however, there is limited [3]evidence about the success of these approaches, but some good work is beingdone.

Associate Professor Gould's current research has tried to build a foundation to address research gaps, particularly with regard to health providers. This began with qualitative research with 'Our stories', which looked in some depth at the experience of mothers; then there was some research with fathers. Her team's pilot study was 'ICAN QUIT in Pregnancy', which went on to become SISTAQUIT and iSISTAQUIT. The team has also developed an app (see below).

This work is based on principles of co-development with communities and being transparent in what is done with communications and stakeholders. The team prefers to publish everything so that people can see that nothing is hidden, and it works within a behaviour change framework. Most importantly, the team works to privilege Indigenous voices and foster Indigenous leadership.

The team uses an 'ABCD' approach: **A**sk and assess smoking; **B**rief advice to quit; **C**essation – behaviour change techniques and nicotine replacement therapy; and **D**iscuss family, social and cultural context. This last element is particularly important for Aboriginal people and especially for pregnant women.

The SISTAQUIT program concentrates on getting health workers skilled up for this work, because if women are not getting help from their health care providers, then how can we expect them to quit on their own? "It's tough."

In phase 1, the team co-tested materials with Indigenous workers, then pre-tested them. Phase 2 was the ICAN QUIT in Pregnancy study, piloted with six services in three states. Although the aspiration was always for this to be a national program, the budget meant that it began with three states (NSW, QLD, SA). Funding was then obtained for Phase 3, a randomised control trial (webinar training vs. usual care) in five states (NSW, QLD, NT, WA and VIC), involving 22 services. Some are developing these resources for women, and other services administer their usual care but will get the training later.

Phase 4 is the implementation trial with SISTAQUIT (20 further services), and phase 5 is also being considered, which would be a scale-up of SISTAQUIT to cover all of Australia. There has also been interest from other countries, including New Zealand and Canada.

The team's new program is iSISTAQUIT, which is funded by the Department of Health as part of the TIS program. All sites that sign up will receive the

intervention. The program involves providing a CO meter and oral supplies of NRT. The training would include self-paced e-learning modules with the ABCD approach and templates to use. As of February 2020, participation sites are being recruited, so anyone who is interested should mention their interest. A social media campaign will be included, and the team is looking for social media advisers to help with this campaign. It is expected that four or five short videos will be filmed in locations across Australia.

The MAMA-EMPOWER app that the team developed is for smoking, nutrition, physical activity and social and emotional wellbeing. It has been pre-tested and will be the subject of a randomised control trial later this year. Again, those who are interested are encouraged to express their interest.

There is also the PAPAS project – Partners and Paternal Aboriginal Smokers – which is intended to talk to men about what they need for their own smoking cessation, and what their partners need to make their home smoke-free.

Finally, there are some opportunities available:

- a high-value scholarship for an Aboriginal PhD or MPhil candidate
- educational and social media advisers for iSISTAQUIT
- an Indigenous research assistant for the MAMA-EMPOWER app study
- a call for papers on smoking in pregnancy for a special edition of the International Journal on Environmental Research and Public Health.

(*Note*: also article published shortly following the Roundtable: Gould, Havard and Lim, 2020)

Professor Calma thanked Associate Professor Gould for her presentation. He mentioned that, although 'Aboriginal people' had been mentioned, these initiatives apply to Torres Strait Islander people as well. He also said that Trudy McInnis is working with the National Best Practice Unit to develop a fact sheet on products available under the Pharmaceutical Benefits Scheme. Although this had turned out to be more complex than originally thought, it should provide some helpful guidance.

Socioecological mapping of barriers and enablers to smoking cessation among Indigenous Australian women during pregnancy and postpartum periods **— Tabassum Rahman (University of Newcastle)**

Tabassum Rahman explained that her presentation was based on her PhD work on the mapping of barriers and enablers to smoking cessation among Indigenous women during pregnancy and in the post-partum period. She noted that discussions about smoking in Indigenous communities did often not include acknowledgements and understandings of the underlying factors

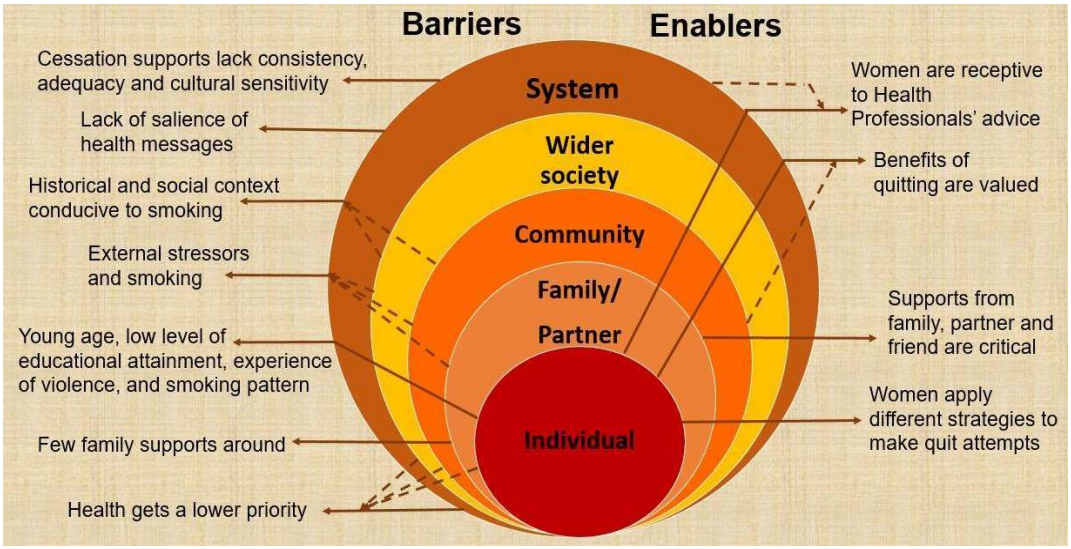
that affect this.

Between 2004–05 and 2014–15, there was a decline in adult daily smoking in Indigenous communities. Among Indigenous women who were pregnant, between 2009 and 2017, prevalence also declined, by 8.6 percentage points. However, despite the reduction, the prevalence of smoking during pregnancy among Indigenous women remained four times higher than for non-Indigenous women.

Previous reviews had shown that women trying to quit may face different barriers at different levels, such as policy, family or personal experiences. Other reviews had found limited evidence on the effectiveness of strategies that are specific to Indigenous people, including pregnant Aboriginal women. Viewing barriers and enablers through the lens of a sociological model can provide important guidance for future interventions for smoking cessation.

This sociological model considers the health behaviour of an individual in the context of where it happens. After a systematic search and critical appraisal, five qualitative and nine quantitative studies were identified. A synthesis was being done of the qualitative and quantitative evidence because the research is very diverse in its methodology and the aspects of smoking cessation being examined.

Ms Rahman referred to her Barriers and Enablers poster (below) (Rahman, Eftekhari, Bovill, et al., 2019), noting that barriers often exist at the system, societal and community levels, and that enablers are often at the individual level, but that both are complex and overlapping.



Barriers include the consequences of certain policies for Aboriginal communities, starting from colonisation and the ongoing legacy of dispossession and disadvantage, including intergenerational trauma caused by removing children from their families, and limited opportunities in

education, employment and affordable housing. All of these factors compound the challenges for women, as did pervasive racism and discrimination, which could cause isolation from the wider society. All of these things set the stage for smoking as a health behaviour. One factor that emerged from this review was the role of stress – whether this related to putting food on the table, incarceration, trauma, domestic violence, or a premature death in the family.

Cessation care efforts were found to be neither adequate nor consistent – for example, the conflicting advice to cut down on smoking or to quit completely. Family issues were a significant factor in that it is very hard to quit when those around you are smoking. However, family could also be a powerful support, so this factor was nuanced.

Ms Rahman also found that women are receptive to care in pregnancy but care workers could lack confidence in broaching the subject. The implications are:

- A comprehensive approach is needed.
- It is necessary to enhance the confidence and knowledge of health professionals.
- Care needs to be more informative and targeted to people.
- There is a need to alleviate discrepancies in the social and cultural determinants of health.
- Care needs to build on strengths.

Future research could examine:

- Indigenous women's experience of maintenance of abstinence;
- the association between social and emotional wellbeing of the women and smoking and quitting behaviour; and
- the potential for multifaceted interventions combining smoking cessation techniques and major social determinants.

Significant life events and the impact on tobacco use — Dr Raglan Maddox (Australian National University)

Dr Maddox noted that it was very interesting to see how the conversation about tackling Indigenous smoking had changed since he was first involved with the program in 2009-10.

He explained that his presentation would focus on significant life events and their impact on tobacco use and the work that he and Professor Lovett were doing at ANU as part of the Mayi Kuwayu and the Tackling Indigenous Smoking study. (The Mayi Kuwayu study is a national longitudinal study of the links between culture, health and wellbeing for Aboriginal and Torres Strait Islander people; a list of research publications is available at: https://mkstudy.com.au/research-publications/.)

Dr Maddox acknowledged the earlier mention of a 9.8% decline in smoking among Aboriginal and Torres Strait Islander peoples between 2004–05 and

2014–15, which meant 50,000 fewer smokers than there would otherwise have been. He congratulated everyone involved for their hard work in achieving this.

In discussing the factors involved in Indigenous smoking and the determinants of health, he said that colonisation is too often forgotten. Referring to the ABCD model, he said that with the **D**iscussion aspect and social and cultural context, we have a head start if we understand that colonisation has occurred and continues, with its effects ongoing. We can understand that from a population perspective. It is therefore a very different conversation in Indigenous communities compared to the general population, and we need to acknowledge that difference.
The Mayi Kuwayu study attempts to unpack the impacts of colonisation and how these are perpetuated. Dr Maddox explained that, while this may seem deficit-based, the flip-side is that there is significant potential for change, and there are things that can be done do to shift those risk factors to preventative factors.

The current knowledge is that removal from country, exposure to missions/reserves and the stolen generations (parent/grandparents) have ongoing effects, and that colonisation has disrupted knowledge of Indigenous affiliation/identity. These things still have repercussions today, and this can be seen played out in the media, for good and for bad – mostly for bad. This impacts day-to-day life and weathers away on a person's quit attempt(s) and maintaining a quit attempt, whether that person is a woman of reproductive age or another part of the broader Indigenous population.

Contemporary trauma is another interesting component – things such as no access to country, worry about being stolen, growing up in foster care or a children's home, and feeling disconnected from culture. All of these have a significant impact on everyday life stresses and the lack of control when trying to maintain a quit attempt.

Dr Maddox mentioned the relevance of some other social determinants of health. There is strong evidence about exclusion from education, exclusion from work, lack of financial resources, over-representation in the justice system, and other factors. This could be seen in the latest *Closing the Gap Report* (Commonwealth of Australia, 2020).

Referring to Associate Professor Gould's presentation, Dr Maddox suggested that we should be looking further back, before pregnancy -- pre-pregnancy and earlier – to get improved control and better health and wellbeing more broadly; then we would see a decrease in smoking prevalence.

Dr Maddox said that the factors he had just mentioned affected other health behaviours, such as exercise, drinking, smoking and never smoking. He also noted that there is encouraging information about smoking initiation, and these are 'good news stories' that should be celebrated. Increasing the initiation age speaks to the health promotion work that communities are doing to address these issues.

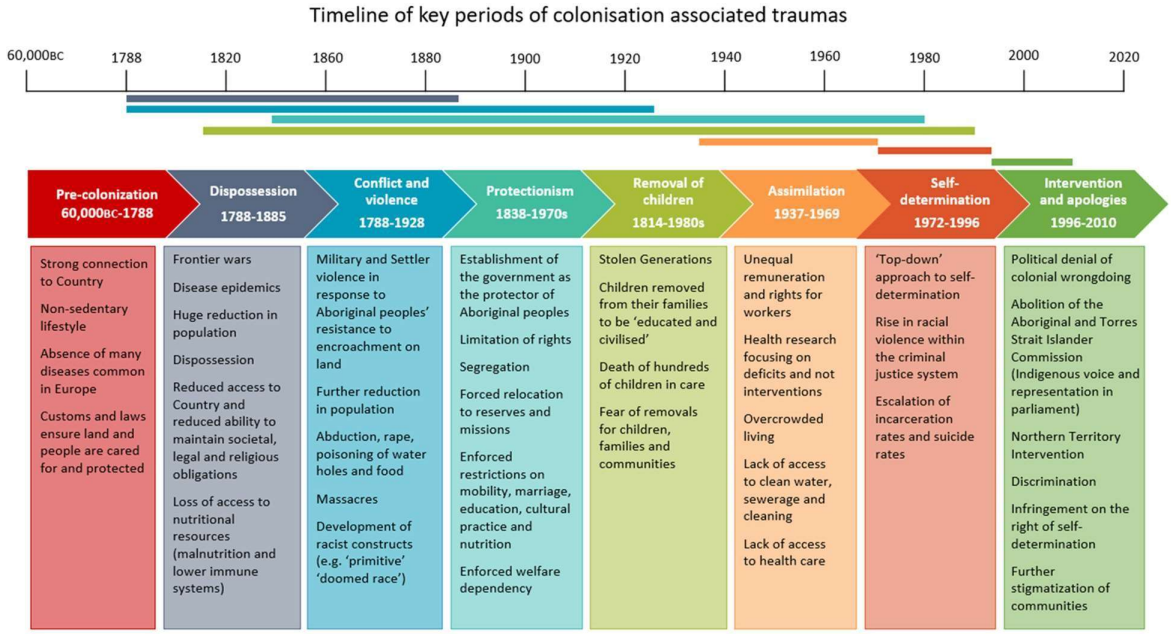
The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan that Professor Calma referred to earlier has culture at its centre (Department of Health, 2015). There are many protective factors that could address these issues.

Turning to the things that can affect people's life chances, with child development and birth, Dr Maddox noted that many of the current approaches to wellbeing are heavily weighted to the antenatal period, but what is often left out is this context of the active colonisation process. Looking at inter-generational impacts, he said that removal from land, missions/reserves and inter-generational trauma all had a significant and cumulative impacts. We also know that language, being with Elders, being connected to country, belonging to family/mob are all protective behaviours. Acknowledging that broader context could help to better address reducing tobacco use. The fact that addressing tobacco use is difficult is not a reason not to do it. This goes to the research that Dr Maddox undertook with Winnunga Nimmityja Aboriginal Health and Community Service in the Australian Capital Territory between 2012 and 2016. Participants in that catchment area were very keen to engage in conversation about smoking. They wanted health professionals to speak to them about it, but they also wanted ongoing care from their clinicians. They wanted to determine the conversation and how they engaged with it.

On the other hand, many clinicians would say that they did not want to have that conversation -- so it was about that relationship.

Another aspect was culturally safe care from a trauma-informed approach. If people want to have that conversation and make that attempt, we need to provide that culturally safe space so that they feel that they can have the conversation in a positive way. Professor Lovett has done some excellent work on creating culturally safe spaces. He measured anxiety and found that different clinicians would evoke different responses, even if they were asking the same questions, so that relationship was essential.

Dr Maddox referred to a timeline slide (below) which summarises the last 60,000 years, from pre-colonisation to the present (Healing Foundation, undated; Sherwood, 2013). It notes the impacts of colonisation and that these are ongoing, so we could ensure that it is front and centre in meeting our clients. This timeline ends at 2010, and it is up to us to determine the direction of future developments.



Reflections on evidence from trials to support women to stop smoking in pregnancy — Associate Professor Catherine Chamberlain (LaTrobe University)

Associate Professor Chamberlain introduced herself as a descendant of the Trawlwoolway people of north-east Tasmania and said that she had been working in the smoking in pregnancy field for quite a while. In her presentation, she would be talking about the Cochrane review of interventions for promoting smoking cessation during pregnancy, in 2003, started by Professor Judith Lumley (academic, author, perinatal researcher) about 30 years ago; the smoking in pregnancy trials in Indigenous communities; and some personal reflections on factors that may have an impact on the effectiveness of interventions. She said that she was pleased to see complex trauma discussed at the Roundtable, as this is a significant issue in her current work.

Associate Professor Chamberlain said that the original Cochrane review was printed on a dot- matrix printer. A key reason for Professor Lumley undertaking the review at the time was that there were still arguments about whether it was tobacco smoking that was causing poor outcomes for infants born to mothers who smoke, or whether these outcomes could be caused by other factors experienced by women who smoke (e.g., poverty, poor living conditions, etc). The latter argument was being advocated by tobacco industry proponents.

As it is not possible to 'randomise' women to smoke or not smoke in pregnancy, Professor Lumley examined outcomes among infants born to women who were randomised to receive a smoking cessation intervention (or

no intervention). Results showed significantly lower rates of preterm births and low birth weight babies among mothers who were the same as the comparison group, except for being randomly allocated to receive a smoking cessation intervention in pregnancy. This provided strong evidence that tobacco smoking is a major direct cause of poor outcomes in pregnancy, including preterm birth and low birth weight. The review also provided some evidence of general types of smoking cessation interventions that may be more effective than others, but exactly 'what works' and 'what doesn't' has been harder to understand from randomised controlled trials of these complex interventions.

In the most recent update of the review in 2017, even though the rates of quitting were comparatively low (13% of mothers receiving counselling quit compared to 9% of mothers receiving 'usual care'), there was still a big impact on the health of babies. Among women randomised to receive support to quit (the majority of whom were still smoking), there was a 17% reduction in low birthweight, higher mean birthweight, and a 22% reduction in neonatal intensive care unit admissions. Even though the interventions achieved only a six percent difference in the number of women who smoked, the review showed that a modest difference actually had a big impact at the population level in reductions in babies of low birthweight, admissions to neo-natal intensive care and the like. In 2009, the University of York did some modelling of the outcomes that showed that interventions would save the UK's health system £500,000 per year.

Associate Professor Chamberlain said that the evidence from the review had been used to inform many guidelines, including those for the World Health Organization, the National Institute for Health and Care Excellence (UK), and the US Preventive Services Taskforce. She had worked on an advisory group for the NHMRC Stillbirth Centre of Research Excellence (CRE). Because of the impact on stillbirth, the CRE has been doing a lot of work involving smoking cessation interventions and pathways, with information available on the website for people to access.

A snapshot of intervention results over 102 trials showed good effects from counselling, incentives and feedback, and borderline effects from health education and NRT. With regard to these interventions with Indigenous pregnant women not showing strong effects, Associate Professor Chamberlain said that there was no evidence that they did not work -- it was just that there was no evidence that they did work. They could work and have some effect -- we just don't know. Participating in randomised controlled trials can be a challenge for many Indigenous people, so we don't know how much this affects the trial results.

Having moved from smoking to diabetes, Associate Professor Chamberlain said she had seen similarities in the characteristics of the qualitative research for these two issues. The reasons for interventions with Indigenous women with diabetes not being so effective include perceptions of risk, low self-efficacy, and associations with childhood maltreatment and trauma.

The ineffectiveness of fear-based messages had been discussed earlier, and Associate Professor Chamberlain said that she believed that these theories may explain why those interventions were not so effective. Strategies requiring a considerable degree of agency are less likely to be effective if people have less self- efficacy. It could therefore be argued that some of the interventions that require a high level of agency actually increase health inequalities rather than decrease them because they work less well with some people than others.

Emerging evidence is helping to increase how we understand complex trauma and the convergence of risk factors that occurs in the perinatal period. Not only are all these things occurring in a person's life during pregnancy, but we are also beginning to understand that there are physiological and hormonal changes that occur in pregnancy that heighten people's fear and cortisol responses. It is a protective mechanism, a naturally heightened fear response to protect the baby -- but it could make things tough, as well.

All of these pre-existing vulnerabilities could affect women during pregnancy. It could be pre-existing mental illness, exacerbated historical trauma, housing factors, or any or all of the sociological things discussed earlier. There could be an increased risk of family violence. There are many reasons that childhood trauma could be triggered during pregnancy. So even if a women had been managing the effects of distress in the period before pregnancy, many of these things could be triggered at the time of pregnancy. There are also additional issues such as previous birth trauma, sleep deprivation and the like.

Complex trauma also is an important issue. The World Health Organization has recently recognised complex post-traumatic stress disorder in the most recent edition of the International Classification of Diseases Manual 11. We know about post- traumatic stress disorder (PTSD), caused by exposure to severe threats such as war or car accidents etc., and that this involves symptoms related to a sense of threat, avoidance and re-experiencing. We now understand that more people experience 'complex PTSD' following exposure to repeated severe threats from which they cannot escape. Childhood maltreatment and interpersonal violations are the most common antecedents of complex PTSD. In addition to PTSD symptoms, people experiencing complex trauma also experience symptoms related to relational disturbances, negative self-concept and affect dysregulation (trouble regulating emotions).

From an epidemiological perspective, the evidence is overwhelming that complex trauma has a huge effect on health. Some modelling done by Bellis and colleagues in the United Kingdom (2014) estimated that 23% of smoking nationally could be attributed to child abuse (Bellis, Hughes, Leckenby et al., 2014). Font and colleagues (2016) conducted modelling that suggested that the effects of child maltreatment actually outweigh the effects of poverty for many of these risk behaviours, including smoking.

The focus of Associate Professor Chamberlain's current work is a project called Healing the Past by Nurturing the Future: co-designing perinatal awareness, recognition, assessment and support strategies for Aboriginal parents experiencing complex trauma. This is a four-year National Health and Medical Research Council (NHMRC)-funded project involving a large evidence review and pulling together a range of qualitative and quantitative research, available on the website.

Eight core themes for support have emerged which are relevant to parents who smoke:

1. Foster empowerment
2. Self-care
3. Compassionate care and support
4. Build connections
5. Provide parent education and opportunities to develop skills
6. Provide practical assistance and support to develop life skills
7. Reduce isolation
8. Offer a range of healing and therapeutic approaches.

There is considerable evidence that counselling could be helpful, but it is not the only therapeutic approach that could be helpful in the context of trauma; because it is a physiological response, physical strategies such as diet and exercise, as well as many other strategies, could be important.

In conclusion, Associate Professor Chamberlain noted that there is no evidence that individual support and interventions are not effective, so it is important to continue them.

She added that it is also necessary to continue a strong focus on structural strategies and a comprehensive approach. Some work was done on this a few years ago, emphasising the importance of a comprehensive approach, bringing together the recommendations of the National Tobacco Strategy and the principles and priorities of the National Aboriginal and Torres Strait Islander Health Plan (Chamberlain, Perlen, Brennan et al., 2017).

Discussion

Glen Benton (Aboriginal Quitline Victoria) introduced himself as a Wiradjuri man who works for an organisation that supports people to quit smoking, but in a mainstream setting. He had come from a role where he was working with women and children transferring from traumatic situations and was happy to hear about research that supports what we have known for a long time about the impact of trauma. He asked how this information about what we know works in relation to empowerment could be embedded into the mainstream professions and have it accepted.

Professor Calma mentioned the Tackling Indigenous Smoking Resource and Information Centre (TISRIC), an information centre on the TIS website on Health*Info*Net, with various fact sheets and other resources. He said that TIS also funds Indigenous Quitlines to operate and train counsellors to be

culturally competent. This needed to be continually reinforced.

Simone Jordan (Awabakal Ltd.) said that she would be looking for ways to implement research like this in programs which relate to chronic conditions such as smoking, diabetes and heart disease. With regard to complex trauma, she said it was frustrating that this needs to be justified and explained, even though the evidence has been there for a long time. She said, while we recognise it because we work with it and live it, there needs to be a way to 'up the ante' so that government organisations recognise it.

Professor Calma said he hoped that this would be done in the revised *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan*. A research list would also be compiled and made available on the TISRIC website.

A participant said that, as a non-Aboriginal health professional in the hospital system, she believed that there are issues of institutional racism. This meant that, where the strengths of Aboriginal culture and communities are not built into policies and frameworks, these are not sustained. A recent violence, abuse and neglect framework has specific consideration of Aboriginal families, culture and strengths interwoven throughout the document, but a child welfare document has only two mentions of Aboriginal communities, both negative.

Dr Marilyn Clarke (Mid North Coast Local Health District NSW) agreed that the strengths of Aboriginal culture and communities need to be embedded from the start.

Professor Calma asked how the information on smoking and pregnancy can be embedded within the nursing and midwifery curriculum at universities.

Glen Benton (Aboriginal Quitline Victoria) reiterated that fear-based messaging did not work in Aboriginal communities, and that it is necessary to empower communities and reignite resilience.

Sarah Agius (Aboriginal Health Council of South Australia) echoed the previous comments on complex trauma. On embedding the data within the professions, she said that we need to ensure that frontline workers are equipped with that knowledge. The role of local community workers is important in making clients feel comfortable.

Professor Calma said the TIS program always emphasises the benefits of not smoking, and seeks to reframe the conversation in this way. There is a new project on plain packaging that is considering giving attention to what happens if you don't smoke.

Associate Professor Philippa Middleton (South Australian Health and Medical Research Institute – SAHMRI) asked for people's views about the proposal for carbon monoxide monitoring and whether this type of monitoring is fear-based.

Response: From the TIS side of it, “we use it all the time”.

Response: “With pregnant women it is, because you have the CO reading with the baby’s reading and you consider that; but if it’s just the person, not always.”

A participant thanked Dr Maddox for his presentation and said that culture could sometimes be put on the backburner. She emphasised the need to strengthen a culture-based approach with cultural awareness training so that it is embedded.

Professor Calma noted that the Mayi Kuwayu study is focused on the impacts of culture on health. He said that culture is at the centre of the Implementation Plan refresh. This had been influenced by another report that the Department led, the *My Life, My Lead* report, which he recommended to participants. That report had been endorsed by Cabinet, and so it was incumbent on all government agencies to implement the findings. There has been some progress, but it is important to remember that it is necessary to influence mainstream programs, which is where the big money is.

Juliette Mundy (Miwatj Health Aboriginal Corporation) said that when the CO monitor numbers go up, this provides an opportunity to discuss what is going on in a person’s life – it could be about domestic violence, for example. So it provides an opportunity to discuss how the person is going to deal with that situation and is not always a negative thing.

Professor Calma said this was particularly so with regard to the ‘D’, or discussion aspect, in that if someone is in the presence of the family that has an influence also. He said that he had visited Geraldton Regional Aboriginal Medical Service (WA) late last year and was very impressed with the work that was being done there in nursing and midwifery. CO monitors (Smokerlyzers®) were being used quite a bit, and TIS intends to do some work with them to showcase good practice on how that can be done.

Associate Professor Gillian Gould said that the message does not have to be fear based -- it could be fairly neutral; it depends who is delivering it. Dr Marilyn Clarke (first Aboriginal obstetrician and gynaecologist) had made a video where she delivered that information to a pregnant woman gently. What is important is the way it is done: it must be respectful and well delivered, with a positive upswing to make it empowering.

Creating space for change: lessons from a successful smoking cessation in pregnancy program — Associate Professor Deborah Askew (University of Queensland/Inala Indigenous Health Service)

Associate Professor Askew introduced herself as a researcher at the Inala Indigenous Health Service and the University of Queensland who ran a program on smoking cessation in pregnancy. She acknowledged her colleague, Kym Yuke, who started the program with her. She said that this program recognised smoking as a symptom, and that recognising the causes and helping smokers to deal with these puts people in a better position to consider cessation.

While TIS is moving to a population approach, smoking cessation is an individual behaviour. Although the program considered the population perspective, the approach still relied on supporting each individual to make a decision to quit smoking and to celebrate successes in this process.

The program ('Empowering Strong Families', supported by a TIS Innovation Grant) had had fantastic successes. It enrolled 41 pregnant women, included significant others, and resulted in four women stopping smoking during their pregnancy. That was one way of looking at success; another is that, from those 41 women who started the program, each of their 45 or so babies had a better start in life because of the care and support that the program provided.

The approach involved case management and outreach. It was holistic, recognising that a pregnant woman is a person with a range of hopes, needs, etc. It was solution- focused, so everything that could be celebrated was celebrated. It involved attitude change, talking about it, was relationship-based, and depended on trust. It was delivered in a primary health care service, so wrap-around care was offered, as well as supporting participants to deal with other agencies, such as Centrelink and Housing, because institutional racism makes this difficult. The approach recognised the uniqueness of each person's story.

Privileging the voices of Aboriginal women in the discussion: What ngidhi yinaaru nhal yayi (this woman told me) about smoking during pregnancy — Dr Michelle Bovill (University of Newcastle)

Dr Bovill introduced herself as a Wiradjuri woman from Mudgee, New South Wales, who grew up on Worimi country in Port Stephens. She completed her PhD in 2018 on smoking in pregnancy with Aboriginal and Torres Strait Islander women in NSW, Queensland and South Australia. Her research fed into the pilot trial on smoking in pregnancy, 'I Can Quit in Pregnancy' (led by Associate Professor Gillian Gould), and has turned into a randomised

controlled trial with SISTAQUIT. Dr Bovill's current project, 'Which way?', has been funded by NHMRC and the Heart Foundation.

Dr Bovill said that she felt privileged to yarn with Aboriginal and Torres Strait Islander women and to hear their stories, and that she wanted to privilege their voices in this discussion on smoking in pregnancy. Her presentation would include a collation of her research to date in the area of smoking in pregnancy and combined the voices of Aboriginal and Torres Strait Islander women from these four publications, as well as from her ongoing dialogue with Aboriginal women in communities.

One clinical finding of her research is that Aboriginal women are actively making quit attempts during pregnancy, so motivation is high. A second is that there are problems with the 'R word'--'reduce'-- as the advice should be clear and should be to quit, and empowerment and support to do this should be provided. Reduction is also being advised in clinical guidelines, so there is not clear messaging on what clinicians should be providing. Aboriginal women had told her that doctors should stop telling them to reduce their smoking. When they had been advised to this, they were doing so. A clinical trial had shown that 70% of women advised by their doctor to make a quit attempt were making a quit attempt (Eades, Sanson-Fisher, Wenitong, et al., 2012).

This raised the conundrum of what kind of support should be offered, and Aboriginal women had offered a couple of key ideas. Systematic reviews had indicated that there is no evidence of effective smoking cessation strategies with Aboriginal women. It is important to note that there have been limited trials among pregnant Aboriginal and Torres Strait Islander women, so the data are not perfect. Aboriginal women expect support from their health care providers. This is everyone's business, and some important work is already being done to address that area of need.

Aboriginal women had told Dr Bovill they need good health messaging. They explained that they receive their information from such sources as television ads, social media and marketing, and it is necessary to ensure that supportive and empowering messages are given to mums to quit smoking during pregnancy.

However, women have also said, "They talk about small babies" and they want to know what that means. Aboriginal women want to know about the long-term effects of smoking in pregnancy for the health of that child. These are difficult things that need to be integrated into the messaging given to women.

Dr Bovill noted that there is also a need for an evidence base for new and innovative interventions that are built on the interests of Aboriginal people. She explained that 'Which way?' asks Aboriginal women in NSW what they want to help them quit.

Aboriginal women had told her that they are interested in things such as mindfulness,

yoga and alternative approaches to cessation. It had been shown with white populations in the United Kingdom that these things could help, but it may be that Aboriginal women are unable to afford those approaches.

Dr Bovill said that she plans to conduct yarning circles and a systematic review of what women have said they want and what the evidence base is. She will then seek to undertake a national survey of Aboriginal women to see whether what women in New South Wales want has relevance across the country, and then proceed to take this to a trial over the next four years.

Birthing in our Communities — Luke Dumas and Sharrna Parter (Institute for Urban Indigenous Health) (IUIH), Queensland

Sharrna introduced herself as a Darumbal woman from northeast Queensland. Luke introduced himself as the coordinator of the Deadly Choices program, which is a holistic program that has been operating for ten years. Its activities include:

- a six-week tobacco education program
- tobacco stalls
- a tobacco pledge – Deadly Places, Smoke-free Spaces (promoting smoke- free homes and cars)
- Tobacco Champions.

There are 100 Deadly Choices staff around the state, with staff numbers having grown rapidly over the past 12–18 months. The tobacco stalls are at the forefront of the IUIH clinics, where staff can approach people and show positive messages. They had run 2,000 stalls in the past 12 months, with more than 13,000 people attending, just under half of whom were smokers.

IUIH has Tobacco Champions across the 23 services they look after across southeast Queensland. This involves training Aboriginal health workers to be Tobacco Champions for their communities, to offer motivational interviewing and smoking cessation support, and to deliver NRT. This approach had been a success in southeast Queensland, and there are plans to offer it across Queensland.

The recent evidence on the prevalence of smoking during pregnancy was that:

- 48% of women smoked during pregnancy in June 2019;
- with the Deadly Choices Mums & Bubs program, the prevalence was up to 51%.

Only one person referred to the program actually quit, and 70% relapsed during or after pregnancy. These were big issues.

Feedback from the clinics was that 25% of GPs and obstetricians who responded said they never prescribe NRT during pregnancy. The most frequently cited barriers were low confidence in the ability to prescribe NRT, and safety concerns about NRT in pregnancy.

So there were mixed messages, with women not knowing whether they should be on NRT while they were pregnant. Messaging was not consistent through our clinics, and that is something that will be addressed now.

To tackle these issues, a 'Mums & Bubs' program was developed, and partnerships with member services in southeast Queensland and across the state were being strengthened. There are political and other issues involved. The workers on the ground are not actually employed by IUIH but by the Aboriginal Medical Service, and part of IUIH's role is to train them.

There is also a strong Quitline partnership. In one month, IUIH made just under 500 quit referrals, and four were successful.

IUIH works in both urban and remote communities and also conducts social marketing campaigns.

Work is also being done with young children, and the data suggest that there has been a decrease in the uptake of smoking. They are also now interviewing young mothers, which would help with the Mums & Bubs program.

Discussion

A participant asked how Luke and Sharrna measure their outcomes from events. They replied that they used a sheet to record people's smoking status. They have people on the ground who capture the data. They use a program called Qualtrics on iPads.

Another participant asked if there were any plans to train workers to be registered tobacco treatment specialists. They said that yes, it was hoped that GPs, clinicians and Aboriginal health workers across the state would be registered.

Trudy McInnis asked **Associate Professor Askew** whether her program was cost- effective and provided value for money. Associate Professor Askew explained that the funding was for a two-year program and, because funding was received in November, this reduced the time-frame to 18 months. With a pregnancy taking nine months, this reduced the number of people that could be included. She said it was a relatively costly model, and that value for money had been a criticism, but the work with Aboriginal women meant that 45 babies had a better start in life.

Professor Calma mentioned the work on epigenetics and genomics and suggested that, given the cost of lifelong support, it was not bad value for money. Help had to start prenatally.

Aboriginal Health Council of South Australia: Maternal Health Tackling Smoking Program — Ngara Keeler and Sarah Agius (Aboriginal Health Council of South Australia Ltd) (AHCSA)

Ngara and Sarah brought greetings from the Lower Murray/Coorong/Fleurieu Peninsula country. They acknowledged the traditional owners of the land on which they were meeting, the Ngunawal people, and paid respects to the Elders past and present.

The Maternal Health Tackling Smoking Program, delivered by AHCSA, is funded through Drug and Alcohol Services SA as part of an overarching approach. The objectives of the program are to reduce the prevalence of smoking among pregnant Aboriginal women and their families in South Australia. Ensuring that Aboriginal children are born healthy is paramount to improving Aboriginal health and is pivotal to Closing the Gap between Indigenous and non-Indigenous health.

Although there had been positive results in SA, much more work is required. In 2017, smoking rates had decreased to 41.3%, from 52.9% in 2010. There was a correlation between the effective and popular 'Stickin It Up the Smokes' social marketing campaign -- which continues to encourage women to make quit attempts by delivering smoke-free messages, engaging with local ambassadors/role models as part of a coordinated approach to supporting pregnant women -- and the increased number of Aboriginal women making successful quit attempts during pregnancy.

The role of the Aboriginal Health Workers was to take complex information and translate it to our people, which is a challenge. Strategies include:

- empowering women through education and information;
- well women's pamper day and group activities;
- one-to-one brief interventions, referrals, and follow-up support; and
- one-to-one support sessions.

Those delivering the program connect with language and culture as Aboriginal women to try to get the outcomes that have been discussed. They look at the positives and how that supports behaviour change. They look at colonisation, the history of smoking, the impacts it has, and the science behind cigarettes – including that cigarettes are designed to be addictive and that Aboriginal communities are targeted. They work with member services in South Australia and try to support them. Mary-Anne Williams (Maternal Health Tackling Smoking Project Officer) had had a major role in this project over the past nine years. She would engage with women to have this conversation in a safe place.

Aboriginal Maternal Infant Care (AMIC) students are supported with their role, with workers encouraged to have conversations with their clients about smoking.

Sometimes there is a fear that having the smoking conversation would strain their relationship, so the program works on ways to empower the

AMIC workers.

The team is working to build effective two-way partnerships, and to develop culturally appropriate pregnancy resources. There were currently four months left of the program in which to achieve this, but the TIS team, which the Drug and Alcohol Services SA (DASA) team worked closely with, would continue to support pregnant women. The difference between the DASA program and the TIS work was that the program was more able to focus on one-on-one follow-up whereas the TIS team has the outreach role, but these are complementary.

Throughout the program, Mary-Anne Williams, who led it for nine years, managed a two-phase state-wide social marketing campaign. The first part was 'Stickin It Up the Smokes', which showed mothers who had given up smoking during pregnancy, and used them as ambassadors. The second phase was when their children were born, and there are resources showing the benefits of the mum giving up the smokes.

The newest initiative was the release of a Facebook page, where all of these resources could be captured in one place.

The Aboriginal Health Council of South Australia now has a new CEO and, while this project was due to end in June 2020, a strong partnership had been formed with the Pepi Pod project, a research project by Flinders University that works on SIDS and discourages co-sleeping.

There was also a new 'Stickin It Up the Smokes' on the puyublasters site, a 'Bump to Bub' flip chart resource for health professionals, and a smoking-in-pregnancy kit.

The plan for the next four months is:

- develop an Indigenous smoking action plan;
- increase the number of ambassadors;
- offer CO monitoring services online;
- maintain partnerships.

Waminda's Balaang and Binjilaang (Tackling Indigenous Smoking) South Coast Project — Kristine Falzon and Hayley Longbottom (Waminda — South Coast Women's Health and Welfare Aboriginal Corporation), New South Wales

Kristine and Hayley acknowledged Ngunnawal country. Their organisation, Waminda, is based in Nowra, has 125 staff, and had been operating for 30 years as a women-only service. All staff are trained to deliver smoking cessation services. The organisation is wellness-focused, so GPs and allied health professionals have a cultural induction before dealing with clients. Waminda works within their model of care and healing framework. Three-quarters of the staff are Aboriginal women, and the majority are local Koori women, so culture is at the core of Waminda's service delivery.

Besides the quantitative data, it was difficult for staff to measure the full impact of the project on an individual's family because of the holistic nature and overall positive 'ripple effect' the project was able to achieve. One of the best things about this initiative is that the staff were professionals working within their own community – walking alongside clients – making women safe and secure, and ensuring referral pathways are also culturally safe.

Within the organisation, the TIS project coordinator worked within all Waminda sites championing tobacco control/support with staff and clients. One staff member in particular had her own journey within the workplace, and it worked well for her to achieve her goals. The overall TIS program had a regional manager, regional Coordinator and two project staff working in the north of the region in Illawarra within the Coomaditchie community and one in the far south within the Wallaga Lake community. The project work is based on self-determination, with the Dead or Deadly program which is tailored to the needs of the woman. With exercise and an improved diet, improvement in other areas was achieved, including smoking cessation.

What we know is that fear tactics do not work well with adults but work better with the young kids in schools.

Waminda's midwives provide maternal classes in the building and included smoking cessation within their groups. The service also has also found CO monitors to be good and worked well within all the programs. The service is all about trauma- informed care and not wanting to add to people's existing stresses. Their family/community basis is their strength, with a focus on providing a wrap-around service to the women and their families to make informed decisions about their wellbeing and lifestyles.

Smoking & Pregnancy in Cape York – challenges and celebrations — Dallas McKeown (Apunipima Cape York Health Council), Queensland

Ms McKeown acknowledged the traditional owners of this country, and introduced herself as a Yuuwaalaraay woman from southwest Queensland. Her colleague,Carrie Rofe, a program support officer for Tackling Indigenous Smoking, is a Wakka Wakka woman from southeast Queensland.

She explained that Apunipima is a part of the SISTAQUIT research program discussed earlier. Services in Cape York communities are split among Apunipima, the Royal Flying Doctor Service (RFDS) and Queensland Health. Apunipima provides a comprehensive family doctor service alongside podiatry, diabetes nurse educators, nutrition programs, dietitians, social and emotional wellbeing, as well as child and maternal health services. Queensland Health provides acute care services and the RFDS provides general practice doctors and chronic disease nurse services.

Ms McKeown presented data for two communities, Kowanyama and

Pormpuraaw. She said it must be remembered that the numbers may look higher or lower than they actually are because Apunipima accounts for only a part of the health care services for the communities. Apunipima uses an electronic record system and Queensland Health uses paper-based records, making it difficult to get an accurate picture and data sharing problematic.

In the two decades since its inception, Apunipima had grown from a small advocacy organisation to one of more than 250 staff. Today, it continues with its mission to eliminate health inequality on the Cape and deliver a comprehensive primary health care service to 11 Cape York communities. Apunipima adheres to a family-centered model of comprehensive primary health care which sees clients as individuals embedded in families and communities.

According to the 2016 Australian census, there were 944 people living in Kowanyama. The community is predominantly young (with children aged 0–14 years making up nearly 30% of the population) and 91% identifying as Aboriginal and/or Torres Strait Islander.

In Kowanyama, 211 adults who had been seen by Apunipima had diabetes; this suggested that one in every three Aboriginal and/or Torres Strait Islander adults in Kowanyama had diabetes. This was higher than the national average, which is reported as approximately 13% of Aboriginal and Torres Strait Islander people having diabetes.

According to the Apunipima data, there were 30 adults in Kowanyama with heart disease, which equated to one in every 20 people. There were 104 adults with kidney disease, or about eight in every 50 people of the Aboriginal and Torres Strait Islander population.

Of clients seen by Apunipima, 70% had not had their smoking status recorded; of those who had, 15% reported that they smoked. Given that, nationally, 41% of Aboriginal and Torres Strait Islanders report that they smoke, it likely that the percentage of smokers in Kowanyama is much higher than 15%. Of the 37 total pregnancies in 2018, 24 had their smoking status recorded and, of these, there were 14 women who smoked during pregnancy.

Pormpuraaw, according to the 2016 Australian census, had a population of 749. The community was predominantly young, with a median age of 31.

There were 114 adults with diabetes on the Apunipima register in Pormpuraaw, representing 23%. Twenty-three per cent of Aboriginal and/or Torres Strait Islander adults had diabetes. This was higher than the national average for Aboriginal and Torres Strait Islander people (approximately 13%). In Pormpuraaw, nearly 22% of Aboriginal and Torres Strait Islander adults seen by Apunipima had high blood pressure (just over one of every four adults).

On average, a pregnant woman would receive eight antenatal visits (range:

four to 13 visits) with Apunipima during a pregnancy. In 2018, of the 17 pregnancies, six women were active smokers and four had successfully quit smoking.

As part of the SISTAQUIT program, Apunipima was designated as 'usual care', so all pregnant women would receive the following care:

- The **Tackling Indigenous Smoking** program, which aims to improve the health of Aboriginal and Torres Strait Islander people by reducing the prevalence of tobacco use through population health promotion activities.
- The **Apunipima Maternal Child Health Strategy**, which focuses on preconception to 19 years of age. The strategy guides the delivery of optimal clinical care while retaining a focus on prevention and early intervention to reduce risk factors for chronic disease and build protective factors to support child health, growth and development.
- **Bump2Bubba** – Optimal Infant Nutrition, which aims to build on existing knowledge and strengths of community members to promote the importance of optimal nutrition in pregnancy and early life. Nutrition staff work alongside community-based staff to build confidence and capacity to deliver consistent maternal and child health nutrition messages.
- The **Baby One Program**, which creates the opportunity to achieve real improvements in the antenatal period and first 1,000 days of a child's life.

Six women are currently enrolled in the program. Incentives are used to provide for the family. There is an anecdotal belief that smoking would result in a smaller baby, resulting in an easier birth. There is an evident disconnect between knowledge of smoking during pregnancy affecting the baby versus 'smoking will harm my baby'.

Ms McKeown said that the data she was presenting provides a snapshot of the scale of ill health and overwhelming burden of disease faced by many remote Indigenous populations. She said that it is essential to consider the individual's right to choose what their priority is and at what level they wish to engage.

Undertaking health programs relies on clear communication between individuals and organisations, and this includes IT systems that exchange information in a timely manner. Using multiple service providers requires a robust communication process.

Challenges in Cape York include weather, sorry business, community unrest, and priorities of individuals and families. Stressors may include issues with perceived lack of support from a partner during pregnancy, money issues, family dysfunction, domestic violence, boredom with community life, and concern with the fidelity of a partner when having to leave community for specialist appointments.

Ms McKeown presented information showing the prices of groceries from the previous week in the community store, which indicated how grocery vouchers given as incentives to participants were likely to be spent. She said it was imperative to use a strengths-based approach that draws on the strengths of the communities.

A cause for celebration was that, of the 13 pregnant women in one of the SISTAQUIT site communities, six were ineligible to participate because they were non-smokers! When asked why they didn't smoke, they had said they had given up for the baby, that they didn't want a small baby; they wanted a healthy baby.

Smoking and pregnancy in the Miwatj region — Juliette Mundy (Miwatj Health Aboriginal Corporation), Arnhem Land, Northern Territory

Ms Mundy began by acknowledging the traditional owners of the land where the Roundtable was taking place and also acknowledged the people of northeast Arnhem Land, where she works. This region covers an area of 33,359 km^2, with a total population of about 10,000, of whom 93.6% are Aboriginal and Torres Strait Islander peoples. A language other than English is spoken at home by 89.3% of the population (ABS Census data).

Miwatj operates seven clinics and one Wellbeing Centre across the top end of the region and is now the primary health service provider for all Yolngu people, which is more than 8,000 regular resident clients. Miwatj also operates a renal program at Angurugu.

There are ten TIS community workers, working within their own communities. The organisation was established with the aim of becoming the health service provider for the region and had made significant progress in achieving this through its regionalisation strategy over the past ten years. Following a period of rapid growth, it transitioned the last two clinics in the region in July 2019 and is now in a period of consolidation.

The organisation's strategic goals underpin how programs are delivered, and two in particular are relevant with respect to the TIS program. Aim number 3 says that the success of the program depends upon engaging with Yolngu mala (leaders), and Aim number 6 is about empowering staff and communities to take control of their own services and healthcare.

Ms Mundy presented the following estimates of smoking prevalence: Australian population: 13%; Aboriginal and Torres Strait Islander people: 38%; Yolngu: 62%.

Although it is known that children well under the age of 15 are smoking, data are not routinely collected for this age group. Opportunistic surveying had shown self- reported smoking by children under the age of ten, and nearly half of the 210 children age 10–14-years-who were surveyed self-reported

being smokers.

Smoking status had remained fairly stable across the past five years across all of these communities, with some small year-to-year fluctuations in quit status (less than 12 months; more than 12 months); however, it is difficult to interpret any trends.

Recorded smoking in pregnancy status for the region showed that 53% are smokers, 10% quit during pregnancy and 37% are non-smokers. From this, it appears that smoking rates are lower among pregnant women than among the Yolngu population generally, but they are still high. Ms Mundy said that there is a need to find out more about the stories of those women who successfully quit during pregnancy and whether this was sustained.

Two publications detail the history and culture of smoking in the region – how smoking came to be adopted and how people view it now: *Short ones – Tobacco Stories from Arnhem Land* is a book, while Ngaralii – The Tobacco Story of Arnhem Land is a video.

The first aim of the Miwatj TIS program is to 'de-normalise tobacco with an evidence- based population health approach'. Social media and Yolngu radio are used for this. The aim is particularly important because of the historical and cultural connection to tobacco in Arnhem Land. There has been some success with video clips, and a recent research project with Menzies School of Health Research identified the hallmarks of a successful strategy for smoking-related Facebook content (child focused, featuring Yolngu, practical with clear direct message). In addition to a social media strategy, there are plans to obtain funding for a comprehensive campaign.

Also planned is the development of curricula for school-based education and other outreach education, for example with the Arnhem Land Progress Aboriginal Corporation (ALPA) and Community Development Program participants.

Other priorities are:

- upskilling TIS Community Workers through cross-program collaboration, e.g. Kidney Week;
- sustained support for smoke-free spaces, including schedule of support for revisiting households that have identified they want to become smoke free;
- working with community organisations such as ALPA to provide Quit support to staff and support smoke-free policies, and a partnership with Gove AFL;
- an Ambassador program – finding positive role models who do not smoke or who have successfully quit;
- partnering with sport and healthy lifestyles, and learning on country;
- improving health literacy and breadth of health stories for tobacco through community priorities, e.g. Health Advisory Groups, Community Reference Groups, working with community

organisations.

Around 60% of people surveyed mentioned the health of children as a primary motivation for wanting to have a smoke-free home; however, there are challenges due to issues such as overcrowding in houses.

Over half of women surveyed listed stress as a reason for smoking, and less than a third of the women surveyed reported enjoying smoking.

Miwatj TIS community workers provide education in language, on country and in community centres.

There are issues with maintaining a TIS workforce, such as high staff turnover; managing remote workforce; workspaces; need miyalk (female) workers to do that djama (work); and non-uptake of Quit support training due to other clinical needs.

Access issues include: Quitline not being accessed by Yolngu, as it is not seen as meeting their needs; limited follow-up for NRT referrals; training for clinical staff; no access out of normal office hours; and social and emotional health and wellbeing. Attitudinal issues include ngarali (tobacco) being seen by some as part of culture; health literacy; and ngarali being a balanda (white person) problem.

Key avenues to explore in the next couple of years include: better data collection; achieving a better understanding of the harms of smoking; collaboration with other organisations working with families and pregnant women; and organisational advocacy to address the social determinants of health.

Enhancing smoking cessation care in Aboriginal maternity services: Implementation of Quit For New Life in the Hunter New England Local Health District of NSW — Dr Justine Daly (Hunter New England Population Health, New South Wales)

Dr Daly began by acknowledging the traditional owners of the land, the Ngunnawal people, and paid respects to Elders past and present. She explained that the Quit for New Life program is an initiative funded by the New South Wales Ministry of Health specifically to enhance smoking cessation care delivery in Aboriginal Maternal and Infant Health Services (AMIHSs) across the state. Each local health district was provided with a certain amount of funding over five years, from 2012 to 2017, so each district was able to develop their own model to suit their Local Health District (LHD). The Hunter New England LHD covers a very large area, from Newcastle to Moree, nearly to the Queensland border. There are 11 Aboriginal maternal and infant health care services in the LHD, including some in very remote locations.

The Hunter New England implementation model was intended to establish a

service that became part of routine care so that it could be sustained once the funding was no longer available. The model was developed by a working group and informed by client survey data and staff consultation. It focused on having the care led by Aboriginal Health Workers. An Aboriginal Health Worker and a midwife would work together. There was also a focus on engaging women to begin their smoking cessation journey – taking those first steps and then hopefully building confidence and taking it forward – as there had been feedback that staff were finding it difficult to have women accept help.

To make it sustainable, the program focused on capacity building of the existing staff of the AMIHSs – training them to increase their skills and confidence in providing best practice smoking cessation care. They were provided with site support officers (Aboriginal Health Promotion Officers from the Population Health Team), staff from Aboriginal Population Health, who worked with the AMIHS teams to support them and solve problems or overcome barriers as they arose. Additional staffing hours were funded because it was known that implementing a new model of care could place a burden on the service. They were already working to capacity with their role in antenatal care. They greatly appreciated this, and the program received great feedback for acknowledging that implementing new things took more time.

They were all given carbon monoxide monitors and were able to provide free NRT directly to the women. Performance monitoring was implemented, with quarterly feedback reports to the services about how well they were going in delivering care, and set performance targets for increasing care delivery. This was supported through the Executive Leadership Team with the District Chief Executive taking a keen interest in the implementation of Quit for New Life across the Local Health District.

The model consisted of four steps: Assess, Explain, Offer and Arrange. The CO monitor was used during the assessment step to help engage women by focusing on reducing their CO levels for the health of their baby and offering them support such as Quitline referrals and NRT to reduce their CO levels and become smoke-free.

During program implementation, there was a significant increase in acceptance of NRT (13% to 60%, $p < 0.000$) and behavioural support 13% to 65% ($p < 0.000$) by smoking clients. However there was no difference in acceptance of Quitline referrals (8% vs 16%, $p=0.21$).

Key success factors were:

- Model of care based on evidence and informed by client and staff consultation processes
    - focus on carbon monoxide levels as a way to engage women in quitting, and letting them set small, achievable goals to begin their quit journey
    - providing free NRT in the appointment to facilitate immediate commencement of treatment

- Practice change support strategies to support the implementation of the model of care into routine practice.

Quitskills Maternal Specific Training and Quitline Enhancement SA/NT — Melanie Schmidtke (Cancer Council South Australia)

Ms Schmidtke began by acknowledging the traditional owners of the land on which the meeting took place and paying her respects to Elders past and present. She also acknowledged and thanked the Aboriginal and Torres Strait Islander members of the Quitskills team at Cancer Council SA for making her presentation possible through their generosity and the sharing of their knowledge and life experiences.

Cancer Council SA has TIS funding for the Quitskills program, which was a nationally framed program, and for Quitline SA/NT. Quitskills has a particular course tailored to maternal health workers. It was a pilot program that commenced in 2018 and in its first six months was conducted as a single-competency course across three states, with community consultation. From July 2018 onwards, Quitskills was delivered as a three-competency course nationally. Currently, both options are being considered, given the challenges of remote areas.

Quitskills is delivered in three parts: an online learning module; two days of training and assessment; and a workplace project and men's group. By December 2019, 22 courses had been delivered across remote areas, from Katherine to Mt Magnet to Ceduna.

Participants have successfully achieved competencies under the program, but the Quitskills team face the same challenges that have already been discussed with regard to remote areas, such as language, literacy skills, distractions that can come with working in a community environment (sorry business, weather, family interruptions etc.). Also, given that these courses are being run from a clinic, there is an expectation that clinic staff would still be available, so there can be a tension between providing the course and attending to clients, who are literally lining up outside the door.

For Quitskills, lessons learned include the need to build a level of trust in relationships and connections with communities so that Quitskills is not seen as just swooping in with a lot of information and then leaving. Ms Schmidtke said that it is important to maintain that connection once the training had finished. There were also issues to manage in terms of staff turnover, as has been previously discussed.

In relation to opportunities for the Indigenous Quitline Enhancement Project, Ms Schmidtke highlighted the training of Indigenous counsellors in the appropriate approaches. There was an incentives program whereby women could receive a number of items such as baby blankets as they continued their journey with Quitline. There were also the challenges of making Quitline relevant to people in remote areas where there were perceived language

barriers – and calling Quitline in Adelaide was just not going to happen. There is a need to let people know what Quitline can do and how it can support people and, where it can't work, finding another way to give that support, because the message the program had received was that people want that face-to-face interaction.

Reflections from research on supporting women to quit — Associate Professor Megan Passey (University of Sydney)

Associate Professor Passey began by acknowledging the traditional owners of the land, the Ngunnawal people, and paid her respects to Elders past, present and emerging. She also acknowledged the traditional custodians of the land in which she lives and works, the Bundjalung country of northern New South Wales, which had recently experienced fires, and now had floods.

She also acknowledged the women who formed the community reference group for her PhD, who worked with her for seven years providing advice, support and guidance. When the money ran out, or when things got tough, they kept her going, and she would like to acknowledge what they did for her.

Associate Professor Passey's PhD work involved interviewing women of reproductive age about their smoking. It also entailed surveys with pregnant women and with antenatal care providers across New South Wales and in the Northern Territory. In the New South Wales context, that included the Aboriginal Maternal Infant Health Service midwives and Aboriginal Health Workers who work with Aboriginal women; and in the Northern Territory, it included whoever was providing the antenatal care to the pregnant women.

That research work was used to develop a quitting program that involved intensive support for women, as well as financial incentives.

Associate Professor Passey noted, first, that, as earlier speakers had said, complex trauma is not properly recognised by Australia's health system. Within pregnancy, many of issues of trauma are exacerbated. While pregnancy can be considered a wonderful time of bringing new life into the world, it is not a bed of roses and, for many Aboriginal women, it exacerbates many pre-existing complexities in their lives. If it is a woman's first pregnancy, she may not be in a stable relationship; the pregnancy may not be planned; she may not have stable housing; she may not even have a Centrelink number. Pregnancy makes all of these issues more complex.

Yet at the time they are wanting to become a mum, and these women really are motivated to do the best they can for their babies; but for many, there is a lot of chaos in their lives, and sometimes it just gets worse. It really is a hard time for them to quit smoking. Associate Professor Passey said we have to recognise that, support them, and resource that support. While we might

recognise it, and talk about it, within the antenatal care system it has to be resourced – and it is not being resourced.

There are some great programs, but within the broader system for antenatal care, we do not provide that wrap-around support and deal with the complexities that women face.

Associate Professor Passey's second point was that, while it is good to have these specific programs, nearly all pregnant women see a midwife, and hopefully an Aboriginal Health Worker. They may see a general practitioner, and all of them at some time would have to book into a hospital for the birth of their baby. So it is everyone's business – the business of everyone in the health system who interacts with pregnant women -- and yet we are not addressing this very well.

A separate piece of work that is not specific to Aboriginal and Torres Strait Islander women looked at the systemic and clinical barriers to providing smoking cessation care within routine antenatal care in New South Wales – and these are complex issues. In the past, we have tended to train midwives or Aboriginal Health workers in smoking cessation. We had not, however, addressed the systems issues -- we had not trained the managers, looked at the data systems, or made the resources available. All of these complexities do exist.

Associate Professor Passey's recent work has looked at the broader health system and at the systemic barriers. Rather than just training midwives and thinking that, somehow, miraculously, they will be able to do all these things without support and without those systems issues being dealt with, we need to address the whole system and ensure that the supports and processes are in place.

This is everyone's business and it must be embedded within the system. In the training that had been run for midwives and with managers in a small pilot program, Associate Professor Passey and her team had developed resources and changed the data system for recording information, and they were trying to make of all those systems come together.

Following that work, midwives had said that previously they had no idea how important smoking cessation was. They had not realised that smoking was as harmful as diabetes, and that it was such a big issue. They were now starting to switch around.

Discussion

A participant said that for Aboriginal counsellors the kind of information they delivered was not complex. It could be delivered in an appropriate way and was not something that couldn't be taken on. But health workers had their own remit and scope of practice, and didn't have the resources and skills available to them to address those other issues. She asked whether this meant that it was the concept of case management in complex care that is missing – that is outside the scope of the traditional Aboriginal Health Care

Worker. She asked who in the community were addressing these other issues. Were there case managers, and were there services to deal with these issues?

Associate Professor Passey said the New South Wales Aboriginal Maternal and Infant Health Service she was speaking about did provide antenatal care in an outreach model with a midwife and an Aboriginal Health Worker working together. She said that the concept was that they do case management, and in many cases they are able to provide that degree of care. One of the problems with smoking cessation is that you actually need very intensive interventions and contact early in the pregnancy, whereas the standard structure for antenatal visits is that they are less frequent in early pregnancy, with frequent visits later. She questioned whether they really have the capacity to have the flexibility to address that complexity over the pregnancy.

Melanie Schmidtke said no, the way that Aboriginal Maternal and Infant Health Services are set up did not relate to the number of Aboriginal babies in that area but was more about who applied and got funding. They were struggling to meet the demands of the women coming through their doors. Some tried to do those extra follow-up calls and visits, but they do not have the capacity to provide the level of support required.

Professor Calma said that this sort of support could come from the ACCHSs, but with mainstream services you just do not get the triaging or higher levels of support other than just the visit.

A participant said there were some fantastic services that do provide wrap-around support, but a recent perinatal mapping project conducted a survey of Aboriginal health care providers that found that trauma and grief was the main issue they were dealing with: 98%, and almost half of those people, said they did not yet have the capacity within their services yet to specifically with trauma. There was the care and the wrap-around service, but we need to develop that specialist expertise in how to provide safe care, how to have those sensitive discussions, and how to actually provide that specific support.

Melanie Schmidtke said that the South Australian Aboriginal Family Birthing Program had been able to use some local Close the Gap funding to employ family support workers to work with Aboriginal women – and some men – in conjunction with the social work and multidisciplinary team. This is one way of addressing the social determinants of health.

A participant noted that everyone is struggling – but that in the remote West, everyone is struggling more. All the services that are available in urban areas do not even exist there, so people are trying very hard to deliver everything, and it is almost impossible.

Associate Professor Deborah Askew said that, while this is a seminar on Indigenous smoking cessation, she wondered whether the conversation

should be broadened to include healthy pregnancies. In her recent work with Aboriginal communities on alcohol, people did not talk just about alcohol, but also about smoking, drugs and other things. So they were not seeing it as just that single issue. She understood that sometimes funding is available for a particular issue such as smoking, but one way of flipping the conversation is to promote healthy pregnancies. It is difficult to address everything, but we could not address smoking without addressing alcohol, and we could not address those without addressing complex trauma, etc. She said that everything that the person, family and community does will ensure healthy pregnancies and healthy babies.

Professor Calma said that while tackling Indigenous smoking is the TIS program's remit, those co-dependencies are recognised, and those matters would be dealt with more in the group sessions.

Kristine Falzon said that, as an example, in the Shoalhaven area referrals to their program are important, with people accessing a wider range of services after that first contact at the hospital when a referral would go to an Aboriginal organisation. She stressed the importance of working in collaboration and coordinating services.

Juliette Mundy said that one of the Miwatj programs should provide those wrap- around services but it is about getting qualified clinicians to stay in communities. She said that another Miwatj program involves senior women working alongside the clinicians. The problem is that you need younger women to come up and be trained, because there is an entire generation of older Aboriginal Health Workers and women working in that space who want to retire, but there is no-one else ready and willing to step up to fill that space. The challenge is really overwhelming.

Brooke Dickson (Australian Nurse Family Partnership Program) said that they deliver a wrap-around service but referred out, and found that some women did not take up those referrals. So it is a case of making sure that the referral agencies and networks they referred to in order to get that specialist care were working from that same framework. An element they had been building into their programs was trauma-informed practice. If those referral networks do not work from that same framework, it is challenging to see that those women are supported in addressing their complex needs.

Following the presentations and discussions, Roundtable attendees moved to discussion groups at five tables (blue, red, green, black and yellow). See Appendix to this Report for discussion group questions and feedback from each group.

Discussion following group sessions

Professor Calma thanked discussion groups for their comprehensive responses. He said that, while Questions 1 and 2 gave a little guidance on what should be the priorities, he did not think the group reports had clarified this – for example, pre- pregnancy, during pregnancy, post-pregnancy etc.

Michelle Schmidtke said that communities need to decide their priorities -- priorities could not be prescribed, because each community is unique. Being too structured about this would have the effect of negating community ownership.

Professor Calma said that, rather than being prescriptive, the intention was to draw from participants' experience. He asked whether there are particular research challenges which need to be promoted – remembering that research does not always have to be funded from major research institutions, and governments could also sponsor research in priority areas.

Another issue is the question of when incentives should be provided to be most effective -- in the early stages or first encounter with an Aboriginal Medical Service, remembering that a lot of what we are discussing happens through the community- controlled sector, and we need to consider how to reach people who do not come to that sector. Within the TIS program, women who participate in the program throughout their pregnancy receive a reward of various materials at the birth of their child, which is like an incentive after the event.

A Northern Territory participant raised the issue of chewing tobacco, which many people struggle with, including children as young as eight. Addiction to nicotine does not necessarily mean cigarettes, and this needs to be addressed.

Also of concern is the chewing of rolling tobacco and the smoking of bumpers (cigarettes made from leftover **tobacco** from other unfinished **cigarettes**), on which there is no research, but which must be very toxic.

It is also important to think more broadly about the ways that nicotine is taken – not just smoked but patches, vapour, water pipes etc. – because nicotine is harmful to the developing embryo and women are changing the ways they use nicotine, and there needs to be research on that.

Some concern was expressed about the term 'incentives', partly because of possible backlash if there is a benefit for Aboriginal people only. Rewards are powerful in this space, but the 'I' word can evoke the idea of a cash card. Another issue is that the focus is on pregnant women who smoke -- so what

about pregnant women who do not smoke? Are we just incentivising or rewarding those who are pregnant and smoking, and not recognising those who are just pregnant? Birth kits could be delivered to anybody.

On research gaps, the evidence is strong about social opportunity and the need for a different approach with pregnant Aboriginal women that recognises the importance of friends and family; however, this is limited research on interventions which take that approach. There is a need for more research on the colonial approach discussed earlier, as we are still pursuing a Western medical approach and adapting it for Aboriginal women. There is a need for evidence of a culturally appropriate approach developed from the ground up rather than an adapted Western model.

There is also a need for new randomised controlled trials and funding for these. Although they are the most rigorous way of testing some of the approaches being discussed, they are a nightmare to conduct and are not cheap.

Professor Calma mentioned the Medical Research Future Fund being rolled out and the need to be ready to respond. **Associate Professor Askew** said that for NHMRC ideas grants, the emphasis had been shifted so that randomised controlled trials might not be so necessary, and other types of evidence, such as those discussed today, might go down well; they are looking for innovation and creativity, and assessment is based on the team, not the track record, so this is an important change in the funding stream.

Professor Calma asked **Dr Marilyn Clarke**, as the only practising obstetrician in attendance, what needs to happen and how we can influence the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. She replied that she has a seat on the College's Women's Health Committee which produces the College's Statements and Guidelines, and that they do listen to her. She said that, more broadly, with regard to the issues of Medicare item numbers, obstetricians, along with other health care professionals, are delivering antenatal care, and that there is an item number with built-in screening for issues such as domestic violence, which is used. She said the item number would be a relatively easy target to explore to expand to smoking cessation care. In general, the health system is not so good at incorporating the social determinants of health into routine clinical care. Dr Clarke said that she will be interested to see the refreshed *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan*.

A participant raised the issue of smoking by Aboriginal Health Workers, which she said had been referred to earlier. She suggested that it is better for an Aboriginal Health Worker to be an ex-smoker who could also understand a woman's journey and could speak from a position of having come out the other end stronger. She asked whether this is still an issue and whether it should be the subject of a targeted approach.

It was acknowledged by others that this is a challenging issue, with a lot of Aboriginal Health Workers smoking. The policy provisions in relation to this were discussed, including not allowing workers to smoke outside the building in uniform, and using Smokerlyzer® challenges every month to identify those who smoke. It is a difficult policy to implement, and it could also be problematic because these health workers experience their own trauma, institutional racism and everything else, and in the health system they were at the bottom of the pecking order and everything was blamed on them. People had conducted research criticising Indigenous health workers as being a problem for smoking cessation in the community, and the same level of scrutiny should be applied to all staff, including GPs and everyone else, rather than targeting only the Indigenous staff.

Professor Calma said that most AMSs do have policies, although how these are administered is another matter. This is an issue that the TIS workers continually raise with the councils, practice managers and CEOs, with various degrees of success -- some are stronger than others. Having a smoke-free policy used to be a condition of funding for AMSs, and he, as the former Race Discrimination Commissioner, had said that that condition should not apply only to AMSs but to every organisation that received Commonwealth funding. So it was then taken out of the funding agreement completely, as they did not want to apply it to the general population.

Closing remarks — Professor Tom Calma AO

Professor Calma thanked everyone for attending and for providing the benefit of their experience. The TIS team would try to do justice to the participants' contributions. He said that in this International Year of the Midwife we should look to curriculum change. Among other things, the NBPU-TIS is hoping to develop fact sheets. There is a research and information centre (TISRIC) which will have the links to the research.

Professor Calma said that the Medicare number suggestion was a great one Some are claiming cessation work and others are not; we need consistency. Today had provided useful guidance, and that guidance would be followed up. (This paper contains views on a Medicare item number: Gould, Chiu, Oldmeadow, et al.,2020). He mentioned the priority groups, and the several co-dependencies that need to be looked at, particularly drug dependency, which sends smoking rates up greatly. He displayed a graph of Indigenous smoking prevalence which showed decreasing rates of smoking for urban Indigenous people but static rates for remote and very remote regions. This raised the question: how do we make a difference?

Over the period from 2004 to 2018–19, there were almost 50,000 fewer smokers, a 9.8% reduction or more than 23,000 lives saved. That was something to celebrate. Professor Calma again commended to participants the *My Life, My Lead* report and its recommendations on the social determinants of health. The *National Aboriginal and Torres Strait Islander*

Health Plan 2013-2023, developed in partnership with Aboriginal and Torres Strait Islander people and their representatives, provided a long-term, evidence-based policy framework as part of the overarching Council of Australian Governments' (COAG) approach to Closing the Gap in Indigenous disadvantage. This approach was set out in the National Indigenous Reform Agreement (NIRA) signed in 2008, establishing a framework of national targets and policy building blocks.

The revision of the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* which is being undertaken would have culture at its centre, and alcohol and tobacco would be among the key determinants that it would focus on. The federal Government is very supportive of this.

Professor Calma also acknowledged the work of TIS teams across Australia. At a national gathering at Alice Springs, he had seen what they were doing and were able to achieve – with an emphasis on remote and very remote communities.

Professor Calma thanked the Department of Health's TIS Team for organising the Roundtable. He told attendees that this was not the end, as the team would endeavour to continue the dialogue. It is important that the wealth of knowledge and experience expressed today is not only recorded in a report, but shared through the establishment of a network so we can remain engaged. Professor Calma concluded by thanking everyone for their contributions to the Roundtable.

Key points (paraphrased and verbatim from presentations)

Health messaging

- Health messaging is good and effective if it is positively framed. While fear-based messaging may be helpful with Aboriginal people with a high efficacy to quit, it is not helpful for recipients with low efficacy to quit, as they tend to deny, avoid, or find it all “way too hard”. Pregnant women are vulnerable in this regard.
- Aboriginal women had said they need good health messaging. They explained that they receive their information from such sources as television ads, social media and marketing, and it is necessary to ensure that supportive and empowering messages are given to mums to quit smoking during pregnancy.
- What we know is that fear tactics do not work well with adults but work better with the young kids in schools.
- Messaging is seldom about the chronic health story. People need to know that the harmful outcomes of smoking during pregnancy are not only short-term, such as low birthweight, but that the effects can continue for a lifetime.
- Women have also said, “They talk about small babies” and they want to know what that means. Aboriginal women want to know about the long-term effects of smoking in pregnancy for the health of that child. These are difficult things that need to be integrated into the messaging given to women.

Counselling

- Counselling is one effective strategy and can double the quit rates, but health education and brief risk advice are not sufficient on their own.
- There is considerable evidence that counselling could be helpful, but it is not the only therapeutic approach that could be helpful in the context of trauma; because it is a physiological response, physical strategies such as diet and exercise, as well as many other strategies, could be important.

Training the health workforce

- Women are receptive to care in pregnancy but care workers could lack confidence in broaching the subject.
- Cessation care efforts were found to be neither adequate nor consistent – for example, the conflicting advice to cut down on smoking or to quit completely.
- Training the health workforce is a particularly important focus. This training can help increase quit rates in the general population.
- It has been found that pregnant Indigenous women want health professionals to speak to them about smoking, but they also want ongoing care from their clinicians. They wanted to determine the conversation and how they engaged with it.
- It is necessary to enhance the confidence and knowledge of health professionals.
- Care needs to be more informative and targeted to people.
- If women want to have that conversation and make that attempt, we need to provide that in a culturally safe space so that they feel that they can have the conversation in a positive way.

- Undertaking health programs relies on clear communication between individuals and organisations, and this includes IT systems that exchange information in a timely manner. Using multiple service providers requires a robust communication process.
- Dr Marilyn Clarke (first Aboriginal obstetrician and gynaecologist) had made a video where she delivered that information to a pregnant woman gently. What is important is the way it is done: it must be respectful and well delivered, with a positive upswing to make it empowering.
- CO monitors (Smokerlyzers®) are being used quite a bit, and are viewed as being effective in supporting conversations with women.

Incentives

- Incentives are probably the biggest influence in reducinglow birthweights relating to Indigenous women who smoke, in that they can triple quit rates and cessation can last up to three months post-partum.

Pre-existing vulnerabilities

- The current knowledge is that removal from country, exposure to missions/reserves and the stolen generations (parent/grandparents) have ongoing effects, and that colonisation has disrupted knowledge of Indigenous affiliation/identity. These things still have repercussions today, and this can be seen played out in the media, for good and for bad – mostly for bad. This impacts day-to-day life and weathers away on a person's quit attempt(s) and maintaining a quit attempt, whether that person is a woman of reproductive age or another part of the broader Indigenous population.
- Previous reviews had shown that women trying to quit may face different barriers at different levels, such as policy, family or personal experiences.
- Pre-existing vulnerabilities could affect women during pregnancy. It could be pre-existing mental illness, exacerbated historical trauma, housing factors, or any or all of the sociological things discussed earlier. There could be an increased risk of family violence. There are many reasons that childhood trauma could be triggered during pregnancy.
- So even if a women had been managing the effects of distress in the period before pregnancy, many of these things could be triggered at the time of pregnancy. There are also additional issues such as previous birth trauma, sleep deprivation and the like.

Taking a holistic approach

- Aboriginal women said they are interested in things such as mindfulness, yoga and alternative approaches to cessation. It had been shown with white populations in the United Kingdom that these things could help, but it may be that Aboriginal women are unable to afford those approaches.
- Women's family/community basis is their strength.
- Wrap-around care has been effective, as well as supporting participants to deal with other agencies, such as Centrelink and Housing, because institutional racism makes this difficult.

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Glossary

'ABCD' approach: a system in which all health care workers identify people who smoke and offer them support to quit by:

- **A**sking about their smoking status and documenting this;
- **B**rief intervention (advice) to stop smoking, regardless of the person's desire or motivation to quit;
- **C**essation support, including Behaviour Change Techniques and Nicotine Replacement Therapy;
- **D**iscussing family, social and cultural contexts of smoking.
  For hospitals, **C** and **D** are sometimes referred to as **C**ommunicating at **D**ischarge (recording action taken when patient is discharged).

Aboriginal Medical Service (AMS): a primary health care service which provide an alternative to mainstream health care providers for Indigenous Australians; may be a community-controlled health service or a State-funded service headed by Aboriginal medical and nursing staff.

Aboriginal Community Controlled Health Service: a primary health care service initiated and operated by a local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.

Aboriginal and/or Torres Strait Islander Health Worker: an Aboriginal and/or Torres Strait Islander person who has a minimum qualification (Cert III) within the fields of primary health care work or clinical practice; they provide a range of services for individuals, families and community groups including in specialty areas including drug and alcohol, mental health, diabetes and eye and ear health.

CO meter/CO monitor: a hand-held device which measures the level of expired carbon monoxide (CO) in the breath, which is an indirect measure of percent carboxyhaemoglobin (COHb) in the bloodstream -- COHb is formed when the CO in tobacco smoke out-competes oxygen to bind with haemoglobin (Hb) in the blood, reducing blood oxygen and resulting in negative impacts on the health of a pregnant woman and her unborn baby. (For information: https://www.health.nsw.gov.au/tobacco/Factsheets/expired-co-monitor.pdf)

NACCHO: National Aboriginal Community Controlled Health Organisation -- the national leadership body for Aboriginal and Torres Strait Islander health in Australia, representing 143 Aboriginal Community Controlled Health Organisations (ACCHOs).

Quitlines: a free, confidential telephone-based service that helps tobacco users stop smoking through a range of services including: information, advice, coaching and counselling; referrals; mailed materials; training to healthcare providers, Web-based services and, in some cases, free

medications such as nicotine replacement therapy (NRT). The Indigenous Quitline Enhancement Project provides accessible and appropriate services to Aboriginal and Torres Strait Islander people.

Tackling Indigenous Smoking program: national multi-component program designed to reduce tobacco use among Aboriginal and Torres Strait Islander peoples; funded and managed by the Australian Department of Health since 2010; emphasises evidence-based population health approaches to discourage the uptake of smoking and encourage quitting. (For information: https://www.health.gov.au/initiatives-and-programs/tackling-indigenous-smoking).

Mayi Kuwayu study: national longitudinal study based at the Australian National University which examines how Aboriginal and Torres Strait Islander wellbeing is linked to connection to country, cultural practices, spirituality and language;

Nicotine Replacement Therapy: products (gum, patches, sprays, inhalers, or lozenges) designed to assist in smoking cessation by releasing a lower, more slowly absorbed dose of nicotine compared to smoking, and without; NRT contains a controlled dose of nicotine without the other harmful chemicals in tobacco.

NHMRC: National Health and Medical Research Council -- an independent statutory agency within the portfolio of the Australian Government Minister for Health and Ageing, which is Australia's leading expert body, and leading national funder, for health and medical research.

Smokerlyzer®: a hand-held device which biochemically establishes a person's smoking status by measuring the amount of carbon monoxide (CO) on in exhaled breath; device can be used as a motivational visual aid to encourage smoking cessation and to measure progress during the cessation process.

TISRIC: Tackling Indigenous Smoking Research and Information Centre, developed and maintained by the National Best Practice Unit (NBPU)-TIS and hosted by Health*Info*Net, to provide online access to evidence based and best practice approaches to tobacco control for Aboriginal and Torres Strait Islander peoples.

Group reports

WORKSHOP QUESTIONS
Blue and Red Tables

1. In the current iteration of the Tackling Indigenous Smoking program, which ends on 1 July 2022, all available funding is allocated to: Regional Tobacco Control Grants (RTCG); Quitskills; Quitlines; the National Coordinator; iSISTAQUIT; the National Best Practice Unit; and evaluation.

   Within that context, what else could be done, or what could be done better, to support Indigenous pregnant women to not smoke? (eg, what could/should RTCGs or Quitlines do better or differently?).

2. Based on everything you know and have heard today, and in the current environment of what is and is not already happening, if you could choose one more thing to support Indigenous women to not smoke during pregnancy, what would it be; why; who would be responsible; and for how much?

3. You have 5 minutes to talk to the following people about their role in funding and championing Indigenous women to not smoke or to quit in pregnancy. What do you say to the:

   - Commonwealth Treasurer?
   - Northern Territory Chief Minister?
   - Mayor of the City of Melbourne?
   - Mayor of Torres Shire Council?
   - CEO of the NSW Royal Hospital for Women?
   - Northern Queensland Primary Health Network?

Optional if time permits

4. What areas require more research in relation to Indigenous pregnant women not smoking in pregnancy, if any, and why? Secondly, what is needed to ensure that the research is translated to implementation action?

WORKSHOP QUESTIONS
Green, Black and Yellow Tables

1. In the current iteration of the Tackling Indigenous Smoking program, which ends on 1 July 2022, all available funding is allocated to: Regional Tobacco Control Grants (RTCG); Quitskills; Quitlines; the National Coordinator; iSISTAQUIT; the National Best Practice Unit; and evaluation.

   Within that context, what else could be done, or what could be done better, to support Indigenous pregnant women to not smoke? (eg, what could/should RTCGs or Quitlines do better or differently?).

2. A) You are in charge of a major grants program to reduce the rates of Indigenous women smoking in pregnancy. What proportions of your grant funding would you allocate to supporting:
   - Indigenous girls younger than child bearing age to not smoke;
   - Indigenous girls/ women of child bearing age to not smoke;
   - Indigenous women who are pregnant to quit smoking.

   B) Please identify who are key players to address each of these activities, eg Commonwealth / State or Territory / community controlled health sector, and what strategies should be considered?

3. What are the most significant barriers to pregnant Indigenous women not smoking in the following locations?
   - Very Remote Australia
   - Remote Australia
   - Regional Australia
   - Urban Australia.

Optional if time permits

4. What areas require more research in relation to Indigenous pregnant women not smoking in pregnancy, if any, and why? Secondly, what is needed to ensure that the research is translated to implementation action?

Blue table

Question 1

- Build capacity of workforce. Increase Aboriginal and Torres Strait Islander staff
- More investment in scholarships for Aboriginal and Torres Strait Islander women to complete nursing/midwifery study
- Embedding education and importance of smoking cessation information in health professional education. Empower all health professionals to use this education in clinical practice. Prioritise smoking discussion as part of normal clinician/client interaction.
- Medicare item no. for smoking intervention? Specific to pregnancy.
- Encourage all health staff to have tobacco intervention training. Can this be built into funding requirements?
- Focus on research to ensure TIS interventions can be evidence-based.
- Build capacity of TIS teams to conduct research and monitoring (evaluation, manage/analyse data, build understanding)
- Re-evaluate what/how data is collected/used
- Outcomes based vs output based performance measures
- Region-specific Quitline counsellors
- More funding opportunities specific to smoking cessation
- Review of service provision and funding relationships

Question 2

- A shift in perception around why women are smoking – for everyone.
- Understanding the need for collective, community action on an 'individual behaviour'.
- SEWB programs – address drives for smoking.
- Continue to build evidence base
- Increase wrap-around services – clinical support
- Early pregnancy support workers – additional investment in young people and decreasing smoking commencement
- Making smoking cessation messaging relevant to interests of Aboriginal and Torres Strait Islander women
- Role models/ambassadors to use in TIS messaging – "Healthy, smoke-free women".

Question 3

- Treasurer – economic agreement
- NT Chief Minister – What are you doing? What is your role? (school attendance)
- Mayor of Melbourne – make local footy smoke free
- Smoke free as a precursor to entry into amateur sporting carnivals
- CEO hospital – Birthing on country services – holistic wrap-around care.

Red table

Question 1

Incentives for quitting

- Progression payments for not smoking
- Measured CO_2 readings
- Currently successful in NZ/UK.
- More capacity/resources to support women
- Contingency funding
- Partnerships – other services carry message
- Leverage on services visiting remote areas, depending on capacity/agreement

- Increase reach/availability of NRT and provide NRT to others in the home/family as support
- Some barriers – remote access/access through hospital pharmacy affects continuity of dispensing
- Educate – knowledge is power
- Strong messages embedded into community on hazards of smoking, in language where needed
- Benefits of quitting
- Look for ambassadors locally/role models
- Cultural/trauma informed care and training in all curriculum at universities.
- Clear messages to quit, not cut down
- Ongoing education for midwife/maternal health workers

Question 2

- Free/accessible NRT for household
- Increase capacity of workforce supported financially/emotionally/educationally to provide smoking cessation support in every community (benefits all health outcomes, not just TIS)
- All health workers and family support workers and GPs for implementation
- Compulsory SC training – responsibility with Department of Health/Government (policy, funding, direction)

Question 3

- Commonwealth Treasurer – see above
- CTG/self-determination in workforce
- Should tax from tobacco revenue be funnelled back into health/education?
- NT Minister – funding health services to target TIS/CTG impacts
- Mayors – smoke free designated areas locally
- Both – Health promotion
- Partnerships with TIS
- CEO – mandatory training – KPIs

Green table

Question 1

1. Trauma-based focus
2. Specific trauma-informed training/practice model relevant to roles in support – community – TIS/AQL/AHS.
3. Specifically targeted training
4. Consistent strategies and messaging
5. Holistic pregnancy care – link with existing
6. Update the sector nationwide on latest best practice outcomes
7. More direction to/creation of online support resources
8. More resources/service direction for how partners can help support in quitting (LGBTIQ too)
9. Clarification/difference between men's/women's business and responsibility

Question 2

A: 30% 30% 40%

B: ACCHOs, AHS, Co-ops – more community stories and social and cultural determinants (online, TV, social)

Question 3

Very remote – access less support	stress
Remote – distance/language	trauma

Regional – some cultural isolation – small towns — being pregnant can present a healing opportunity

Racism in regional transport

Urban – shame, good role models

Need more female quitting/pregnancy champions

Yellow table

Question 1

- Evaluation needs to enable sharing of stories (what has worked and what hasn't and why) and support services to adapt learnings to local context (ie, ensure evaluation identifies nuanced delivery of services in different contexts.
- Incorporate trauma-informed care in training of on-the-ground TIS workers/all health service staff/DoH staff
- Strengthen linkage between Indigenous health/smoking programs and all-of-health system/sectors (ie, Indigenous smoking is everyone's business)

Question 2

- Societal issue so shouldn't silo, especially due to diversity.
- Needs to be led by communities themselves.
- (Holistic) causes of smoking need inter-sectoral approach

Question 3

Very remote –	Lack of services, workforce, strong community norms
Remote –	Stress/cost of living/immediate priorities
Regional –	Economic exclusion/education/housing/
Urban –	Failed system

Black table

Question 1

1. Quitlines dispense NRT – once contact is made, follow-up can occur
2. Pharmacy – training to pharmacists – NRT
3. Community stores – do they stock NRT; what cost?
4. Research to gauge NRT use in communities – remote, rural and urban
5. Funding to ACCHOs for service provision vs state/territory
6. Yarning in groups to address smoking – MBS item, shared medical appointment
7. Community of practice

Question 2

Younger –	Depends on what's currently known
Child bearing –	What resources are available
Pregnant –	What program collaborations exist
	Community knowledge and readiness
	Broaden KSHs – education, housing, justice

Question 3

Very remote – skilled workforce normalisation, access to support and NRT

Remote – skilled workforce normalisation, access to support and NRT

Regional – normalisation, access to support and NRT

Urban – normalisation, access to support and NRT