Tobacco Control and Aboriginal and Torres Strait Islander Australians

Background

Smoking prevalence rates amongst Aboriginal and Torres Strait Islander people are significantly higher than in the overall Australian population. The most recent smoking prevalence figures for Aboriginal and Torres Strait Islander people indicated that 46% of those aged 18 years or over were current smokers compared to 21% of the non-Indigenous population (Australian Bureau of Statistics, 2006).

The high prevalence of cardiovascular, respiratory and other tobacco related diseases in Aboriginal and Torres Strait Islander people compared to other Australians has been clearly documented. Smoking is considered to be one of the major preventable risk factors for these chronic diseases and the significantly shorter life expectancy of Aboriginal and Torres Strait Islander people.

Tobacco control in Aboriginal and Torres Strait Islander people has not been addressed consistently due to other health-related problems being given higher priority. However, recently there has been increasing engagement between those working in tobacco control and Aboriginal and Torres Strait Islander communities and organisations recently. This is supported by Australian Government policies and programs, such as the National Tobacco Strategy 2004-2009 and the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009.

Recent Reviews of Indigenous Tobacco Control

1) Indigenous Australians and Tobacco-A Literature Review (Ivers, 2001 & Ivers, 2003)

This review highlighted the problem of tobacco use in Aboriginal and Torres Strait Islander Australians as described in the Background.

The review identified the lack of evidence of effective tobacco control activities in Indigenous communities. There were only four tobacco interventions in Indigenous communities that had been evaluated. Training health professionals in delivering brief intervention and a national anti-tobacco media campaign showed positive outcomes, although neither assessed tobacco smoking as an outcome. A trial of a CD-ROM on tobacco for use with Indigenous children and a pilot study of smoke-free workplaces were not able to show positive impacts.

The high quality evidence (mostly Level I) to support the effectiveness of interventions to decrease the prevalence of smoking in other populations was presented. This includes
brief interventions by health professionals, nicotine replacement therapy, bupropion, quit smoking courses and community interventions including legislation and media campaigns. Each of these interventions was rated for its applicability to Indigenous people. Ivers considered that the effectiveness of interventions such as media campaigns, quit smoking courses and quitlines would be enhanced if they were targeted at Indigenous people.

This review concluded that evidence of effectiveness in other populations should be used as a starting point. It was considered that most of the effective tobacco control strategies would be appropriate for use in Aboriginal and Torres Strait Islander communities.

2) NACCHO report –Tobacco Time for Action (Lindorff, 2002)

This report was a qualitative survey of Aboriginal and Torres Strait Islander communities and Aboriginal and Torres Strait Islander Community controlled health organisations. Overall the survey found good levels of knowledge of the health risks associated with smoking. However, there was concern that 29 % of male Aboriginal health workers (n=28) rated smoking up to 1 pack of cigarettes a day as safe.

Key issues highlighted:
- the need for national coordination of tobacco control in Aboriginal and Torres Strait Islander communities (acknowledging the contribution of the Centre for Excellence in Indigenous Tobacco Control)
- inadequate levels of funding/ lack of recurrent funding if tobacco control was to be a national health priority in Aboriginal and Torres Strait Islander communities
- the social context of smoking in contemporary Aboriginal and Torres Strait Islander communities- smoking was considered to be an important group activity that contributed to social cohesion.
- the need for community control and engagement with tobacco control initiatives given the social context of smoking.
- health issues were more important than cost to Aboriginal and Torres Strait Islander people who had quit smoking.

Suggested approach for tobacco control programs

- Comprehensive programs with long-term funding involving training for health workers, health promotion resources, availability of subsidized nicotine replacement therapy. Community based or outreach program would be preferable.
- Programs should be multidisciplinary and address issues of social and emotional wellbeing and stress.
- Health Promotion programs should include children.
- Pregnant women and families with young children were considered a key target for environmental tobacco smoke initiatives.
3) Galnya Angin – Partnerships in Indigenous Tobacco Control (Centre for Excellence in Indigenous Tobacco Control, 2005)

This report documented an audit of tobacco control programs and organisations around Australia. 90% of organisations (nine of ten) with Indigenous representation conducted Indigenous specific tobacco control programs compared to only 30% of organisations (eight of 27) without Indigenous representation. Only three state and territory governments funded Indigenous tobacco control projects. Many programs relied on yearly funding from community grants. Program evaluation was an important component of tobacco control research funding, however, only two of six national organisations funded Indigenous specific research.

Five states and territories were delivering (or had developed) training in tobacco control for Aboriginal health workers and other health professionals working with Indigenous people. The Aboriginal health worker national training package being developed includes tobacco cessation counselling in the health promotion stream.

The audit identified existing programs that demonstrated how tobacco control could be implemented with Aboriginal and Torres Strait Islander people. The Koori Tobacco Cessation project is an example of a comprehensive anti-tobacco program at two Aboriginal Health Services in NSW. It involved a survey and training for Aboriginal health workers and the development of a quit smoking program with nicotine replacement therapy. The initial three month evaluation reported that seven of 115 participants reported abstinence after the program. Importantly the program has ongoing funding from the Office for Aboriginal and Torres Strait Islander Health.

A more comprehensive approach is being developed in far north Queensland with interventions to include event support program, school based tobacco education, a smoke-free policy guide for organisations, tobacco brief intervention in health services, quit support groups and monitoring of Queensland tobacco laws in communities. This is being implemented in eight Indigenous communities as a randomised controlled trial over three years.

An interesting youth project was conducted with Nunga teenagers in Adelaide. This involved close collaboration between the children and health workers in the development of a video for use with high school students. The video is being distributed to teachers in schools with higher numbers of Aboriginal students in South Australia. The children involved greatly improved their knowledge of the effects of tobacco and developed useful media production skills.

A partnership between Aboriginal organisations and an area health service in central NSW involved the development of local resources and training for Aboriginal health workers about the effects of environmental tobacco smoke. There were also radio advertisements with local identities and anti-smoking posters designed by a local artist on community buses. Childcare centres were involved with children receiving hats and bibs with messages about environmental tobacco smoke. An evaluation involved approaching
a sample of local Aboriginal people on the street. It was found that 13% recalled the radio advertisement and 5% recalled the bus posters.

**Recommendations of the audit**
- Increase Indigenous representation in tobacco control organisations.
- States and Territories should establish a process to ensure sustainable funding of interventions.
- Ensure tobacco control training for Aboriginal health workers is accredited.
- Make professional development training in Indigenous tobacco control available.

**Workshop on reducing smoking in Aboriginal and Torres Strait Islander People, June, 2005**

This workshop convened by DoHA involved jurisdictional representatives from NSW, Qld, NT, SA and other stakeholders (researchers, NGO’s etc).

The workshop produced 10 recommendations-

1. Implement and phase-in a number of specific initiatives aimed at establishing a strong policy and legislative foundation prior to the development of a media campaign.
2. Coordinate the collection and maintenance of smoking control materials in national repositories with long-term funding to ensure availability over an extended period of time.
3. Establish a working group under the auspices of the National Health and Medical Research Council, to assess guidelines for pharmacotherapy for smoking cessation in pregnancy and in adolescents.
4. Develop an appropriate infrastructure to ensure adequate support for people wanting to cease smoking.
5. Develop a coordinated approach for training tobacco intervention professionals to work in Aboriginal and Torres Strait Islander communities. This includes building a sustainable network of Indigenous trainers and delivery mechanisms. Training should be consistent, sustained, effective and evidence-based.
6. Promote consistent and prominent research results, including program evaluation outcomes, of the effects of tobacco use on the health of Aboriginal and Torres Strait Islander people.
7. Develop cost-effective ways of regular and more frequent monitoring Aboriginal and Torres Strait Islander smoking incidence.
8. Develop and implement an appropriate research program, including market research, which should be fully evaluated.
9. Following the research program, develop a national campaign specifically aimed at encouraging Aboriginal and Torres Strait Islander people to cease smoking. The campaign would be multi-level and focused on Indigenous communities, with clear badging, and with specific elements that were consistent both locally and nationally.
10. Undertake research on what smoking cessation interventions are appropriate for adolescents, and whether recommendations in relation to adults, such as subsidised or free replacement therapy, should be available in some structured way to adolescents as well.

These recommendations represent a long-term comprehensive approach to Indigenous tobacco control. The consensus of the participants was that Recommendations 4 and 5 should have the highest priority. It was considered important that there was a focus on nationally consistent training and support for tobacco control for health professionals working with Indigenous communities. This support should include smoking cessation programs for all those who work in Indigenous health.

**Other evidence**

Chapman (1993) highlighted the importance of a sustained and multi-pronged intervention approach to changing health risk behaviours. The effect of any single program on population-wide behaviour such as smoking will be limited.

Ivers, Farrington et al (2003) conducted a non-randomised trial (Level III-2) of the use of free nicotine patches in three remote Indigenous communities in the NT. Participants chose either nicotine replacement therapy (NRT) plus a brief intervention or brief intervention only. 15% of the NRT group reported they had quit at 6 months compared to 1% of the brief intervention only group. This is lower than the quit rates achieved with NRT in other populations. However, 34 of 40 (90%) in the NRT group had used less than 10% of the recommended course of patches. The recommendation of this study is that there are small percentage of Indigenous smokers who would benefit from using free NRT.

Alford (2004) suggested that a broader focus on a healthy lifestyle approach may be more appropriate than a single focus on tobacco cessation. It was considered that such a holistic approach would be more likely to build community skills and resilience.

A multi-component tobacco intervention (Ivers et al, 2006) was conducted in six remote Aboriginal communities (3 intervention and 3 control communities) in the NT. The intervention included a combination of sports sponsorship, health promotion campaigns, training health professionals in the delivery of smoking cessation advice, school education about tobacco and policy on smoke-free public places. The impact of the intervention was an increase in knowledge about the effects of tobacco and readiness to quit. In one community there was a significant decrease in tobacco consumption measured by tobacco sales, with non-significant decreases in the other two communities. However, overall there was no significant change in tobacco use in the communities after 12 months.

A survey of women attending an urban Indigenous health service (Heath et al, 2006) suggested that female smokers of child-bearing age were more likely to be contemplating
or actively attempting to quit smoking than other smokers. Thus, this group may be more motivated to quit smoking due to increased understanding of the effect of smoking on their children and pregnancies.

**Policy Options**

1. Target specific communities/regions with programs that provide support and training for local staff to provide brief tobacco cessation interventions and supportive quit programs including NRT.

2. Target specific communities/regions with programs that provide more intensive interventions similar to the approach in North Queensland or by Ivers (2006) described above.

3. Develop or adapt resources to enhance community understanding of the effects of tobacco effects including environmental tobacco smoke with a priority on young people including primary school aged children, pregnant women and families with young children.

4. Media campaigns that involve local identities/locally produced artwork to promote tobacco cessation, and the effects of environmental tobacco smoke.

5. Funding for CEITC to audit recent and future evaluations of identified tobacco control initiatives.

Existing evidence suggests that appropriate impacts of programs include increased knowledge, increased readiness to quit smoking and increased number of attempts to quit smoking. It is unrealistic to expect major decreases in smoking prevalence as short-term outcomes of most smoking interventions. Smoking gradually declines as a result of the combined effect of increasing tobacco control activities including smoking cessation.

It is clear that there needs to be an approach which supports ongoing programs that develop as a result of successful initiatives. Successful programs have resulted from harnessing community support for tobacco control initiatives. DoHA and OATSIH funding should initially be directed towards programs that demonstrate this community engagement. The three reports describe increasing awareness of the effects of tobacco and desire to engage with tobacco cessation in Indigenous communities. Thus this is likely to result in increasing competition for existing funds and/or the need to increase funding for tobacco control.
References


