What ngidhi yinaaru nhal yayi (this woman told me) about smoking during pregnancy

Reducing smoking during pregnancy among Aboriginal and Torres Strait Islander women is a national priority, but there has been little exploration of their experiences and desired support

When conducting research for my PhD, I sat in the home of a local Aboriginal mother and explained the research process. The mother looked at me and said, “So what, you’re gonna go tell them doctors and mob what I say? That’s deadly! Yeah go tell them my story”. This article aims to uphold my responsibility to privilege Aboriginal women’s voices and direct them to doctors and health practitioners who are crucial to improving our health outcomes.

Here, I offer a critical literature review and share my gulbarra (understanding) achieved through giilang (story), with a purposeful incorporation of Aboriginal and Torres Strait Islander women’s voices as sources of knowledge and reference in this discussion. These voices and reflections are drawn from several publications arising from my PhD research. I want to unite what the literature has informed us about smoking during pregnancy (western knowledge) with Aboriginal and Torres Strait Islander women’s lived experiences (Indigenous knowledge).

This is what ngidhi yinaaru nhal yayi (this woman told me) about smoking during pregnancy.

Smoking during pregnancy

Let me make it clear right from the start. Aboriginal and Torres Strait Islander women are quitting smoking during pregnancy and care deeply about the health and wellbeing of their babies.

While there has been an acknowledgement that the proportion of Aboriginal and Torres Strait Islander women smoking during pregnancy has declined, reports more frequently measure and monitor smoking rates during pregnancy and compare these to non-Aboriginal pregnant women. For example, 43% of Aboriginal and Torres Strait Islander mothers reported smoking during pregnancy compared with 12% of non-Aboriginal Australians.[1] However, two things happen when we measure and monitor in this way. First, this approach assumes that Aboriginal and Torres Strait Islander communities are homogenous. We are not; we are extremely diverse in cultures, customs and experiences. Second, it creates the impression that smoking during pregnancy is the issue and that Aboriginal and Torres Strait Islander women present a deficit. This is detrimental because our lived experiences are not the same, nor have they been for generations. Colonisation, dispossession onto missions and reserves, the removal of children, unpaid labour, and refusal of the equal right to education, employment and health care over generations has led to a gap in social and cultural determinants of health.[2] This gap is founded on racist policies that positioned Aboriginal and Torres

Strait Islander people as inferior to other Australians.[3] The gap and deficit mentality follow us today and can be found in countless government reports on Aboriginal and Torres Strait Islander disadvantage. When we don’t contextualise in terms of colonisation and the resulting social and cultural determinants of health, and fail to privilege Indigenous knowledges, we cannot truthfully address any area of health inequity. While it has been identified that Aboriginal and Torres Strait Islander women experience multiple barriers to quitting smoking during pregnancy, little work has been conducted to ask Aboriginal and Torres Strait Islander mothers about their experiences of quitting and what they believe could support them to become smoke-free during pregnancy.

Quit attempts are being made

“A lot of people are more wanting to give up smoking but not having the information”[4]

Across New South Wales, Queensland and South Australia, Aboriginal and Torres Strait Islander women often shared a desire to quit smoking and reported making several quit attempts during pregnancy. Aboriginal and Torres Strait Islander people in general are more likely than other Australians to make a quit attempt but are less likely to succeed,[5] which raises the question, “what is happening when Aboriginal and Torres Strait Islander people make a quit attempt?”. Stories of quit attempts lasting at least 24 hours but often less than a full week were often shared. If we listen to Aboriginal and Torres Strait Islander women, we can hear that motivation to quit is high.[6]

The problem with reduction

“I think doctors need to stop telling people to cut down”[7]

Aboriginal and Torres Strait Islander women across communities yarra (say) reduction in cigarette consumption was suggested by health providers. This

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tendency to advise reduction in tobacco consumption rather than recommending to women that they quit completely has been previously reported.[8] Advising women to cut down cigarette consumption during pregnancy when they are unable to quit smoking is still being promoted across the country in clinical practice guidelines.[9] If we only ever report quit rates, yet Aboriginal and Torres Strait Islander women are only being advised to reduce, how will we ever achieve the lower smoking rates of the non-Aboriginal population?

"I was doing 10 to 15 cigarettes down to 1 to 2 cigarettes a day. I think that is a big, a big reduce"[4]

Aboriginal and Torres Strait Islander women are proud of their success in reducing cigarette consumption. Why shouldn't they be? Women are successfully following the advice of their health providers. The only randomised controlled trial conducted with Aboriginal and Torres Strait Islander women during pregnancy reported that 70% of women who were advised to quit smoking by their health provider made a quit attempt.[10] A recent survey of Aboriginal women who smoke revealed positive attitudes to advice and support from doctors (61%) and midwives (62%).[11] However, health provider support for planned smoking cessation is reported to be weak.[12]

Pregnancy is a life stage during which there are multiple opportunities to offer cessation support to mothers. Each opportunity should repeat the unambiguous message that the best thing for mothers' and babies' health is to quit smoking completely, explain that they are not alone, and offer cessation support. We therefore hit a dilemma: what cessation support should even be offered? Systematic reviews on Aboriginal tobacco control have concluded that there is limited evidence of effective programs for Aboriginal and Torres Strait Islander people in general[13] as well as during pregnancy.[14]

Community led initiatives are key to successful outcomes

"Everybody looks up to their Elders and stuff, as you know, maybe just a yarn or a get-together to discuss smoking could help"[4]

Aboriginal women in NSW yarra (speak) of their desire to receive support from their community and Elders. Elders understand community dynamics and the context of women's lives in a way that (non-Aboriginal) health providers cannot. But what would this look like in a health care setting? How can we ensure that consistent messages are offered throughout community to support being smoke-free?

"I was just thinking that these products, I wouldn't use them. I'd think about the side effects"[7]

Aboriginal and Torres Strait Islander pregnant women yarra (speak) of their desire to use non-pharmacological and stress management approaches for smoking cessation.[11] The use of alternative approaches (such as yoga and mindfulness) has been reported in white populations with high socio-economic status; however, the effectiveness of some of these approaches is as yet uncertain.[15,16] Aboriginal and Torres Strait Islander health does not focus on the individual, but rather the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential.[17] It is therefore important that any support program to address health inequities also focuses on community engagement and empowerment. Aboriginal and Torres Strait Islander women want control and ownership of the quitting process and should be empowered to quit smoking.

If we truly want to support Aboriginal and Torres Strait Islander women to quit smoking during pregnancy, we need to privilege their voices in the process of developing effective and meaningful supports.

I have been privileged to hear Aboriginal and Torres Strait Islander women from Worimi, Awabakal, Biripi, Goomeroi/Kamilaroi/Gamilaraay and Boandik communities share their stories with me about smoking and becoming pregnant. I acknowledge my responsibility to pass on these stories to inform the conversations about smoking during pregnancy among Aboriginal and Torres Strait Islander women. What ngidhi yinaaru nhal yayi (this woman told me) about smoking during pregnancy changes the conversation about this national priority. What is now owed to these women is more action. Action by health professionals to advise Aboriginal and Torres Strait Islander women to quit smoking during pregnancy, and action to find meaningful support strategies to achieve abstinence. Developing appropriate support strategies for Aboriginal and Torres Strait Islander people should draw on traditional and contemporary knowledges, values and practices.

Over the next 4 years, with the support of a National Health and Medical Research Council Early Career Fellowship and a National Heart Foundation Australian Aboriginal and Torres Strait Islander Award, I will commence this exploratory work in partnership with NSW Aboriginal communities through the Which Way? project. This project will partner with four communities to explore what Aboriginal and Torres Strait Islander women desire to support smoking cessation and develop an Indigenous led evidence base on smoking cessation. This work will build on the request for non-pharmacological support and align with a holistic definition of health and wellbeing. It is my belief that by developing, implementing and evaluating a support strategy that Aboriginal and Torres Strait Islander women desire, our communities can achieve smoking abstinence.

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