Goreen Narrkwarren Ngrn-toura – Healthy Family Air

Reducing Smoking Amongst Pregnant Aboriginal Women in Victoria: An Holistic Approach

Final report

VACCHO

From: Victorian Aboriginal Community Controlled Health Organisation

To: Department of Health

Prevention and Population Health Branch

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Note on terminology:

VACCHO acknowledges that although the terms 'Aboriginal' and 'Indigenous' have been used throughout this document, we are referring to both Aboriginal and Torres Strait Islander people in Victoria.

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CONTENTS

1. EXECUTIVE SUMMARY

ISSUE

Smoking in Aboriginal communities is a major issue with rates around 50% nationally [i]. The effect of smoking in the Aboriginal community is huge with smoking causing 20% of preventable deaths and responsible for 12.1% of the burden of disease [ii]. Smoking doesn't just impact on health but also adds to peoples' financial stress [iii]. Smoking in pregnancy is considered a particularly pertinent time for intervention with smoking effecting birth and long-term outcomes for both the child and the mother [iv]. For these reasons the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) applied for funds from the Victorian Department of Health, Prevention and Population Health Branch to undertake the Goreen Narrkwarren Ngrn-toura – Healthy Family Air action research project which was implemented at three VACCHO member sites. The Victorian Aboriginal Controlled Health Organisation (VACCHO is the state peak body for Aboriginal health with a membership of twenty-four Victorian Aboriginal Community Controlled Health Services. It's role is to provide support to the membership and advocate on their behalf.

FINDINGS

1. Literature review

Results of the literature review recommended focussing on organisational development, training and community development to address pregnancy and smoking cessation in Aboriginal communities [v].

2. Organisational development

All three research sites reported strengthening of smoke free policies in terms of either content or implementation. Signage developed by the project using social marketing theory was particularly cited as having been helpful in redirecting smokers to appropriate smoking areas and raising awareness about collective impacts of smoking. Notably issues of smoking cessation signage being defaced and removed had ceased with installation of the new signage. This signage focussed on community responsibility rather than individual responsibility in keeping with Aboriginal collective practices. In post intervention interviews with service staff and parents both groups commented on the signage as having impact in redirected smokers. The presence of Tobacco Workers also acted as a reminder to staff and clients that they should be abiding by the signage and smoke free policy. These workers used strategies, such as humour, to non-confrontationally redirect smokers. Interviews with staff and parents indicated support for smoke free sites with a small number of

smokers concerned about inconvenience and a small number of staff concerned about the logistics of redirecting smokers. One small rural site was auspiced by a larger service (that also auspiced two other services) and policy redevelopment took longer at this site as it inevitably involved negotiation across more than two organisations.

3. Training

The project provided one day Quit training at all sites. Post intervention interviews with staff found that while the training was perceived as useful and informative it could have been strengthened by having more application to the Aboriginal Community Controlled Health sector and the experience of workers in these services. Some staff had attended two day quit facilitation training in Melbourne and one rural worker commented that their attendance at this training had been hampered due to priority of clinical service and client responsibilities. Some workers wanted greater access to more specific brief intervention training to build their client communication skills and some staff had attended training in New South Wales to obtain these skills. Organisation wide access to training, experienced smoking cessation personnel and team work was cited by interviewed staff as important to ensuring consistent communication with clients about smoking cessation.

4. Community development

Environmental scans conducted at the beginning of the research project identified a number of barriers to smoking cessation support and smoke free policy implementation. One issue of concern was that some health professionals expressed scepticism about whether Aboriginal people could give up smoking. Their experience was they had witnessed long term quitting rarely in clients they saw and interpreted this as a disincentive to discuss smoking with clients, as the perception was that many were not ready to cease smoking. Using social marketing theory a series of posters were developed with stories of Victorian Aboriginal people who had made quit attempts or who had successfully ceased smoking long term. In keeping with findings of the literature review pregnant women were included alongside other community members to prevent stigmatisation. An additional benefit of these posters was that staff reported using the stories to assist explain quitting processes with clients. Interviews with parents found that some parents had read the stories while others had not.

A quitting kit was developed to assist staff talk to clients about quitting. In post intervention staff interviews it was mentioned that all kits had been distributed but feedback about usefulness was absent. Ideally discussion with recipients of kits would have provided valuable information, however, this was outside the scope resources available for the project. A combination of smoking cessation activities was perceived by staff in post

intervention interviews to strengthen smoke-free polices and smoking cessation activities. Post intervention interviews with parents identified that there was some confusion about smoking cessation support services available to them. Barriers to smoking cessation were commonly voiced by staff and parents as stress, anxiety, boredom, thinking about smoking cessation during pregnancy and consistent exposure to others smoking. Diversionary activities, such as, employment and shopping were cited as methods for cutting down smoking.

5. Recommendations

a) Smoking cessation training for health professionals be strengthened through inclusion of smoking cessation experiences of Aboriginal people
b) Improved access to brief intervention and quit facilitator training for staff at Aboriginal Community Controlled Health Organisations
c) Social marketing techniques are useful for addressing localised and site specific barriers to smoke free policy implementation
d) Community and family responsibility are important messages in smoke-free policy implementation
e) Provision of smoking cessation counselling and products strengthened smoking cessation messages and smoke-free policies

6. Future Research

a) Stress and smoking

Aboriginal and Torres Strait Islander adults are twice as likely as non-Aboriginal and Torres Strait Islander adults to report high/very high levels of psychological distress[vi] . Consistent with other evidence, this research found that stress was perceived as a barrier associated with smoking cessation [vii]. Gaps in knowledge particularly exist about how to support Aboriginal people to cease smoking who were experience stress and how health workers can perceive smoking cessation support as not further burdening clients.

b) Smoking cessation systems

The project also identified that little was understood in terms of systems approaches to delivery of smoking cessation support. How can an Aboriginal Community Controlled Health Organisation develop good practice smoking cessation implementation that is inclusive of the diversity of teams and functions of the organisation? For instance, organisations may have child care centres, cultural centres, family services etc. Tobacco cessation responsibility, however, often sits within the primary health care function of the organisation and maintaining consistent referral opportunities and access to smoking cessation support across the organisation can provide a challenge.

c) Aboriginal women who maintain smoking during pregnancy

In interviews with pregnant women some mentioned smoking more during pregnancy. The women perceived a heightened awareness of a need to cease smoking because of their pregnancy, which in turn led them to increased stress or guilt. Women believed this situation led them to thinking about smoking more and then smoking more because of this. Pregnant women also mentioned distractions as helping to cut down on smoking, such as, employment or shopping. Little is known about habits of Aboriginal women who continue to smoke through their pregnancy. Understanding more about Aboriginal pregnant women who smoke may provide better information and evidence for supporting these women to address their smoking.

BACKGROUND AND CONTEXT

VACCHO is the peak body representing 24 Aboriginal Community Controlled Health organisations in Victoria. VACCHO's role is to build the capacity of its membership and to advocate for issues on their behalf. As the peak Aboriginal health body in Victoria VACCHO is committed to taking a lead on the issue of tobacco cessation. In 2008 VACCHO undertook the Goreen Narrkwarren Ngrn-toura – Health Family Air action research project. Participating in the project were three Victorian Aboriginal Community Controlled Health Organisations (ACCHO) and a pilot site (VACCHO).

The aims of the research were to:

- Develop, implement and evaluate a multifaceted holistic intervention aimed to reduce smoking amongst Aboriginal pregnant women and carers of young children.
- Increase the understanding and knowledge of how to best support Aboriginal communities to reduce smoking amongst pregnant women and carers of young children.

APPROACH

Action research methods were considered appropriate for this project for many reasons. A critique of research conducted with Australian Aboriginal peoples is that health and social problems are described with little focus on improvement [viii, ix]. For this reason participatory action research designs have been recommended, whereby, solutions are sought for identified health issues [x]. These research designs have cycles of planning, action, observation and reflection embedded within allowing refinement of solutions [xi, xii]. Both qualitative and quantitative data can inform action research cycles [xiii].

In Australia, Aboriginal researchers have argued that research must centralise on core structures of Aboriginal ontology (ways of being) as a

framework [xiv]. Research methods require consideration of Indigenous knowledge and practice to enable reassertion of this in a colonised world which may create disorder and chaos of the academies [xv]. Use of oral communication research methods such as: narration, contemplative listening, yarning, painting, installation, photography, dancing, oral recordings and filming peoples' stories or yarns, are practices that Aboriginal academics have developed and explored [xvi, xvii, xviii, xix]. It was anticipated that these types of methods would be required in development of the project.

METHODS

There were seven main components to the project as outlined below which created cycles of action to inform changes at Aboriginal Community Controlled Health Organisations to improve smoking cessation implementation for Aboriginal pregnant women. These are further detailed in section 4 of this report.

I. Establishment of an advisory committee
II. Literature review
III. Ethics approval
IV. Piloting of environmental scans at VACCHO
V. Selection of study sites
VI. Environmental scans to identify the main issues
VII. Development of responses to the identified issues
VIII. Post Intervention Interviews and focus groups

2. CONTEXT

Smoking in Aboriginal communities is a major issue with rates around 50% nationally [i]. The effect of smoking in the Aboriginal community is considerable with smoking causing 20% of preventable deaths and responsible for 12.1% of the burden of disease [ii]. Smoking doesn't just impact on health but also adds to peoples' financial stress [iii]. Smoking in pregnancy is considered a particularly pertinent time for intervention with smoking effecting birth and long-term outcomes for both the child and the mother [xx]. For these reasons the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) applied for funds from the Victorian Department of Health, Prevention and Population Health Branch to undertake the Goreen Narrkwarren Ngrn-toura – Healthy Family Air action research project. Three Victorian Aboriginal Community Controlled health Organisations (ACCHO) and a pilot site (VACCHO) participated in the project.

The aims of the research were to:

- Develop, implement and evaluate a multifaceted holistic intervention aimed to reduce smoking amongst Aboriginal pregnant women and carers of young children.
- Increase the understanding and knowledge of how to best support Aboriginal communities to reduce smoking amongst pregnant women and carers of young children.

3. IMPLICATIONS

The research project identified several areas of recommendation and future research which are outlined below.

Organisational development

a) Social marketing techniques were useful for addressing barriers to smoke free policy implementation
b) Develop good practice implementation in managing stress, anxiety and depression and collective smoking for Aboriginal and Torres Strait Islander people wishing to undertake smoking cessation.
c) Develop good practice implementation in systems (including teams and across organisation co-ordination) for delivering smoking cessation support to clients at diverse Aboriginal Community Controlled Health Organisations

Training

a) Smoking cessation training for health professionals be strengthened through inclusion of experiences of Aboriginal people
b) Improved access to brief intervention and quit facilitator training for staff at Aboriginal Community Controlled Health Organisations

Community development

a) Community and family responsibility were important messages in smoke-free policy implementation
b) Combinations of smoking activities strengthened smoking cessation messages and smoke-free policies
c) What are the smoking patterns of Aboriginal pregnant women who smoke?

4. APPROACH

RESEARCH DESIGN

The research questions for the project were:

- What interventions are required to support Aboriginal and Torres Strait Islander women to cease smoking?
- How can interventions to support Aboriginal and Torres Strait Islander women to cease smoking be implemented in Aboriginal Community Controlled Health Organisations?
- What are the impacts from these interventions?

There were seven main components to the project and these are discussed in more detail below.

I. Establishment of an advisory committee
II. Literature review
III. Ethics approval
IV. Piloting of environmental scans at VACCHO
V. Selection of study sites
VI. Environmental scans to identify the main issues
VII. Development of responses to the identified issues
VIII. Interviews and focus groups

METHODS

I. Establishment of an advisory committee

An advisory committee was established consisting of the following membership representation: VACCHO, Quit Victoria, Monash University, Victoria University, Menzies, Department of Health, Royal Women's Hospital Koorie Women's Business Unit and The Women's Drug and Alcohol Service. The Advisory group met regularly every six to eight weeks over the period of the project. Once sites had been selected for the project, membership of the advisory committee was extended to representatives from each site. These included Koorie Maternity Services workers (midwives and Aboriginal Health Workers) and Tobacco Workers.

II. Literature review

A literature review was commissioned through the Centre for Excellence in Indigenous Tobacco Control (CEITC)[V]. The methods used and findings of the review were utilised to inform the research project, in particular, to ensure firstly that Aboriginal Community Controlled Organisations were providing supportive environments for smoking cessation and to include pregnant women as part of smoking cessation initiatives and to not stigmatize pregnant women by singling them out for smoking cessation initiatives.

III. Ethics approval

Ethics application was submitted to the Monash Human Research Ethics Committee and approved.

IV. Piloting of environmental scans at VACCHO and development of Smoke-free policy and an implementation plan.

AS VACCHO is the peak body in Aboriginal health in Victoria it was considered important to ensure that VACCHO was following best practice in smoke free policy. Tools developed for the project, such as, environmental scans and methods for improving implementation of smoke free policies were piloted at VACCHO.

The environmental scan involved (i) documenting VACCHO's current practices in regard to smoking and smoking cessation, (ii) comparing VACCHO's current smoke free policy with recommended practice and (iii) an electronic survey of VACCHO staff about smoking activity and their smoke free policy knowledge. Environmental scan questions can be found in Appendix One and summary of recommended policy practice can be found in Appendix Two. Findings were presented at VACCHO staff meetings and staff members were asked to suggest ways of improving smoke free policy and its implementation, which were followed up by the research team.

V. Selection of study sites

The project resources allowed for involvement of three VACCHO member services to participate in the research. The research team worked in conjunction with the Koorie Maternity Services Team at VACCHO to develop an expression of interest with associated selection criteria for VACCHO member services to make application to become a site in the project (these selection criteria are available in Appendix Three). The expression of interest was disseminated to all VACCHO members and a total of ten applications were received. The applications were reviewed by the research team and a diversity of sites was selected to maximise understandings across different settings. The three sites selected represented a small rural, large rural and metropolitan site in order for the project to ascertain issues and opportunities that could arise for a diverse range of services.

VI. Environmental scans to identify the main issues and opportunities

The research team attended each of the three sites to introduce the project and plan an initial environmental scan. The scan included a set of questions based on recommended smoke free policy activities (which can be found in Appendix One), a hand drawn map to assist document

environmental scan questions (Appendix Four) and a staff survey (Appendix Five). Scans were conducted in conjunction with senior management and Koorie Maternity Service workers at each site. Employees of services were surveyed about their smoking and perceptions about the organisation's smoke free policy. These surveys were in electronic and paper based formats, this flexibility was required as some staff did not have access to email or computer, for instance, maintenance workers, gardeners and cleaners. Individual service results were collated and provided to health service staff for discussion.

VII. Development of responses to the identified issues

The results of the literature review [v] and findings of the environmental scans informed interventions at each service and these are outlined below.

Organisational development

The researchers worked with each service to redraft smoke free policies and involve staff in their development. Each policy had site specific related information included, for instance, appropriate distance for smokers to be away from the organisation's buildings to smoke, influenced by geography, such as, size of organisational grounds and location of busy roads. These policies were then submitted to each organisation's board for approval.

Training

The researchers worked with Quit Victoria and the advisory committee to review existing Quit Victoria one day training content aimed at employees of Aboriginal organisations. Content was reviewed and altered by the Advisory Committee this included consideration of feedback from staff surveys and environmental scans. In particular, information about pregnant women and smoking cessation was included. The researchers then coordinated training at each of the sites.

Community Development

The researchers, in conjunction with staff at the three sites, used social marketing theory to develop responses to support and reinforce smoke free policies and information contained in the staff training. Evidence from the literature review suggested this was an important step in providing localised smoke free leadership [v].

Results of staff surveys and environmental scans were made available to staff members at each site in feedback sessions. The aim was to create discussion, raise awareness about the organisations smoking policies and provide avenue to have input into smoke free policy implementation. The sessions occurred through posting of findings in staff kitchen areas,

individual discussions with staff members, emails to staff members and discussion at staff meetings.

This information, was used to assist inform social marketing approaches to addressing barriers to implementation of smoking policies. Social marketing was developed as a theory in 1971 and defined as programs aiming to influence the social acceptability of ideas [xxi]. Social marketing involves several steps including formative research and program planning which includes identification of the product, price, place and promotion [xxii].

VIII. Interviews and focus groups

Researchers worked with staff members at each site to conduct interviews or focus groups to discuss smoking at the services (questions can be found in Appendix Six and Seven). These were conducted in September 2011. Researchers sought advice from the staff at services about the best way to proceed to conduct focus groups and interviews. Each site requested varying methods that suited their time, space and community.

- Site one originally wanted to have interviews with staff and a focus groups with Aboriginal mothers. However, on the day of the focus group some staff felt that it would be confronting for mothers to talk about smoking during their pregnancy and decided to cancel the interviews. Mothers were not asked if they would feel uncomfortable rather it was a staff perception that this was a problem.
- Site two, involved interviews at two locations. This was because the service was auspice by another larger service and workplace policies were developed at the larger service. At the first and second location four staff interviews were held with a total eight interviews. The focus group with Aboriginal mothers included six mothers and was held at the larger service.
- Site three, involved two staff interviews. Staff requested that researchers then provide an information session afterward to assist facilitate a community discussion about smoking. This was seen as preferable to talking to mothers about smoking as a community and family focussed approach was preferred.

Prior to interviews or focus groups commencing an information session was held regarding participation in the interviews and focus groups and people were provided an opportunity to ask questions. People wishing to participate were then asked to complete a consent form. Interviews and focus groups were tape recorded, transcribed and analysis was conducted for themes. Staff interviews were analysed separately to the focus group with mothers.

5. RESULTS

I. Literature review

The literature review directed the parameters of the environmental scan and the consequent initiatives developed for the VACCHO project. Findings of the literature review recommended that key tobacco control activities with pregnant Indigenous women be inclusive of:

Training

- Training provided to Aboriginal Health Workers to improve their confidence and capacity to deliver individual clinic-based interventions, and community-based tobacco control activities (as described in the recommendations below).

Organisational development

- Interventions provided in the primary health care setting to advise and support the women to quit. Such interventions should be integrated into existing clinical care practices, and may include: brief interventions, behavioural counselling, or motivational interviewing; NRT provision, where deemed safe; and delivering Quit courses.
- The development of policies and protocols in Aboriginal organisations (such as smoke-free workplaces and cars) to provide supportive environments in which to deliver smoking cessation programs.
- Strategies for Aboriginal Health Workers to support and encourage them to quit smoking themselves, including the development of supportive work environments.

Community development

- Strategies that de-normalise smoking in Aboriginal communities, and provide skills and supportive environments for pregnant women to quit.
- Multi-component family- and community-focused programs that take a multi-pronged and holistic approach to tobacco control, and incorporate components that target families and communities, not just pregnant women.
- Implement programs more broadly that address social disadvantage.

II. Pilot of tools at VACCHO

The piloting of tools at VACCHO, in particular, provided the researchers with information about the anticipated time and resource required to work with the three selected sites. It also allowed researchers to understand some of the complexities of smoke free policy implementation within an Aboriginal Community Controlled Organisation and consider avenues for problem solving solutions.

The process identified that VACCHO's smoke free policies needed to be strengthened, staff members were not clear about how to implement VACCHO's smoke-free policy and that a number of smokers at VACCHO were contemplating smoking cessation attempts. The environmental scan identified that signage about smoke free areas needed to be installed and that there were cigarette butts located close to the front and rear exit areas indicating smoking activity close to building entry and exit points, contrary to the existing policy.

This information in conjunction with recommended smoke free workplace policies were used to develop and implement a VACCHO smoke-free policy. Yarning sessions were held to involve and educate staff in the policy development and implementation. This involved inviting staff via email to a yarn in the main meeting room to discuss the survey results and ask people about their thoughts and concerns about smoking at the organisation, the findings of this project have been previously published in the Health Policy Journal [xxiii].

III. Environmental scans

Collated environmental scans from the three sites revealed several themes, which are summarised and outlined below.

Organisational development

- smoke free policies did not include all recommended elements for and needed review (see Appendix Two)
- existing smoke free policies were not being fully implemented
- smokers and butts were highly visible around buildings
- smoke free signage was poorly (if at all) visible and at time defaced or removed

Training

- few staff had undertaken training to support smoking cessation attempts and there were no plans in place for training provision
- staff training in smoking cessation was desired

Community development

- there was a perceived lack of resources for talking to clients about their smoking
- there was a belief that Aboriginal people did not desire or attempt to cease smoking
- a desire for Aboriginal organisations to show leadership in implementing smoke free policies and develop staff with skills to implement the policies as a priority

Survey results

Collated staff survey results from the three services provided the following results. Total staff employed at the three services was 120, with 48 survey respondents giving a 40% return rate. The higher proportion of women is consistent with findings of workforce analysis of the sector whereby a higher proportion of women are employees [xxiv]. Notably, just less than half the employees were smokers and of this half were contemplative about smoking cessation. A small number of smokers and non-smokers believed smoking should be allowed near doors, vents and children, however, the most thought this should not be allowed.

Gender
Male 8 (16%), Female 40 (83%)
Age Group
15-24, 6 (12%), 25-34, 10 (21%), 35-44, 9 (19%) 45+, 23 (48%)

Manage staff
Yes 11(23%), five of these 11 were smokers, 10 of the 11 thought staff should be supported to quit
No 37 (77%)

Smoking status
Smoker 20 (42%)
Irregular smoker 2 (4%)
Previous smoker 11(23%)
Never smoker 15 (31%)

Smoking frequency (smokers only)
Daily, 21 (95%)
Less than weekly, 1(5%)

How many cigarettes smoked a day (smokers only)
<5, 1 (4%)
5-10, 5 (23%)
11-15, 9 (41%)
16-20, 4 (18%)
21+, 3 (14%)

Thinking about smoking cessation (smokers only)
No, 3 (14%)
Cutting down, 8 (36%)
Next month, 5 (23%)
Next 6 months, 6 (27%)

Question: Should-	Smoker N=22			Non-Smoker N=26		
	Yes	No	Missing	Yes	No	Missing
Staff be supported to stop smoking	20	0	2	25	1	0
Smoking be allowed in company cars	0	20	2	1	25	0
Smoking be allowed near doors	4	17	1	2	24	0
Smoking be allowed near windows/air vents	0	21	1	2	24	0
Smoking be allowed near children	3	18	1	2	24	0

IV. Training

At the time of commencement of the project Quit Victoria offered two main types of training for health workers Aboriginal Community Controlled Health Organisations. Health workers could attend a two day Quit Facilitator course held in Melbourne (offered generically to the health sector) or a one day provision of an overview of smoking and smoking

cessation developed specifically for presentation at Aboriginal Community Controlled Health Organisation. The one day training was designed to be delivered for a variety of staff, such as, health professionals, medical drivers transporting clients and family care workers. The one day training had some information about smoking in pregnancy and this was strengthened via the advisory committee and collaboration between the Women's Alcohol and other Drugs Service and Quit Victoria. In particular, information was added about Nicotine Replacement Therapy and good practice in how to use this therapy during pregnancy. Training was delivered at all three sites and in addition a small number of workers attended the two day Quit facilitator training.

V. Development of responses

Smoke free policies

Each site required strengthened smoke free policy, see appendix two. After discussions with staff members about findings of the smoke free policy review, environmental scans and staff survey the researchers provided each organisation a draft smoke free policy. A barrier encountered in improving smoke free policy was attempting to prioritise policy redevelopment with organisations' boards that were time poor and where competing activities took precedence, such as, strategic planning, accreditation and processes associated with meeting funding deliverables. In 2011 it was announced by the Commonwealth Department of Health and Aging that organisations receiving commonwealth funding would be required to be smoke free. This information alongside the work that had already taken place accelerated smoke free policy redevelopment and approval of policy change at the board level.

Resources

Resources were developed using social marketing techniques. Social marketing involves several steps including: formative research, identification of products, price associated with these products, place where product is sold and promotion of the product. Each of these elements in terms of this project are described below.

a) Formative research was informed by the findings of the literature review, environmental scans and survey results.
b) From this research two products were identified, i) implementation of smoke free policy by staff members and people attending the organisation and ii) for staff members to feel confident about talking to clients about smoking cessation.
c) The associated price for these two products varied. For staff and people attending the organisation to implement the smoke free policy the associated price was i) a behavioural change in physicality of smoking which involved walking some distance to have a smoke and ii) a value change toward the belief that

individual smoking affects others. For staff to feel confident about talking to clients about smoking cessation, the associated price was i) attendance at training and ii) a change of beliefs to include that Aboriginal people do and can give up smoking, so that smoking cessation in consultations would be perceived as worthwhile venture to facilitate.

d) The place for the two products also varied. Implementation of the smoke free policy involved the entire service and associated staff and people attending. It also involved specifically the CEO and Board Members who facilitated approval of any changes to policies. For staff to feel confident about talking to clients about smoking cessation this involved places where client consultations occurred.
e) Promotion included development of a number of resources aiming to address i) increased implementing the smoke free policy by staff and people attending the organisation and ii) staff to feel confident about talking to clients about smoking cessation. The approaches taken to achieve this are outlined below.

Posters of quitting stories

To address the issue of staff perceiving that Aboriginal people did not desire to attempt to cease smoking, posters were developed for waiting rooms that depicted local Aboriginal entities who had ceased smoking. In keeping with findings of the literature review stories from Aboriginal women who were pregnant were included alongside stories from elders and men. These large posters were displayed in primary care waiting rooms. Posters can be viewed and downloaded from the Smoke Free Mob website at www.smokefreemob.com.au.

Facilitation of training

The research officer worked closely with Quit Victoria and the organisations involved in the study to i) identify staff for training, ii) negotiate suitable training days, and iii) organise a training venue and catering. Promotion of opportunities to attend two day Quit facilitator training was provided with a small number of staff opting to attend.

Signage

Smoke free signage was created to address the issue of limited visibility of signage to let people know where smoke free zones were. In keeping with literature review findings these signs focused on family and community responsibilities regarding smoking. For instance, rather than say ‘don’t smoke here’ one sign said ‘care for your community, smoke free zone’. Signage developed can be viewed at Smoke Free Mob website at www.smokefreemob.com.au.

Resource bag

To assist reinforce messages and support practices about smoking cessation resource bags were made up for staff to give to clients. The resource bags contained:

- a water bottle to encourage drinking water when quitting, with a message on it about supporting people to give up smoking
- stickers that could be placed in cars or in houses in Aboriginal flag colours announcing smoke free areas, provided by Quit Victoria
- a 'smoke free deadly' badge
- tea tree chewing sticks, recommended by an Aboriginal Health Worker in initial environmental scans as an Aboriginal medicinal support for smoking cessation
- a relaxation CD provided by Quit Victoria
- and information about smoking cessation for people attempting to cease and people supporting the

'What is the next step' resources

Staff members had indicated in the environmental scans a perceived lack of resources that were inclusive of representations of Victorian Aboriginal people. They also did not have a supportive 'script' about how to talk to clients using brief intervention techniques. Queensland Health had developed and evaluated 'Smoke Check' resources designed to assist staff to identify what stage of change people were in and how to talk to clients in specific stages of change. These resources had been adapted for use in South Australia and New South Wales.

Researchers contacted Queensland Health representatives and asked for permission to adapt these in Victoria. Permission was granted and the resources were focus tested in a rural (eight Aboriginal and Torres Strait Islander people) and urban (eight Aboriginal and Torres Strait Islander people) setting with Aboriginal Health Workers and nursing staff. Below is a summary of results. Essentially, focus test feedback identified that while

the content was seen as useful, the imagery needed to be altered to represent Victorian Aboriginal peoples. An Aboriginal artist was contracted to adapt existing images into mages more relevant to a Victorian context. This included pictures of people with straighter hair, more varied skin colour, wearing warmer clothing and environments that looked less tropical.

Table: Focus test summary results of Queensland Health brief intervention pamphlets

Urban site	**Rural site**
What do you think of the images? • Cartoon. Might be aimed at the wrong target. More youth focus. • Good. Maybe change images. Make them not all black. What do you think of the colours? • Looks like a comic • Like the colours What do you think of the information? • Good info to know • Straight to the point, easy understandable Would you use these resources? • Yes, suppose so • Yes, it's got info, where to look for support How would you use them? • Give copies to clients, ask clients where they're at so correct pamphlet can be given • Give them one, give them advice, explain it. What do you like about them? • Shows other resources, Quitline. • Not make clients feel bad with relapse • Information simple, straight to the point. Like the way it's written, like someone' talking to you. What don't you like about them? • Not enough photos • Skin colour needs to be lighter, straight hair. • Needs more humour, Victorian lingo.	What do you think of the images? • Alright • Good images What do you think of the colours? • Yes, like them • Calming What do you think of the information? • Basic, simple- good thing • Easy reading. No difference between stats Would you use these resources? • Yes How would you use them? • Depends on the people, if the client brings it up then give them one. • Give pamphlet to them. Talk to them What do you like about them? • Pictures What don't you like about them? • No comments Is there anything else you would like to say? • No further comments

'You looking at giving up, again?' • Link the dangers with stories from the community • Check if NRT in Victoria Is there anything else you would like to say? • No further comments	

VI. Interview results

This section provides a brief overview of the interviews with staff at and pregnant mothers at the three sites. Interviews were recorded and transcribed, the collated data was analysed by the research team for emergent themes.

1. Interviews with staff members at project sites, September 2011, summary

Participants
In total ten staff were interviewed (two staff at urban site, four staff at large rural site, two staff and small rural site and two at the organisation hosting the small rural site). Participants were either involved in delivery of tobacco programs or were working in a Koorie Maternity Service (KMS) Program (see table below).

Number of staff	Role	Presence during project	Site
Two	Tobacco workers	One had started in last month (replaced previous workers) One had moved to a new position and had been in position for 12 months	Large rural
Two	KMS	All	Large rural
One	Tobacco worker	All	Urban
One	KMS	Last 12 months (replaced a previous worker)	Urban
One	Tobacco worker	Last 12 months	Auspice organisation
One	KMS	All	Auspice organisation
One	Tobacco worker	Last 2 months (replaced previous worker)	Small rural
One	KMS	All	Small rural

Thematic interview findings summary

Theme one Tobacco Workers

In the third year of the research project at each of the sites tobacco workers were employed with the aim of increasing access to smoking cessation support for Aboriginal and Torres Strait Islander people. These workers inevitable became involved in the research project assisting to get smoking cessation policies approved and strengthening implementation of smoking cessation policies.

Their presence at each of the sites appeared to be raising consciousness about smoking risks and smoking practices. For instance, one of the roles the tobacco workers implemented was to monitor where people were smoking and redirect smokers to the appropriate smoking areas. Sometimes just the tobacco workers visual presence was enough to do this, such as, in the comment below.

> "they used to be hanging on rails out the front and smoking then they'd see us coming and duck down around the corner" (urban site)

Tobacco workers also used warmth and humour to redirect people to lessen the chances of confrontation.

> "they're not meant to smoke out the front and if I see them I say oi oi oi just a friendly reminder" (urban site)

> "yeah the stickers were funny, it's good to make people laugh then they don't think they're being told off" (large rural site)

Another role tobacco workers were taking on was to support their peers and other staff at their organisations to cease smoking.

> "I just put it out there (to staff) that I'm not here to tell you what to do but when you're ready come and see me"

A challenge for these workers was that two of the three had recently been appointed to the tobacco position with little previous experience in tobacco cessation.

> "I've really only just started so am in the planning stage, I haven't worked in smoking before" (large rural site)

For these organisations this meant rapidly skilling the person up to be able to fulfil their position description. Previous incumbents had left to take on higher duties and go on maternity leave. The tobacco workers

having access to a network was one method of providing support to this skill development

> "I know that when I go to meetings and that I get a lot of good ideas from the other workers and that"

Theme two changing environments

Participants interviewed frequently commented on how changes to site environments supported smoke free sites and encouraged smoking cessation. Signage had been provided as part of the research project in response to a perceived need identified in initial environmental scans conducted at the beginning of the project. The research project staff worked with sites to develop strategies to redirect smokers to smoking areas that were consistent with the organisation's policy on smoking. Participants had used other strategies to lessen the comfort of smokers smoking at each site.

(i) Improved signage

At all sites participants interviewed had observed changes in people's smoking behaviour due to increased signage. The signage had been used in different ways dependent upon the organisation's policy on smoking. For instance, at one site signage had been used to keep smokers away from entrance ways

> "I put the signs on the back door and they work to keep people away from there" (Auspice organisation)

At another site they had been used to redirect smokers to a designated smoking area located at the edge of the service boundary.

> "I've been here 13 years gone past and us 5 in the group working on smoking, a few years ago they would be willy nilly smoking near the door. Now they go straight to the corner [smoking area]" (Urban site)

Generally participants agreed that signage was observed, such as in the comment below.

> "I think that people do notice the signs, I know I did when I started here" (Large rural site)

(ii) Lessening the comfort of smoking

Interview participants had used a number of strategies to lessen the comfort of smoking. In one instance the workers had noted that clients enjoyed having a coffee with their smoke so had implemented changes to reduce this comfort.

> "we used to have coffee and people would come in and have coffee and a smoke, so we changed the coffee to water" (Large rural site)

At another site tobacco workers had recruited smoking staff to utilise the smokalyser to become more aware of what smoking was doing to their bodies.

> "we got the smokalyser and went to them (staff) and they were shocked at their percentage came you know you should have seen their faces, then they tried to not smoke for the afternoon and see what their readings were saying" (urban site)

Creating smoke free sites or areas had also changed smoking comfort by increasing the distance needed to travel to have a smoke.

> "now they (playgroup mums) have to walk further to smoke they don't go out as much, it's really made a difference, they probably only go out once while they're here" (large rural site)

(iii) Smoke free times

Interview participants mentioned creating smoke free times and events to encourage awareness of smoking and it's effects not only on the smoker but on those around them. For instance,

> "we are having a children's day and we want it to be smokefree, there shouldn't be a discussion on it, because if parents want a smoke, I mean somewhere along the line you need to have that discussion so if there's a big banner that says today is smokefree day, let's see what happens, it'll trigger a little memory a seed that says to the mum or dad better not smoke here today, they'll be looking at us" (large rural site)

and

> "so we started to have smoke free lunchtime, for a community that likes to gather part of that becomes to smoke' (urban site)

(iv) Incentives to give up

The workers interviewed were unsure about the benefits of providing incentives to smokers to give up and what should be given as an incentive.

"I don't know how much you should give, how long should you give it for I mean, you could give up for three months you get something nice, I don't know"

"I still think a membership to the gym or something"

Theme three training and resources

During the research project training and resources were provided for each site informed by the environmental scans and staff surveys conducted at the beginning of the project. The training was provided by Quit Victoria and resources included smoking cessation stories and support kits for people giving up smoking. Brief intervention pamphlets had also been adapted from NSW but had not been circulated at the time interviews were being conducted.

(i) Training

Participants mentioned that training gave them further information to utilise to assist smoking cessation, however, at times the material presented didn't quite fit with their experiences in the workplace. For instance,

> *"I grabbed a lot of things I can work with but I found it more like mainstream, I mean with our clients we seem to work different way, totally different way, real comfortable"* (urban site)

Participants also noted a lack of specific training availability in Victoria with staff from two sites travelling to New South Wales to access brief intervention training.

> *"We wanted to do more brief intervention training but found that there wasn't much around, you have to go to New South ay?"* (large rural site)

Participants perceived an increase in avenues for clients to gain support for their smoking cessation when more staff had completed smoking cessation training, For instance,

> *"I've noticed that there has been more one on one support for people because there are more staff to do it"* (auspice site)

(ii) Resources

A number of resources were utilised by participants in their practice. Some were resources developed by the project and others had been acquired as well. The smoking cessation stories were discussed as being useful for a number of reasons,

"the banners are good people stop and read the stories" (small rural site)

and

"we need more positive stories that people have given up" (urban site)

and

"the stories about giving up are good they're not too complicated, short and to the point" (large rural site)

and

"they are people on the ground, they're people who are known in the community and it tells the story about it, that was a journey and it wasn't something easy done, I think that's really good" (auspice site)

and

"I used the stories to talk to clients about their story of quitting to show how it can work" (auspice site)

and

"people stop and read the stories in the kitchen" (small rural site)

and

"if we had local storied that would be even better" (small rural site)

Support kits were mainly mentioned as having been distributed, however, there was no mention of how useful they were perceived to be, particularly in comparison to the stories.

"Yeah we gave all those kits out they went quickly" (large rural site)

A number of other resources were mentioned by participants as being helpful when talking to clients and community about smoking, such as, "smokey suzy" a doll that demonstrates how cigarette smoke effects a baby in the womb, "smokalyzer for measuring carbon dioxide and showing

people an immediate effect of smoking and 'Talking up good air" resource for being relevant to smoking cessation practice with Aboriginal peoples,

> *"I like the Talking up good air I felt very comfortable with that"* (urban site)

Theme four smoke free sites

At all of the research sites organisations had made changes toward becoming entirely smoke free. Interview participants generally agreed it was something that would make smoking cessation easier, such as, comment below,

> *"I would like to see smoke free, they know it's coming they see it at other places"* (urban site)

> *"Everywhere else in health is smoke free we should be too"* (small rural site)

Some people had reservations about how easy this would be to implement particularly in regard to the redirection of smokers,

> *"the staff won't walk off site I don't think, it's too far away I reckon"* (large rural site)

> *"you get those ones that are hard headed and just won't listen and you can't enforce it 24/7"* (large rural site)

> *"we were hoping to get a designated area, out of the way of the childcare centre and school, it would be a very limiting area but it's very hard we were hoping to get somewhere with it but nothing happened"* (small rural site)

Theme five combining strategies

The interview participants frequently mentioned the strength of having combinations of activities aimed at smoking cessation, such as, policies, signage, smoking cessation support. For instance,

> *"I have seen the changes myself, you know it's all things signage, having us [tobacco workers] it all raises awareness"* (large rural site)

and

> *"I think that everything all the work this project did and the other tobacco work we do has worked to build up a message"* (urban site)

and

> *"all that signage and them quit adds are starting to get to people, showing the full on hard adds showing what really happens when you take the smoke in"* (small rural site)

Theme six pregnancy

(i) Relationship between smoking in pregnancy and smoke free polices

Interview participants discussed the initial confusion they had about the relationship between smoke free policy implementation and women smoking during pregnancy. Moving out of a medical and clinical model into an organisational and social determinants model was seen to be a positive endeavour. In particular, introducing to mothers and families to the concept that behaviour about smoking was changing and becoming less acceptable,

> *"so the mums could smoke out the door just here, because we didn't have a policy we couldn't say you can't smoke here"* (urban site)

There was also a perception that changing staff behaviour, particularly as many staff are from the local Aboriginal community, was important to do first

> *"then it sunk in if we want to target pregnant mothers our organisation needed to offer the change here first so we had to work with our staff because our staff work with clients"* (large rural site)

and

> *"I think it has mainly worked with staff, they are much more aware of hazards and there's a limit on where they can smoke now"* (small rural site)

(ii) Smoking cessation motivation in pregnant women

Participants discussed perceptions of pregnant women coming into organisations and their motivations to cease smoking. First time pregnancies and women who had ceased smoking prior to attending a first appointment for pregnancy were perceived as more likely to cease smoking during pregnancy.

"I find first time mums are more concerned about cutting down, mums who have had smoked all through a pregnancy and had reasonable sized babies don't see the point in cutting down" (auspice site)

"Generally with pregnant women if they are going to give up by the time they come to us for the first time they will have given up, if they're still smoking they're likely to keep smoking even if they say they want to give up" (urban site)

(iii) Talking to pregnant women about smoking cessation

Participants mentioned discomfort with asking pregnant women about their smoking or asking women to cease smoking, for instance,

"the midwife really encourages them to cut back because they all say they have little ones and stress around home and everything else so you really can't say stop and that so she says cut to two instead of five" (urban site)

"there's probably some things we don't target enough and those are the smoking and the alcohol, we concentrate on the appointments." (large rural site)

"and what I've been getting is 'I know I'm pregnant I know I smoke I know the dangers, but Fuck it I need a smoke' ohhh alright then'

"it's how we bring it up we have to think outside the box" (auspice site)

"I think the smokalyzer can be a good way to talk to clients and you can show them a change, that they're making progress, it's a positive message, it's really a reward to see those numbers go down" (small rural site)

Training and experience gave some participants more confidence to discuss smoking cessation with pregnant women, for instance,

"I've got more confident as I've gone along, I did the training with quit and then became a quit educator, so I feel a lot more confident about asking mums those key questions about when they want to give up and cutting down. Before I didn't quite know where to go with it. " (large rural site)

Some staff had trouble accessing training due to distance and clinical responsibilities. At this time Quit Facilitator training was offered in Melbourne over two days.

"I haven't had the quit facilitators training, I want to do it I think it would help, but it's got to fit in with my births as well"

Team work was also perceived as supportive for creating opportunities to speak to pregnant women about smoking cessation, for instance,

"I usually raise it with women when there are on their own or I work with a very good GP who may call me in to talk about it" (large rural site)

"I work across the organisation and get referrals from medical and everywhere" (auspice site)

2. Interviews with pregnant women at project sites, September 2011, summary

Participants

There were a total of nine smoking parents interviewed either individually or as a focus group at three sites about smoking, two parents at the small rural site (one focus group), six parents at the auspice site (two focus groups), one parent at the large rural site. Interviewed were seven women and two men.

Thematic interview findings summary

Theme one environmental smoke
All of the interview participants said that they smoked outside, for instance,

"we all smoke, but we all outside, which is only for the kids"

even though sometimes it was inconvenient, such as

"I only slow down when it's raining, cos you walk outside and it's cold"

Theme two reasons for smoking
People cited boredom, stress, coping with anger, time out, addiction and normalisation of smoking as reasons taking up smoking, such as, in comments below

"It's what we've always known, we grew up with it"

and

"I started at thirteen and just never stopped, just kept going"

and

"I started when my cousin started and then I couldn't get off it"

and

"It's my time out"

and

"when I'm angry it's good to calm you down"

Theme three smoking during pregnancy

Some mothers thought that they smoked more when they were pregnant because they were constantly thinking that they should cut down or stop smoking. For instance,

"I reckon I smoke more when I'm pregnant, I crave it"

and

"I reckon it's because you're thinking about trying to give up, you can't stop thinking about it"

and

"when I'm not pregnant I smoke ten a day when I'm pregnant I smoke a packet easily"

Some mothers also thought that smoking was the only way they could get time to themselves to have a quick break, for instance

"It's my time, the kids are inside and I get my time outside with the smoke"

One mother thought that smoking during pregnancies had not affected the babies adversely,

"I smoked through all my pregnancies and they're all ok"

"sometimes I don't enjoy it I think why am I doing this but an hour later I'm back out there again"

"when ya relapse you get these looks, they drive you crazy"

Two mothers had stopped smoking during pregnancy and intended to stay quit,

"it just made me sick in the end so I just stopped"

and

"nah that's it I'm done, I'm not going back"

Partners could be influential in supporting women to give up smoking, such as,

"my partner gave up at the start of the year so I wanted to as well so yeah we wanted to get fit for sport and everything, we didn't want it around our babies"

"I said just give it up, give it a go, see how long you can go without and the she lasted a couple of weeks and kept going"

Or they could also hinder quitting or cut down attempts,

"that makes it hard to give it away because his (partner) outside walking past the window with smoke in his hand"

"he gets stressed out and needs a smoke and then I get stressed out and need a smoke"

Similarly for working mothers workplaces could be a support to help mothers cut down or give, such as

"when I was working I'd only smoke four during the day in the breaks, that's all I could do"

or provide a hindrance

"I had a co-worker who smoked and that made it really hard to stop, so yeah"

Smoke free policy and areas

Parents had mixed reactions to implementation of smoke free policies and areas at their local organisation. Many were supportive of having smoke free zoning, for instance,

"I know that you're not allowed to smoke there so it doesn't worry me"

and

"the health service has just put in that for big lunches you have to be out of a certain boundary to smoke, so that's good no-one wants to eat and smell a cigarette at the same time."

and

"yeah there's signs up now you gotta smoke ten metres away from the building"

and

"the mums used to smoke here at the front door where the kids could see and the smoke went through the vents, now they have to go ten metres that way, its good much better"

and

"It's good, because then it doesn't hurt other people when they're walking past."

One parent said they weren't supportive of smoke free zoning and another although supportive of smoke free zones thought it would be inconvenient

"I don't like smoke free, it's my time and if I want to smoke I should be able to"

and

"I don't like it when you have to walk down the street and around the corner, like here (health service) where you have to go down the laneway"

Some parents drew on comparisons to other areas they knew were already smoke free and had experienced, for instance,

"I reckon they should ban it like they do in Melbourne"

and

"If I'm at target I'll have something to eat, I always smoke after I eat so then I'll go outside have a smoke come back in and do the shopping, it doesn't worry me, I could be in there for hours"

Parents had a number of suggestions for ways that parents in general could be supported better to quit and this included better referral pathways, communication, smoke free zones, physical activity and distracting activities. For instance,

"don't preach, give options, don't say this is what you should be doing"

"if you give people activities then they can realise how much the smoking is effecting them, they get puffed out"

"people should be referred to the tobacco worker from all the people [staff] here"

"banning it more around the place, I think that would help"

"the more active I am the less I worry about it"

There was also some confusion about use of support services, such as,

"is the quitline even free? I heard that if you're on a mobile it's not free"

"more information about where to go for support, they need to advertise it more, the worker comes here I day a week but how do you know and how do you see them"

6. ADDITIONAL RESOURCES

Publications, conference presentations and website arising from the research are listed below.

1) Publications

Journals

Fredericks, B., Adams, K., Finlay, S., Fletcher, G., Andy, S., Briggs, L., Briggs, L. & Hall, R.(2011). Engaging the Practice of Indigenous Yarning in Action Research. *ALARA Journal*, (17) 2.

Fletcher, G., Fredericks, B., Adams, K., Finlay, S., Andy, S., Briggs, L. & Hall, R. (2011). Having a yarn about smoking: Using action research to develop a 'no smoking' policy within an Aboriginal Health Organisation. *Health Policy*. 2011 Nov;103(1):92-7. Epub 2011 Aug 9

Fredericks, F., Finlay, S., Briggs, L., Adams, K., Fletcher, G., Andy, S., Briggs, L. & Hall, R. (2011). Working Up a Smoking Policy. Aboriginal and Islander Health Worker Journal. 35 (3).

Book chapters

Fredericks, B., Lee, V., Adams, M. & Mahoney, R. (2011). Aboriginal and

Torres Strait Islander health case study. In Fleming, M. & Parker, E. (eds) Introduction to Public Health. Cheltenham, Elsevier Press.

Reports
Van der Sterren, A. (2009). Reducing smoking amongst pregnant Aboriginal women in Victoria: a literature review. A literature review to inform the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) project. Victorian Aboriginal Community Controlled Health Organisation, Melbourne.

Newsletters
PHAA Newsletter Item, Vol 26, No 6, 2009, page 10.

VACCHO KMS Newsletter, Vol 1, No 1, 2010, page 3.

2) Conferences

Developing an Aboriginal Community Controlled research project that addresses smoking reduction amongst Aboriginal women in Victoria. (2009). Oceania Tobacco Conference. Darwin.

Action research in action within an Aboriginal Community Controlled Health Organisation. (2010). Action Learning Action Research World Congress, Melbourne.

Goreen Narrkwarren Ngrn-Toura – Healthy Family Air. (2010) World Congress on Internal Medicine. Melbourne.

Work place smoking policy development to support health promotion in Aboriginal Community Controlled Health Organisation. (2011). Aboriginal Health Promotion Association Conference, Cairns.

Developing appropriate smoking cessation health promotion resources with Victorian Aboriginal Health Services. (2011). Aboriginal Health Promotion Association Conference, Cairns.

3) Website

The website provides a working example or vision of activities for smoke free Aboriginal Community Controlled Organisation. It also provides access to the majority of resources developed for the project which can be downloaded for use.

www.smokefreemob.com

7. FUTURE RESEARCH

Aboriginal Community Controlled Organisations have an important role to play in providing leadership and prioritising smoking cessation as an issue. This research determined that, as with more mainstream organisations, effectively implemented smoke free policies are important. What differs is the messaging which requires more community rather than individual responsibility for smoke free environs. Two particular areas emerged that require more investigation.

Stress and smoking

Aboriginal and Torres Strait Islander adults are twice as likely as non-Aboriginal and Torres Strait Islander adults to report high/very high levels of psychological distress[xxv] . Consistent with other evidence, this research found that stress was perceived as a barrier associated with smoking cessation [xxvi]. Gaps in knowledge particularly exist about how to support Aboriginal people to cease smoking who were experience stress and how health workers can perceive smoking cessation support as not further burdening clients.

Smoking cessation systems

The project also identified that little was understood in terms of systems approaches to delivery of smoking cessation support. How can an Aboriginal Community Controlled Health Organisation develop good practice smoking cessation implementation that is inclusive of the diversity of teams and functions of the organisation? For instance, organisations may have child care centres, cultural centres, family services etc. Tobacco cessation responsibility, however, often sits within the primary health care function of the organisation and maintaining consistent referral opportunities and access to smoking cessation support across the organisation can provide a challenge.

Aboriginal women who maintain smoking during pregnancy

In interviews with pregnant women some mentioned smoking more during pregnancy. The women perceived a heightened awareness of a need to cease smoking because of their pregnancy, which in turn led them to increased stress or guilt. Women believed this situation led them to thinking about smoking more and then smoking more because of this. Pregnant women also mentioned distractions as helping to cut down on smoking, such as, employment or shopping. Little is known about habits of Aboriginal women who continue to smoke through their pregnancy. Understanding more about Aboriginal pregnant women who smoke may provide better information and evidence for supporting these women to address their smoking.

8. APPENDICES

APPENDIX 1: Environmental scan questions

Environmental scan questions and documentation

Organisational policies and procedures

1. **Are there any smoking related policies? If so how are they implemented? *(Ask for a copy of any policies)***
2. **Currently are there smoking cessation initiatives being delivered to clients or community? If so please describe.**
3. **How many of the current employees have undertaken the Quit training? When?**
4. **Are there any plans to train people through the Quit program in the future?**

Location

5. **Are there designated smoke free and smoking areas?**
   Plot them on the map using the specified key & photograph where possible
6. **Are there signs indicating either smoke free or smoking areas? Are they clearly visible?**
   Plot them on the map using the specified key & photograph where possible
7. **Who manages the butts either on the ground and/or the butt bins?**
8. **Where are the butts being discarded? Butt bins, garbage bins, the ground?**
   Plot them on the map using the specified key & photograph where possible
9. **How many butts are there on the ground? (*photograph where possible)***
10. **If there are butts on the ground are they in areas where children are present, e.g., children's play areas? (Photograph where possible)**
11. **Where do people currently smoke?**
12. **Are children able to see people who are smoking?**
13. **In the areas where people smoke are children exposed to passive smoking?**
14. **In the areas where people smoke are adults exposed to passive smoking**

APPENDIX 2: Recommended smoke free policy

Policy comparisons at first environmental site scan

	VACCHO	Site 1	Site 2	Site 3	Quit NSW	Quit Victoria
Rationale for policy?	X	X	✓	✓	✓	✓
Smoking banned in areas	✓	X	✓	✓	✓	✓
Designated smoking area?	✓	✓	Total smoke free policy	✓	✓	✓
Support staff to quit?	X	X	X	X	✓	✓
Enforcement	X	X	✓	X	✓	✓
No smoking with clients	X	✓	✓	X	NA	NA
Policy reviewed	X	X	✓	X	✓	✓
Person for staff to contact	✓	X	X	X	✓	✓

APPENDIX 3: Selection criteria

EXPRESSION OF INTEREST TO BE A HOST ORGANISATION FOR THE

Reducing Smoking Amongst Pregnant Aboriginal Women in Victoria: a Holistic Approach research project

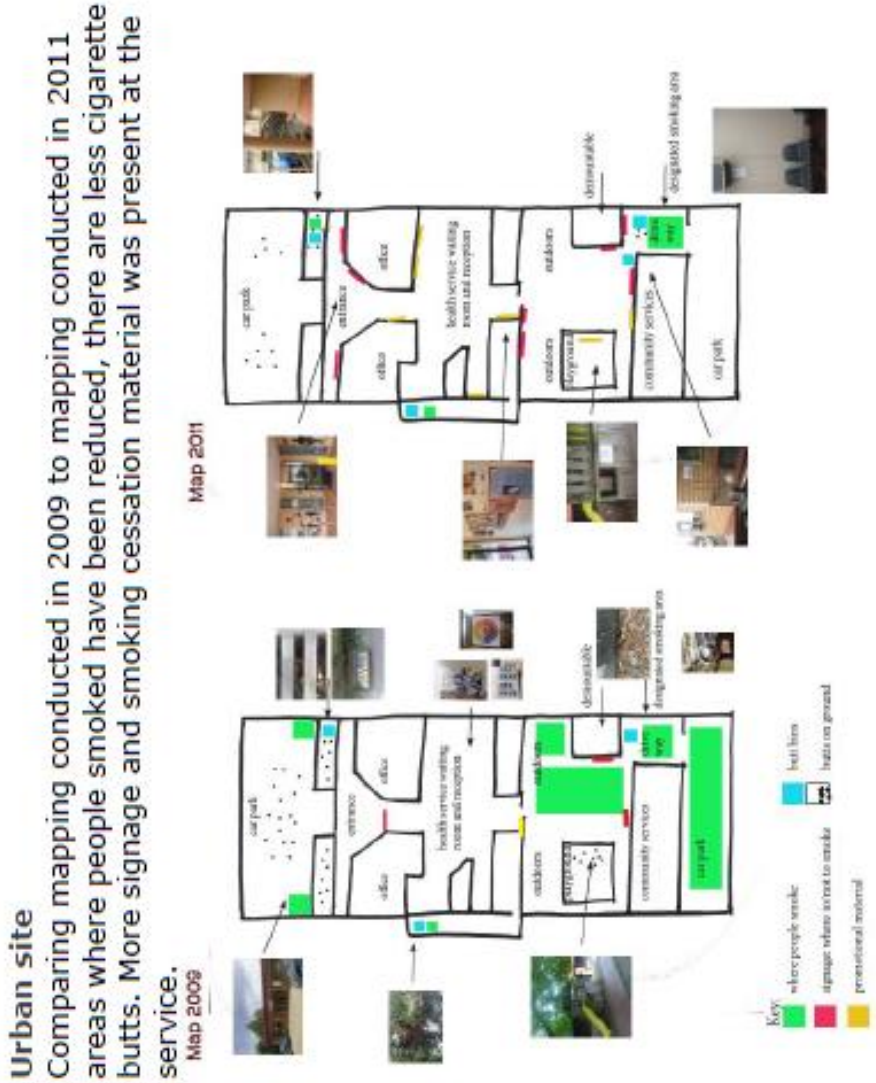
Host Organisation Selection Guidelines

To help you think about whether your service would be able to host the project we have provided the following selection guidelines. Please tick the box next to any statement that applies to your organisation.

- ☐ We are a VACCHO member organisation.
- ☐ We have existing programs that are specifically designed to support pregnant women e.g. Koori Maternity Services.
  Please provide details……
  ……..……
  ……..……..
- ☐ We have early childhood programs.
- ☐ We have evidence of smoking as a health promotion priority. For instance, in our strategic plan.
- ☐ We have an existing health worker who has completed the VACCHO course in Aboriginal Primary Health Care Certificate III, IV or similar.
- ☐ We can nominate a staff member to work on a community development project.
- ☐ We have staff who can attend meetings and training.
- ☐ We have worked successfully in the past with multiple partner organisations.
- ☐ We have an existing health workers who has attended the Quit training or equivalent.
- ☐ We can work in partnership with Quit smoking in order to share knowledge and build capacity between mainstream services and the Aboriginal community.
- ☐ We can work with a VACCHO project worker to host a community development smoking awareness project.
- ☐ We can work with a researcher to evaluate measures and outcomes of the project.
- ☐ We can work with a VACCHO project worker to improve our smoking workplace policies.
- ☐ The number of Aboriginal people in the community we work with is……

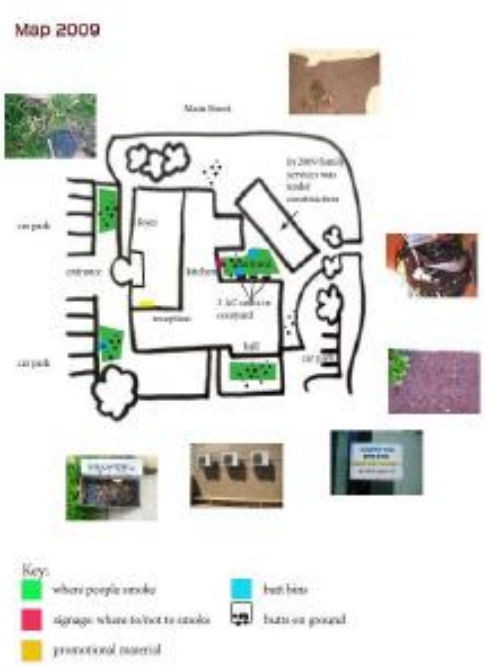
Comments:……
……

APPENDIX 4: Environmental scan maps



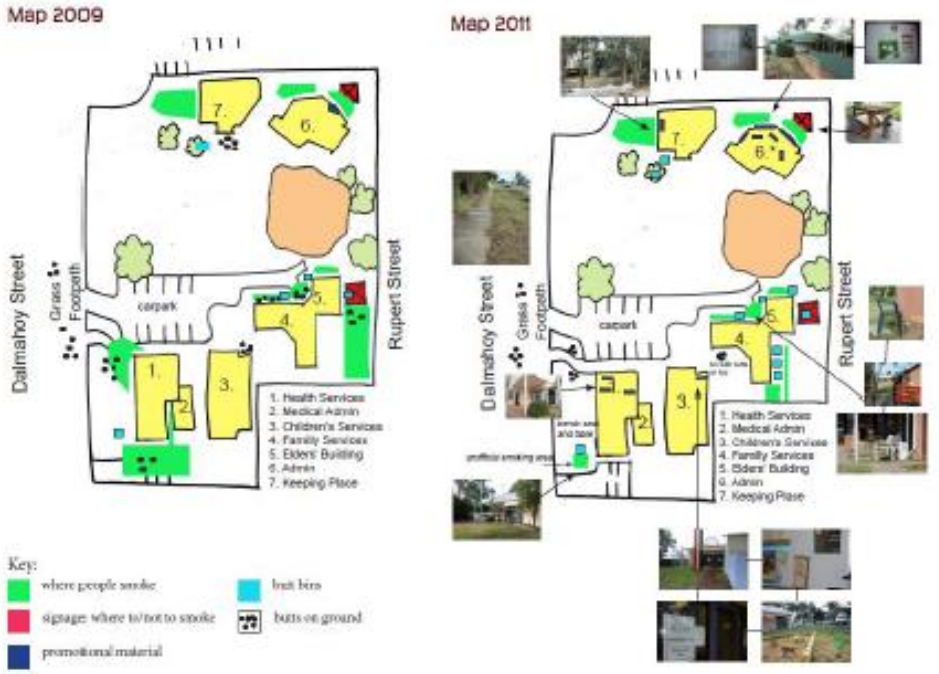
Small rural site

Comparing mapping conducted in 2009 to mapping conducted in 2011 areas where people smoked have been reduced, there are less cigarette butts. More smoking cessation material was present at the service.



Large rural site

Comparing mapping conducted in 2009 to mapping conducted in 2011 areas where people smoked have been reduced and significantly moved from the front of the organisation to the back. More smoking cessation material was present at the service.



APPENDIX 5: Staff survey questions (electronic survey)

1. Are you male or female?
Male
Female
2. Do you manage staff?
Yes
No
3. How old are you?
15-24
25-34
35-44
45+
4. What statement best fits you and your smoking?
I smoke
I smoke but not regularly
I don't smoke now but I use to
I've never smoked
Don't know
5. Do you currently smoke cigarettes, cigars, pipes or any other tobacco products
Daily
At least weekly (not daily)
Less often than weekly
Don't know/Can't say
6. How many do you smoke a day (including pipes, cigars and cigarettes)?
Less than 5 a day
Between 5 and 10 a day
Between 10 and 15 a day
Between 15 and 20 a day
More than 20 a day
7. If you are a smoker would you like to stop smoking?
no thanks I like smoking
I'm thinking about cutting down
yes in the next six months
yes in the next month
8. Do you think (service name) should be supporting staff who want to quit smoking?
Yes
No
9. Do you think staff should take smoke breaks outside of the normal break times?
Yes
No
10. Where do you think staff and visitors should NOT be allowed to smoke?
Company cars
Near the front door
Near the back door
Near any door
Near air vents
Near children
11. Do you think (service name) needs to have a designated smoking area?
Yes
No
12. Do you know (service name) has a smoking policy?
Yes
No
Don’t know
13. Would you like to be involved in reviewing the (service name) smoking policy?
Yes
No
14. If VACCHO is to redevelop its policy how much warning do you feel staff need before the policy comes into practice?
1 Month
1-3 Months
3-6 Months
Not Sure
15. Is there anything else you think is important to say about smoking at VACCHO?

APPENDIX 6: Interview questions service providers

Victorian Aboriginal Community Controlled Health Organisation Inc.

5–7 Smith Street, Fitzroy, 3065
Ph: 03 9419 3350

MONASH University

International Public Health Unit

Within the School of Public Health and Preventive Medicine
Faculty of Medicine, Nursing and Health Sciences

OUTLINE FOR SEMI-STRUCTURED INTERVIEWS WITH KEY STAKEHOLDERS

Goreen Narrkwarren Ngrn-toura - Healthy Family Air

Key stakeholders include:

- Health service executives
- Key staff within the organisation
- Community champions

These questions provide a basic outline only, to facilitate discussion where required.

Reminder: Provide project information and obtain consent prior to commencing interview

Pre intervention:

1. How important an issue do you think smoking is in your community/organisation?
2. What do you think the main issues are which are causing high rates of smoking in the community/organisation?
3. What do you think are the most important things we should all be doing to support people who want to quit smoking, including women who are pregnant and carers of young children?
4. How could we go about these suggestions?
5. What do you think could be some challenges/difficulties we could have?
6. Who do you think should be involved?
7. Are there any other issues you would like to talk about?

Post intervention:

1. How important an issue do you think smoking is in your community/organisation?
2. What do you think the main issues are which are causing high rates of smoking in the community/organisation?
3. What do you think worked well about the intervention?
4. What didn't work so well?
5. What do you think are the most important things we should all be doing now to support people who want to quit smoking, including women who are pregnant and carers of young children?
6. Are there any other issues you would like to talk about?

APPENDIX 7: Interview questions parents

Victorian Aboriginal Community Controlled Health Organisation Inc.
5–7 Smith Street, Fitzroy, 3065
Ph: 03 9419 3350

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OUTLINE FOR SEMI-STRUCTURED INTERVIEWS OR FOCUS GROUPS WITH PREGNANT WOMEN AND CARERS OF YOUNG CHILDREN WHO HAVE RECIVED THE INTERVENTION

Goreen Narrkwarren Ngrn-toura - Healthy Family Air

These questions provide a basic outline only, to facilitate discussion where required.

Reminder: Provide participant information and obtain consent prior to commencing interview

Participant information (please circle):
Pregnant woman/carer of young child under 5 years of age

Post intervention:

1. How would you describe your tobacco smoking (before pregnancy)? (eg how often, how many?)
2. How would you describe your tobacco smoking (during pregnancy)? (eg how much, how often)
3. Were you able to quit or reduce your tobacco smoking (during pregnancy)? If yes, how much?
4. How did you feel about your smoking (during pregnancy)? (wanted to quit, did not want to quit)
5. Do people smoke in your home? If yes, how often…
6. Do people smoke in your care? If yes, how often…
7. Would you be more or less likely to go to public places where people smoke? Or would it make no difference?
8. Do you support no smoking in some places? If yes, which ? eg children's playgrounds, outdoor cafes etc
9. Did you receive support to help you to quit smoking (during pregnancy)? If yes, please describe this support
10. How did you feel about the support you received?
11. What do you think worked well?
12. What didn't work so well?
13. What could we do better to support women to quit or reduce smoking?
14. How could we go about these suggestions?
15. Are there any major problems you can foresee?
16. Who should be involved?
17. Are there any other issues you would like to talk about?

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