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Australian and New Zealand Indigenous mothers' report respect for smoking bans in homes

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ABSTRACT

Background: There is limited data about the reasons behind residential rules to reduce environmental tobacco smoke (ETS) exposure or the establishment or enforcement of such rules in Indigenous populations.
Aim: We aimed to gain an understanding of smokefree rules around Australian and New Zealand (NZ) Indigenous infants.
Method: This was a qualitative study nested within a randomised controlled trial that aimed to test the efficacy of a family-centred tobacco control programme about environmental tobacco smoke (ETS) to improve the respiratory health of Indigenous infants in Australia and New Zealand. Qualitative semi-structured interviews were conducted with 26 Indigenous mothers of infants in Australia (n = 7) and NZ (n = 19). We asked about the presence of smokefree rules, who set the rules, how the rules were set and enforced, and presence of smokefree rules in participants' wider social circle. Interviews were audiotaped, transcribed, and inductively analysed to identify key themes.
Findings: Sixty-nine percent of mothers had partners, 77% smoked and all reported some presence of smokefree rules for house and car. Three main themes were identified: strategies to minimise exposure to ETS, establishing smokefree rules in homes and cars, and, adherence and enforcement of smokefree rules. Several strategies were identified to limit children's exposure to ETS, including rules to limit exposure to third-hand smoke. Mothers extended their smokefree rules to apply to other people's houses or cars, and reported that their family and social circles also had smokefree rules. The main reason for having smokefree rules was for the health of their children. Rules were most commonly set by the mother, often jointly with their partner. Few mothers reported challenges or problems with other people adhering to the smokefree rules.
Conclusion: Women tried very hard to, and believed that they were effective in, protecting their children from the harmful effects of ETS exposure. In this context, health professionals need to emphasise smoking cessation in parents, so that children are maximally protected from ETS exposure.

1. Introduction

There is now sufficient evidence that exposure to environmental tobacco smoke (ETS) harms children, and that interventions to reduce such exposure, in homes, transport or public places, are warranted.[1,2] Although there is now good information about the prevalence of ETS exposure for Indigenous children in New Zealand (NZ) and Australia, less is known about why people may or may not set rules to reduce child ETS exposure and how rules are established or enforced.

In Australia and NZ acute respiratory illness (ARI) is a leading cause of deaths and hospitalisation among Indigenous children aged 0–4 years.[3–5] ETS exposure is the most readily modifiable risk factor for ARI. In 2009, in 9% of NZ-European households, where at

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least one child between 0 and 14 years old lived, smoking was allowed inside the house but the prevalence was significantly higher for Māori households (21%).[6] In Australia, in 2008, 21% of Indigenous children 0–14 years lived in households with indoor smokers (compared with 7% of their non-Indigenous children peers).[7]

Studies have found that parents are increasingly aware of the need to protect children from ETS exposure.[8] In Australia, a study in remote Aboriginal communities in northern Australia found that the most common reasons for restricting smoking in the home, car or at work, was because of already existing rules, smoke free rules at work and concerns for children or people with illness.[9] Internationally common reasons for establishing smokefree homes include: protecting children from adverse health effects, to avoid the unpleasant smell of smoke, the desirability of growing up in smokefree homes, and having few visitors who smoke.[10–13] Increasingly, parental restrictions to protect their children from ETS do not just apply to their homes, but also to cars and other peoples' homes where children spend time.[8]

There are conflicting findings in previous research about the ease or difficulty associated with establishing smokefree rules. Some international research, with rural white and African American participants[10,13] or Australian Aboriginal women,[14] found that the majority of people do not report significant difficulties in setting or enforcing smokefree rules. Participants reported that visitors to their homes knew that they had smokefree rules, they respected and reacted positively to these household rules, and most smokers reported going outside to smoke.[13] In contrast, three other studies, with First Nations Canadian women,[15] Scottish women[16] and Canadian households,[17] found that although some participants did not report any difficulties in establishing smokefree rules, others found it difficult and sometimes impossible to establish or enforce smokefree rules.

Although there have been studies into how and why people establish and enforce smokefree rules in homes or cars, none of these prior studies focused on establishing and enforcing rules in general, that is, homes, cars *and* other people's places, for Indigenous NZ and Australian people. The study described in this paper aimed to gain an understanding of smokefree rules to reduce children's ETS exposure. The study focused on Māori, Australian Aboriginal and Torres Strait Islander people because of the higher prevalence of ARI among these populations, compared to their non-indigenous counterparts.

Tobacco smoking and thus exposure to tobacco smoke is a contemporary problem for Australian, NZ and Torres Straight Islanders. Whilst Māori, Aboriginal and Torres Straight Island people are unique and culturally different, we share similar historical experiences of colonisation and the introduction of tobacco smoking and the subsequent harms.[18] This qualitative study was nested in a larger parallel randomised controlled trial (RCT) that tested the efficacy of a family-centred tobacco control programme about ETS exposure to improve the respiratory health of Indigenous infants in Australia and NZ.[19] The aim of this qualitative sub-study was to explore the types of smokefree rules in existence in these homes, and how smokefree rules are established, adhered to and enforced.

2. Method

Phenomenological theory underpinned the methodology chosen for the study.[20] Our aim was to describe the everyday experience or 'lived' experience of Indigenous mothers as this related to smokefree rules. The method we chose to use was semi-structured interviews with mothers of Indigenous infants. We aimed to explore the phenomenon of smokefree rules around children and care was taken to ensure that the interview schedule enabled open responses, was not leading and therefore did not pre-determine the results. We also allowed time and space to explore themes that were relevant but arose outside of the schedule during the course of the interview. Interviews were conducted with a subsample of women from a large RCT called Healthy Starts in Darwin, northern Australia, and Te Piripohotanga in Auckland, NZ (HS/TP). Participants in the RCT were urban Indigenous women from Darwin and Auckland and their infant, half of whom were randomly allocated to an intervention group who received the tobacco control programme over three home visits in the first three months of the infant's life, and half to a control group receiving 'usual care' (i.e. they did not receive the tobacco control programme). Participants from both the intervention and control groups were included in the study described in this paper. While acknowledging that the two Indigenous communities included in this study are diverse, they do share similar experiences of high smoking rates, and a history of colonisation and dispossession, which continue to impact on their health and access to healthcare today. The main HS/TP trial results are the subject of a separate publication.[21] The study presented in this paper was led by a senior Māori researcher and for the main study, the co-investigators brought different backgrounds: Māori, Aboriginal, non-indigenous, medical and social science.

2.1. Participants

A subsample of women representative of the main HS/TP study was identified from both the intervention and control arm of the HS/TP study and from both Australia and NZ. Participants from the main trial were selected using purposive sampling and telephoned sequentially until the required number was surveyed. The aim was to interview approximately 20 women from each country, half from the intervention and half from the control groups and representing a diverse mix of smoking status and household composition. Participants were sampled until the required number to reach data saturation (i.e. no new themes identified in additional interviews) was reached within the timeframe of the study.

2.2. Data collection

Data were collected using semi-structured interviews that included topics relating to the presence of smokefree rules, who set the rules, origins of the rules, how the rules were set and enforced, and, presence of smokefree rules in participants' wider social circle. Interviews lasted for approximately 20–40 min and were audiotaped and transcribed.

Additional to the qualitative data, relevant baseline and outcome data (demographic data), existence of smokefree rules in home and car, and smoking status of mother at 12-months follow up was extracted from the main study data.

2.3. Procedure

Women who were selected were re-contacted by Indigenous Community Workers (ICWs), who had worked with the participants during the main study, after the completion of the trial, either via letter followed by a phone call (in Australia) or directly by phone (NZ). The women who consented to participate in the sub-study were visited by the ICW at a location convenient to the participant. Questions were asked in a natural conversational style, with the ICWs prompting participants to provide more in-depth information about each topic.