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Smoking behaviours in a remote Australian Indigenous community: The influence of family and other factors[☆]

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ABSTRACT

In Australia, tobacco smoking is more than twice as common among Indigenous people as non-Indigenous people. Some of the highest smoking rates in the country are in remote Indigenous communities in the Northern Territory of Australia. Owing to this high prevalence, tobacco use today is the single biggest contributing risk factor for excess morbidity and mortality among Indigenous Australians. Despite this, there is a lack of published research which qualitatively explores the social context of Indigenous smoking behaviour or of meanings and perceptions of smoking among Indigenous people. The aim of this study was to understand why Indigenous people start to smoke, the reasons why they persist in smoking and the obstacles and drivers of quitting. We conducted semi-structured interviews with a purposive sample of 25 Indigenous community members in two remote communities in the Northern Territory and 13 health staff. The results indicate that there is a complex interplay of historical, social, cultural, psychological and physiological factors which influence the smoking behaviours of Indigenous adults in these communities. In particular, the results signal the importance of the family and kin relations in determining smoking behaviours. While most community participants were influenced by family to initiate and continue to smoke, the health and well being of the family was also cited as a key driver of quit attempts. The results highlight the importance of attending to social and cultural context when designing tobacco control programs for this population. Specifically, this research supports the development of family-centred tobacco control interventions alongside wider policy initiatives to counter the normalisation of smoking and assist individuals to quit.

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Introduction

Background

Currently, tobacco use causes 1 in 10 deaths among adults worldwide or more than 5 million people a year,

making it the leading preventable cause of death globally (Mathers & Loncar, 2006). Indigenous populations are consistently over-represented in smoking prevalence and associated morbidity and mortality statistics in developed countries throughout the world, including Canada, New Zealand and the U.S. (Anand et al., 2001; Bramley, Hebert, Tuzzio, & Chassin, 2005). In this regard, Australia is no different. Despite the fact that Australian tobacco control efforts have made significant inroads in reducing mainstream smoking rates over recent decades (Chapman & Wakefield, 2001), smoking rates among Indigenous people have, thus far, been resistant to such campaigns.

National statistics indicate that in 2004–2005, 50% of Indigenous adults were regular smokers – twice the rate of

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non-Indigenous adults (ABS, 2006). Local reports indicate smoking rates are in excess of 70% in some remote Northern Territory communities (Burgess, 2007). Notably, there has been no significant change in national Indigenous smoking rates since earlier surveys in 1994 and 2002 (ABS, 2004; Cunningham, 1997). As a consequence, 12% of the total disease burden among Indigenous Australians is attributable to tobacco use (Vos, Barker, Stanley, & Lopez, 2007). Tobacco use is the single most important risk factor for excess mortality and morbidity in Indigenous Australians; responsible for one-fifth of Indigenous deaths in 2003 and 17% of the 'health gap' between Indigenous and non-Indigenous Australians (Vos et al., 2007).

Despite the high prevalence of smoking among Indigenous Australians and the disproportionate health costs, relatively little attention has been given to research which focuses on this group. The little research that has been done has for the most part consisted of epidemiological studies of the incidence and prevalence of smoking and the links between smoking and disease (Ivers, 2001). More recent work has examined the social determinants of smoking and found that the most disadvantaged Indigenous people are less likely to be non-smokers, ex-smokers or never-smokers than more socially advantaged Indigenous people (Thomas, Briggs, Anderson, & Cunningham, 2008). This new information is valuable. However, the data were drawn from a large questionnaire and do not allow for a more in-depth exploration of the social context in which Indigenous people smoke or of Indigenous meanings and perceptions of smoking. Far less research, both in Australia and internationally, has qualitatively investigated these issues among Indigenous adults.

The importance of social context for the uptake and maintenance of smoking is increasingly acknowledged (Poland et al., 2006), especially among disadvantaged groups, where factors associated with low socioeconomic status (e.g. high unemployment, poor education, stress etc.) are implicated in high smoking and low quit rates (Baker et al., 2006; Baumann et al., 2007; Harwood, Salsberry, Ferketich, & Wewers, 2007; Haustein, 2006). Indeed, the only published qualitative research study of smoking among Australian Indigenous adults provides support for the significant impact of social and economic stressors, in smoking maintenance among pregnant women (Wood, France, Hunt, Eades, & Slack-Smith, 2008). Intersecting with the social is the cultural context in which smoking occurs. While tobacco is a global phenomenon, used across many different and varied ethnic groups, it is "culture [that] shapes the specific methods and patterns of its use" (Unger et al., 2003, p.S101). The reasons people use tobacco, the meanings of tobacco use, and the implications of not smoking are all determined to a significant degree by cultural context (Unger et al., 2003, p.S101). Given this, it is imperative to more fully understand the context in which Indigenous people start to smoke (or conversely never initiate the behaviour), the reasons why they persist in smoking and the obstacles and drivers of quitting. It is only when we understand these factors can policy and programs on tobacco control start to make some headway in reducing the alarmingly high rates of smoking among this population.

Aims

The study aimed to investigate among Indigenous adults:

- The reasons why and in what circumstances they started smoking,
- The reasons why and in what circumstances they continued to smoke,
- The obstacles and drivers of quitting smoking, and
- The contextual experiences of those who had never smoked.

Methods

Semi-structured interviews with Indigenous community members and health staff were used to investigate the views and experiences of smoking in two selected remote Indigenous communities. Observation of smoking behaviours in one Indigenous community and informal discussions with community members also provided additional data for analysis. A reference group, which included Indigenous representatives, provided input into the research process. This included guidance on questions to be included in the interview guide that were not immediately obvious from a review of the literature (e.g. the use of tobacco for trading in ceremony), advice on important cultural protocols and the importance of recruiting a cultural broker in the community who could assist with introducing the researcher to potential research participants.

Sampling utilised a mix of purposive and snowball techniques, which aimed to be inclusive of the experiences of adult men and women, with a range of smoking histories ($n=25$). Health staff ($n=13$) included government and non-government workers living in the communities and those who travelled regularly from Darwin, the capital of the Northern Territory to work in these settings. Recruitment was assisted by women elders in the communities (Research Assistants), who also provided interpreting skills where necessary. The interviews were semi-structured and followed key themes set out in an interview guide, developed through review of relevant literature on smoking among Indigenous populations and discussions with service providers and the researchers' Indigenous colleagues. The guide was flexible and allowed for the exploration of previously identified themes in subsequent interviews, until common themes began to repeatedly emerge from the data and no new, significant themes were identified. There were however constraints on achieving 'saturation' for participants who were 'never-smokers' and this limitation is described later in the paper.

The interviews with all the community members and the majority of health staff were conducted by the first author (VJ); a 35-year-old non-Indigenous researcher who lived in Darwin and travelled regularly to the study site. It is well recognised that age, class and gender are all factors which shape and structure social relationships and thus influence the research interview process (Manderson, Bennett, & Andajani-Sutjahjo, 2006). The power imbalance between a white researcher and an Indigenous participant in the context of a history of colonisation is especially

notable. To redress this imbalance to some extent, the interviews were conducted at a time and venue chosen by the participant and they were reimbursed \$20 for their time (usually between 45 and 60 min). This meeting was arranged only after the research had been fully explained to participants, emphasising its voluntary nature (using an interpreter where required) and giving them time to think about their involvement (usually some days). Not only did the participant's choice of location shift some control back to the participant, it also provided important context for the research (e.g. seeing first hand the overcrowding living conditions which influence children's exposure to smoking practices). After this process, two people chose not to participate.

Several participants asked to be interviewed in the company of other family members. This put them at ease and in some cases, had the unintended consequence of producing a more 'authentic' account of their experiences, which was useful in the context of talking about an 'unhealthy' lifestyle behaviour. For example, one woman provided a detailed history of a successful quit attempt. It was only after she was prompted by her daughter did she reveal that after not smoking for several years, she had recently started again. We were then able to explore the reasons for her relapse.

The qualitative data were only edited for clarity, with the aim of retaining the local Indigenous vernacular that was used during interviews. The first author (VJ) employed thematic coding to explore the qualitative data. This involved identifying themes and sub themes in the data, refining and reducing these initial themes, building hierarchies and linking themes into a broader theoretical framework (Ryan & Bernard, 2003). Atlas-ti (Version 5) was used to assist in the coding of themes and in data management. The results of preliminary analyses were fed back to the Indigenous Research Assistants and key Indigenous stakeholders, which allowed for further discussion and refinement of the key emergent themes.

Study site

This study was conducted in the Northern Territory, the jurisdiction with the largest proportion of Indigenous people in Australia (around 30%) and where Indigenous smoking rates are highest in Australia (ABS, 2006). In the Northern Territory, the majority of Indigenous people live on Indigenous-owned land in discrete and often remote communities outside of major cities (ABS, 2007), which are often characterised by high comparative levels of socio-economic disadvantage and underserved by both health facilities and practitioners (Smith et al., 2008).

Four interviews were initially conducted in a small inland community in the northwest of the Northern Territory but physical access to this site was difficult and so, the focus was shifted to a larger coastal community in the top end of the Territory (these initial interviews were included in the final sample). While traditional owners have lived in the area for thousands of years, this coastal community as it exists today was only founded in the early 1950s as a trading post and later established as a government settlement. Currently, the population is close to 3000 and is

made up of many different clan and language groups. It is serviced by one health clinic and a school, and most adults in employment are engaged in Community Development Employment Projects (CDEP), an Australian Government funded initiative for unemployed Indigenous people.

Results

Data were collected between August and December 2007. Unless otherwise specified, 'participant' refers to the views of community members [CM]. Community members ranged in age from 23 to 67 years. There were 12 males and 13 females. Two had never smoked, 15 currently used tobacco (one chewed tobacco), 6 were ex-smokers and 2 were in the early stages of a quit attempt. Seven of the current smokers indicated that they contemplated quitting smoking. Of the 13 health workers [HW] interviewed, 4 were Indigenous and the remaining were non-Indigenous. Two lived and worked in remote Northern Territory communities; the others worked for the Northern Territory Department of Health and Community Services in Darwin and they travelled regularly to work in remote communities.

Uptake of smoking

Historical and contemporary influences on smoking initiation

Many participants traced the history of smoking in their community to its introduction by Macassan fishermen from the Indonesian island of Sulawesi. These were the first non-Indigenous people to come into contact with the Indigenous population in the area, while fishing for trepang (sea slugs) from 1700 until early last century (Brady, 2002). On their visits, they regularly traded tobacco with the local people:

For long time, my people, they didn't know how to smoke but all this Macassan mob,¹ they came up – they gave them clothes and tobacco...they used to be non smokers, all my people. (CM)

Interestingly, participants were generally nostalgic about their history of seasonal contact with the Macassans, including the introduction of tobacco and pipes, which were valued as items of trade and became incorporated into social and ceremonial life. Ethnography from the early 20th century noted the ritual aspect of tobacco smoking (the passing of a tobacco pipe was a ceremonial act), and that traditionally, there were a number of social control mechanisms that dictated who took part in these smoking rites (Thomson, 1939). By contrast, the arrival of Europeans to the area and the subsequent breakdown of more traditional lifestyles was reported by participants to coincide with the rise of 'problem smoking' in their community. While it is impossible to know just how many people were addicted to tobacco before colonisation, it is apparent that with the establishment of white settlements, Indigenous people in the region, who already had an established history of valuing tobacco, suddenly had unregulated access to commercial tobacco and over time, enough

¹ Indigenous colloquial English term meaning group of people.

disposable income with which to purchase it at their whim (Indigenous Australians were given the right to unemployment benefits and wage equality in the 1960s).

Regardless of these various outside influences, from these early encounters with tobacco, participants perceived that smoking was a behaviour that had subsequently been handed down through the generations until the present day. Certainly, the significance of intergenerational transmission of smoking behaviour was reinforced by the fact that initiation to tobacco use was almost universally influenced by family smoking practices.

It is now well established that children who observe their parents smoking may come to view smoking as rewarding and socially acceptable and are therefore, are at increased risk of becoming smokers themselves (Shenassa et al., 2003). Consistent with this, participants reported that modelling of adult smoking behaviours was a significant influence on their initiation to smoking. This is highlighted by the recollections of adult smokers:

I had seen a lot of people smoking; well I copy from my mother and my grandmother and my grandfather. We see families how they act, smoke you know and we can copy from them and we say 'I am doing the same like that.' That's why they do it – they can see it from family to family. (CM)

Well, it's like something that's been handed down from father to son sort of thing you know and like the parents; they were their role model. (CM)

While parents were important role modellers, so too was extended family, which holds a dominant place in the lives of Indigenous people. Several generations commonly live in the same residence and extended family play important roles in child rearing, including young siblings and cousins (Penman, 2006). Thus, the smoking behaviours of the entire family unit were important social influences on these participants. So heavy was the exposure of children to cigarette smoking within some participants' families, even very young children were reported to be able to mimic lighting up a cigarette or would actively source cigarettes in an effort to please their parents.

A few participants were spontaneously offered tobacco from family members (usually cousins or siblings); others were introduced to tobacco use when they were asked to roll or purchase cigarettes for others in the family. However, the majority of participants who smoked or were ex-smokers initially stole their tobacco from a ready and available supply from within the household and experimented with cousins and peers, only later to confess their smoking behaviour. Their parents generally discouraged them from smoking, stating they were "too young" to smoke or that it was "bad" for them. However, once their children's behaviour was revealed, there appeared a tacit acceptance of it by parents, who were more concerned that their children were honest about their actions and not steal from other family members. Parents were generally reluctant to buy their children cigarettes, but they often relented, especially if they were smokers themselves.

The influence of family is again revealed in the narratives of the two non-smokers in the study. One came from a large family of smokers and had to resist repeated requests to roll

cigarettes for the others. He attributed his non-smoking to personal resilience and determination. The other, a young girl of 23, described how the positive role models of her non-smoking mother and grandmother helped her to stay away from cigarettes, despite many of her friends smoking.

While the majority of participants who had a history of smoking initiated the behaviour within the family context, some were introduced to smoking by peers or sexual partners. In this setting, there was generally more pressure to smoke to conform or to bolster a particular self image:

A mate of mine and me, we went to the takeaway store just before school started and he had a packet of cigarettes...and he said do you want one and I said "no I don't want a smoke" and he said "come on have a smoke, don't be a wuss, real men smoke" and that sort of stuff. So I had one, coughed up my lungs the first time.... (CM)

Most participants began smoking only a few cigarettes a day (those they either stole from family or were offered from other people's packets). However, the general pattern revealed a rapid escalation in the number smoked daily, and a quick transition from stealing cigarettes and "scabbing" them from others, to buying packets at the shop, as the habit was established.

Drivers of smoking and obstacles to quitting

Social pressures to smoke

It's Monday morning and there are smokers everywhere. Men and women of varying ages are smoking – outside the council offices and at the health clinic door, as well as at the local supermarket. There is an old man in the centre of the road directing traffic – he's had a stroke and his pipe hangs precariously at the corner of his mouth. In an hour, I will wander over to the school and know there will be several others under the 'smoking tree' at the back of the building; smoking and sharing the morning's news. (Field note August 2007)

Perhaps the strongest drivers of smoking and the biggest obstacles to quitting are the social pressures in the community, both implicit and explicit, that operate to maintain the behaviour. Smokers make up the landscape of the community. All participants were either current smokers or lived with family who smoked and all agreed that they could not escape the enormous influence tobacco had on their lives, whether positive or negative. The negative effects were particularly salient in the experience of non-smokers, who described arguments (sometimes violent) over tobacco and missing out on essentials, such as food and power, because cigarettes carved too much out of the family budget. However, non-smokers are in the minority in this community. Indeed, such is the sheer number of people who use tobacco that smoking can be considered a normative behaviour in this context. Moreover, smoking is a communal and collective activity; money is commonly pooled to purchase cigarettes and the sourcing of tobacco can occupy entire family groups for

hours or a day, depending on how far they live from town. The numbers of smokers and people's preoccupation with smoking posed particular problems for people wanting to quit:

People do know [that smoking is unhealthy] – they just find it hard and the pressure. Family pressure is huge – not only family pressure – peer pressure is huge and I think often people...will say to practitioners, “oh yes, I want to give up” and then they go back out and people are smoking around them and it's just so hard. The environment at home is not often conducive to making it easy for people to give up. (HW)

Tobacco is also used in the community as a commodity for reciprocal social exchange and this practice is important in reinforcing smoking behaviour. For example, participants reported tobacco is commonly used in exchange between families for ceremonial duties (e.g. singing) at funerals and other cultural ceremonies. However, the trading of cigarettes is not limited to ceremony; the sharing of cigarettes is everyday practice. Sharing is a hallmark of Australian Indigenous society (whether it be food, money or tobacco) and it is an accepted, indeed an expected, cultural practice, which has its roots in the traditional Indigenous kinship system (Bain, 1974). This system influences all spheres of life including relationships, social control and behaviour and while it has evolved and adjusted to fit within the dominant culture, Indigenous people still prioritise innate kinship bonds which entail sharing as obligatory within the group (Lindorff, 2002). In this context, the passing around and sharing of cigarettes is part of the social fabric of the community. Participants understood that if they bought a packet of cigarettes, they may distribute half or more of the packet to others. If the cigarettes ran out, they may be called upon to share “short ones” (partially smoked cigarettes). During the fieldwork it was not uncommon to see people share a cigarette without a word passing between them or two cars stop in the middle of the road and cigarettes pass between the drivers. A few participants who were current smokers tried to limit the constant demand by buying loose tobacco (there is less demand for this and it generally lasts longer); others would buy one packet to share and hide a personal stash, but all accepted sharing their tobacco as part of life in the community:

Yesterday my nephew bought a packet and he give me five sticks – just enough for sleeping and then this morning, one to have with hot tea and then I came to work. At work, I sit down with my family and I ask them for smoke or if I have money, I go buy smokes and then I share with all the workers or people that walk past and they say “give me smoke, give me smoke” and I give them. But I say “you going to bank? You go and buy some smokes and come back and give me some sticks.”. (CM)

The sharing of cigarettes can be seen to forge social bonds, that is, the act of giving and receiving honours and strengthens kinship relations (Bain, 1974). The consequences then of refusing to give or buy cigarettes for a family member may be perceived as a betrayal of the

kinship bond that exists between two related individuals and regarded as offensive:

[If I don't buy them cigarettes]...they turn around and say “oh, you don't like me. You don't want to be my brother.” (CM)

Sharing of cigarettes also nurtures a sense of belonging and social cohesiveness in the community (Roche & Ober, 1997). As such, non-participation may engender a sense of isolation. Certainly, some participants reported being derided for their decision to quit (although others were supported); and several stated the only way they could quit would be to distance themselves from family, a proposition that is unpalatable for a culture of people who exist in their relatedness to others within a complex kinship system. Coupled with this, the pressures to take part in such a communal activity are often intense. Especially within intimate relationships, the pressure from one partner on the other to share in the experience of smoking or support the other's smoking behaviour was reported to be coercive at times:

My husband said to me “Why you not smoking?...The other people, they are all smoking...You smoke,” he said to me. He was forcing me... “You help me,” I said “can I have just one and test the smoke?” And I smoke it. (CM)

Finally, sharing a smoke provides a context for yarning (talking), sharing feelings and experiences and may present social opportunities not open to non-smokers. The sharing of cigarettes, the meanings imbued by the practice and the ease with which such sharing is transacted all make quitting especially difficult. As one participant remarked, “there is always somebody with cigarette – friend to friend, family to family.”

Smoking for pleasure and nicotine dependence

Participants who smoked or who were ex-smokers also reported that they smoked because they enjoyed it. Aside from the enjoyment they experienced when smoking with others, as already discussed, they reported other pleasurable effects. These included the perception that smoking made them more alert and able to complete tasks; they felt “happy” and “good” when smoking and that it was a “relief”, which might signal the beginning of a period of relaxation or the end of a work day. These descriptors illustrate that despite the adverse health effects of smoking, it is nonetheless an essentially pleasurable activity, which may aid in concentration, moderate mood (Waters & Sutton, 2000) and allow the smoker to exercise a sense of control, no matter their life circumstances. Conversely, participants reported that some aspects of their relationship with smoking felt outside of their control; in particular their dependence on nicotine was a key driving force to maintaining the behaviour and relapsing after a quit attempt:

I tried to give up, but I couldn't...I still had this smoke taste in my body... I know that taste and it makes us want it, it makes us feel so good. But inside it kills us. (CM)

Yeah...I didn't care about my breathing, I just loved to smoke...it's very hard for people to say I can give up

smoking because they're addicted to it and they love to smoke so much. (CM)

Participants used various discursive terms, such as 'habit,' 'addiction' and 'hooked' to describe why they could not quit, or why they felt compelled to go to great lengths to source tobacco. For example, most participants preferred to smoke tailor made cigarettes but when these ran out, they might source loose tobacco; often from older community members. If there was no loose tobacco accessible, some participants reported fossicking for discarded butts to satisfy their nicotine craving:

We get mad about smokes – if we can't have one, we have to look for the butts, we have to walk...up to the office or up there where the shops are; we've got to walk around to look for butts, until we get some of those butts and we get some of that nicotine down us and that will keep us maybe for a night and the next day we have to look for more or for another packet of cigarettes or just maybe even one. (CM)

There is also a black market economy of cigarettes in the community, where a single cigarette sells for around one dollar. This was used by people when their finances did not stretch to buying a packet, if they could not get a smoke from a family member, or if they ran out of tobacco outside of the shop operating hours (e.g. in the evenings or on the week-end).

Physiological dependence on nicotine, coupled with the social pressures to smoke and the plentiful supply of tobacco circulating in the community were a potent mix of factors contributing to high smoking prevalence.

Influential factors associated with low SES

Factors associated with low SES, such as stress, unemployment and other competing priorities were reported less often as contributing to smoking maintenance, compared to the social pressures outlined above and nicotine dependence. However, it is noteworthy that participants generally smoked more when they were not occupied doing other things and overcrowding in homes was reported as a factor, in that it increased exposure and contributed to the normalisation of smoking. Stress, when it was reported, was mainly in relation to a smoking relapse, and more often by women. For example, several participants had quit smoking for extended periods but relapsed after stressful life events, including death of loved ones, family disharmony and financial pressures. Smoking in these circumstances was used as an "outlet" for frustrations, to quell grief and to "relax." It was also reported that some Indigenous smokers expressed a degree of fatalism about their health, owing to health statistics being so poor, and this may contribute to the maintenance of smoking.

Quitting: the family as key motivator

Despite the number of current smokers in this sample and in the community generally, many expressed a desire to quit. In addition to six interviewees who have successfully quit (five women and one man), many others had

attempted it but relapsed in a period of weeks to years. Some had also devised strategies to cut down on the number they smoked, which included: only smoking on meal breaks at work, giving more of their cigarettes away to family, and going 'out bush' and engaging in traditional practices of hunting and fishing. What this demonstrates is that while smoking prevalence may be high, within this sample of community members, there was generally strong motivation to change personal smoking behaviours.

While family relationships were central to smoking initiation among this group, as well as maintenance of the behaviour, somewhat paradoxically, the family (in addition to health concerns) was a prime motivator to quit. Indeed, nearly all of the community interviewees who had successfully quit smoking referred to family as one of the major drivers behind their decision. Six of the seven participants who were contemplating quitting (both men and women) also cited family reasons. Several themes emerged: smokers were concerned with protecting the health of their young children from second hand smoke (especially if they were pregnant or breastfeeding), they wanted to act as positive role models for their children, and were generally tired of the negative impact smoking was having on the family unit (i.e. the constant hassling for cigarettes, the associated cost, and the fighting and "crankiness" that occurred when the supply ran out). The primacy of children cut across all of these themes:

My second eldest he don't smoke now. He got two little beautiful boys. And I said "you better keep off the smokes, 'cause you got responsibility now. Think about them two, not just yourself you know." The children come first, you know. (CM)

The importance of protecting the health of children meant that some current smokers and others who lived with smokers were instituting practices within their homes and other social settings to minimise the exposure of children to second hand smoke. These included making the inside of the house smoke free or physically moving a child away from cigarette smoke. Yet, despite good intentions, the implementation of these initiatives was often challenging, due to the large number of smokers generally living under one roof and concerns about not offending visitors who smoked.

Interestingly, even when health was identified as the motivation to quit, it was usually narrated through the lens of the family and not in relation to the consequences on the individual. Indigenous smokers in this study wanted to improve their health in order to see their children and grandchildren grow up and fulfil their familial responsibilities to them.

Discussion

This study used qualitative methods to explore the reasons why Indigenous people in remote communities start to smoke (or not smoke), continue to smoke and quit. By more fully understanding these processes, we are better placed to design effective anti-tobacco interventions for this population, which has the highest smoking rate in Australia. There are some limitations to the study. Firstly,

we were not able to recruit a significant number of people who had 'never smoked' and thus, the attitudes and perceptions of this group are under-represented. Similarly, it was difficult to engage younger adults to participate in the study (i.e. most participants were over 35 years). Thus, the narratives about smoking initiation refer to participants' experiences, in some cases, several decades ago and might not be fully representative of contemporary youth experiences of smoking. More research with young Indigenous Australians is required to explore the current influences on smoking uptake and maintenance.

Nevertheless, the research findings presented here suggests that there is a complex interplay of historical, social, cultural, psychological and physiological factors which influence the smoking behaviours of Indigenous adults in remote Australian communities today.

From a historical perspective, the entrenched use of tobacco traded with Macassan fisherman in the north of Australia from the 1600s, meant that Indigenous people were a ready clientele for the commercially made tobacco introduced by non-Indigenous settlers during colonisation (Brady, 2002). The shift at this juncture from seasonal access (via the Indonesian fishermen) to everyday, unregulated access, no doubt played a role in the escalating number of Indigenous smokers over the last century (Ivers, 2002), as suggested by some participants.

More contemporary factors which reportedly sustain high smoking rates, in particular social and economic contexts, underline how an addictive behaviour is influenced by cultural norms and processes (Nichter, 2003). For example, many of the determinants of smoking and barriers to quitting in this study were similar to those that exist among smokers in similarly disadvantaged settings elsewhere (Stead, MacAskill, MacKintosh, Reece, & Eadie, 2001). This is particularly so for those socioeconomic factors that participants identified (e.g. stress, overcrowding, boredom, low health priority) as salient, particularly in their experience of relapse after a quit attempt. In this study, high nicotine dependence, characterised by withdrawal, the significant amount of time spent obtaining tobacco and unsuccessful attempts to quit (Shadel, Shiffman, Niaura, Nichter, & Abrams, 2000), was also instrumental in maintaining the behaviour, as has been reported elsewhere (Bancroft, Wiltshire, Parry, & Amos, 2003). However, perhaps the most significant drivers of smoking in this context relate to the unique social and cultural context, that is, the normative nature of smoking and the entrenchment of the behaviour through the exchange and sharing of tobacco. While other research has also identified the normative influence of smoking in geographical areas of high prevalence and how sharing between family and friends is a reinforcer (Stead et al., 2001), the importance afforded to reciprocity in Australian Indigenous communities deserves special attention. In previous research, Brady (1993) underscores the role that social and kinship pressures play in relation to alcohol abuse among Indigenous Australians. She states that while these pressures might be similarly present in non-Indigenous populations, they are qualitatively very different; because of the role that sharing has in reinforcing social relationships. In this context, smoking, for many Indigenous people, is not only

an important social lubricator (Lindorff, 2002; Wood et al., 2008) (for the purpose of having a 'yarn' and sharing feelings) but is also used as an aid to social cohesion (Roche & Ober, 1997) and as a means to uphold the social obligation to partake in reciprocal exchange as an expression of love, affection and relatedness (Brady, 1993). Our results are also supported by research on smoking among pregnant Indigenous women that found that the normalcy and companionability of smoking in this population makes quitting particularly challenging (Wood et al., 2008). Conversely, non-participation may lead people to feel isolated and marginalised in their communities (Briggs, Lindorff, & Ivers, 2003), and may lead to friction within relationships, as was reported by some ex-smokers and the two non-smokers in this study.

The preceding discussion emphasises the social reinforcers of smoking and points to the possible benefits of smoking as a mechanism for strengthening bonds in a community where most resources are limited. In this context one may reasonably expect that the construction of smoking as a 'social problem' may be contested (Gusfield, 1989). While a detailed discussion of this point is beyond the scope of this paper, the narratives of participants supported the view that while there may be benefits from smoking, these were increasingly balanced against the identifiable harms (e.g. to health and the well being of the family).

The results of the study also signal the importance of family (including extended family or kin) in smoking uptake, maintenance, as well as quitting. Previous research has highlighted the fact that children are significantly more likely to smoke if their parents smoke (Shenassa et al., 2003). For example, in one recent study in New Zealand, two-thirds of adolescent smoking was attributed to parental smoking and other factors under parental control, for example, smoking in the house (Scragg, Laugesen, & Robinson, 2003). As supported by our findings, the influence of parental smoking on the smoking behaviour of children is partly the result of role modelling, easier access to tobacco in the household and parental attitudes towards smoking (e.g. the extent of anti-smoking socialisation) (Jackson & Henriksen, 1997). The role of family (including extended family) as initiator, prompter, accomplice and inadvertent source has been researched in the U.S. among ethnically diverse adolescents (Alexander, Allen, Crawford, & McCormick, 1999). Notably, research has indicated that Native American parents have more lenient anti-smoking socialisation beliefs, which may partly result from poor education and low perceptions of parental efficacy (Kegler, Cleaver, & Yazzie-Valencia, 2000; Kegler & Malcoe, 2005). Our results suggest that this might be similar among Indigenous Australians in remote communities but more detailed research with young people and their parents is required to fully explore this area. Certainly, as discussed above, family play an important role in maintaining people's smoking behaviour and making it difficult to quit, through both implicit and explicit pressures to participate in this collective activity. What is notable is the fact that while family may fuel the smoking behaviour of Indigenous people, it was also the key motivator for a quit attempt in this sample. This was so, whether participants were

motivated to protect their own health to extend their longevity for family reasons, or were more concerned about the direct effects of smoking on their children.

Overall, this study demonstrates that the physiological drive to smoke is moderated and affected by socioeconomic status, as well as cultural and social norms that have long antecedents (Brady, 2002). Importantly, the pressures to smoke in a culture which emphasises group identity and belonging and where tobacco use is shared and communal in nature requires a shift in focus to view smoking in this context as a “collective social practice” (Poland et al., 2006, p.60), as opposed to an individual lifestyle behaviour. In particular, the family and the immediate social or kinship group are where “[smoking] rules and the rebellions are played out, negotiated, conveyed to others and passed intergenerationally” (Glover, 2005, p.18). Thus, this research suggests that a worthwhile strategy for anti-tobacco interventions in this population may be to focus on the (extended) family and smoking in the home, which target both smoking adults and young children. Indeed, the importance afforded to the well being of the family and in particular the fulfilment of familial responsibilities towards the care and protection of children among Indigenous Australians (Penman, 2006) provides a valuable opportunity for such an intervention. Similar to research with Native Americans, our results suggest that parents do not want their children to smoke but may benefit from more support and education to help socialise their children against smoking (e.g. not allowing smoking in the house, being consistent in talking to children about not smoking, setting firm ground rules with consequences for children found smoking) (Kegler et al., 2000). Similarly, there appeared some support and action among some participants in instituting smoke free areas around their children. This could be further capitalised on and promoted, not only to protect children from second hand smoke, but as a vehicle to move smoking adults further along the contemplation continuum regarding their smoking behaviour. A family-centred intervention could be delivered by specially trained Indigenous tobacco support workers who could educate and support family members in anti-smoking socialisation for their children, implementing smoke free areas and/or assist them in making quit attempts, with particular attention to managing stress and withdrawal symptoms. Such a strategy would complement wider policy initiatives to counter the normalisation of smoking (e.g. extend smoke free public places and targeted media advertising), and help shift social and family norms of smoking more in line with what has been achieved in the wider Australian community. Such a shift is what is inevitably required to reverse, at a population level, the appalling health statistics among Indigenous Australians, which are attributable to smoking.

References

- ABS. (2004). *National Aboriginal and Torres Strait Islander Health Survey 2002*. Canberra: Australian Bureau of Statistics. ABS (No. 4714.0).
- ABS. (2006). *National Aboriginal and Torres Strait Islander Health Survey 2004–5*. Canberra: Australian Bureau of Statistics. ABS (No. 4715.0).
- ABS. (2007). *Population distribution, Aboriginal and Torres Strait Islander Australians, 2006*. Canberra: Australian Bureau of Statistics. ABS (No. 4705.0).
- Alexander, C. S., Allen, P., Crawford, M. A., & McCormick, L. K. (1999). Taking a first puff: cigarette smoking experiences among ethnically diverse adolescents. *Ethnicity and Health, 4*(4), 245–257.
- Anand, S. S., Yusuf, S., Jacobs, R., Davis, A. D., Yi, Q., Gerstein, H., et al. (2001). Risk factors, atherosclerosis, and cardiovascular disease among Aboriginal people in Canada: the Study of Health Assessment and Risk Evaluation in Aboriginal Peoples (SHARE-AP). *The Lancet, 358*(9288), 1147–1153.
- Bain, M. S. (1974). Alcohol use and traditional social control in Aboriginal society. In B. S. Hetzel, M. Dobbin, L. Lippmann, & E. Eggleston (Eds.), *Better health for Aborigines? Report of a National seminar at Monash University* (pp. 42–52). St. Lucia, Queensland: University of Queensland Press.
- Baker, A., Ivers, R. G., Bowman, J., Butler, T., Kay-Lambkin, F. J., Wye, P., et al. (2006). Where there's smoke, there's fire: high prevalence of smoking among some sub-populations and recommendations for intervention. *Drug and Alcohol Review, 25*(1), 85–96.
- Bancroft, A., Wiltshire, S., Parry, O., & Amos, A. (2003). “It's like an addiction first thing...afterwards it's like a habit:” daily smoking behaviour among people living in areas of deprivation. *Social Science & Medicine, 56*, 1261–1267.
- Baumann, M., Spitz, E., Guillemin, F., Ravaud, J.-F., Choquet, M., Falissard, B., et al. (2007). Associations of social and material deprivation with tobacco, alcohol, and psychotropic drug use, and gender: a population-based study. *International Journal of Health Geographics, 6*, 50.
- Brady, M. (1993). Giving away the grog: an ethnography of Aboriginal drinkers who quit without help. *Drug and Alcohol Review, 12*, 401–411.
- Brady, M. (2002). Historical and cultural roots of tobacco use among Aboriginal and Torres Strait Islander people. *Australian and New Zealand Journal of Public Health, 26*(2), 120–124.
- Bramley, D., Hebert, P., Tuzzio, L., & Chassin, M. (2005). Disparities in Indigenous health: a cross-country comparison between New Zealand and the United States. *American Journal of Public Health, 95*(5), 844–850.
- Briggs, V. L., Lindorff, K. J., & Ivers, R. G. (2003). Aboriginal and Torres Strait Islander Australians and tobacco. *Tobacco Control, 12*(Suppl. 2), ii5–ii8.
- Burgess, P. (2007). *Maningrida Adult Health Check community report and recommendations*. Maningrida, Northern Territory: Malabam Health Board.
- Chapman, S., & Wakefield, M. (2001). Tobacco control advocacy in Australia: reflections on 30 years of progress. *Health Education and Behavior, 28*(3), 274–289.
- Cunningham, J. (1997). *Cigarette smoking among Indigenous Australians, 1994: Occasional paper 4701.0*. Canberra: Australian Bureau of Statistics.
- Glover, M. (2005). Analysing smoking using the Te Whare Tapa Wha. *New Zealand Journal of Psychology, 34*(1), 13–19.
- Gusfield, J. R. (1989). Constructing the ownership of social problems: fun and profit in the welfare state. *Social Problems, 36*(5), 431–441.
- Harwood, G. A., Salsberry, P., Ferketich, A. K., & Wewers, M. E. (2007). Cigarette smoking, socioeconomic status, and psychosocial factors: examining a conceptual framework. *Public Health Nursing, 24*(4), 361–371.
- Haustein, K. (2006). Smoking and poverty. *European Journal of Cardiovascular Prevention & Rehabilitation, 13*(3), 312–318.
- Ivers, R. (2001). *Indigenous Australians and tobacco: A literature review*. Darwin: Menzies School of Health Research and the Cooperative Research Centre for Aboriginal and Tropical Health.
- Ivers, R. (2002). Tobacco addiction and the process of colonisation. *Australian and New Zealand Journal of Public Health, 26*(3), 280–281.
- Jackson, C., & Henriksen, L. (1997). Do as I say: parent smoking, anti-smoking socialization, and smoking onset among children. *Addictive Behaviors, 22*(1), 107–114.
- Kegler, M. C., Cleaver, V. L., & Yazzie-Valencia, M. (2000). An exploration of the influence of family on cigarette smoking among American Indian adolescents. *Health Education Research, 15*(5), 547–557.
- Kegler, M. C., & Malcoe, L. H. (2005). Anti-smoking socialization beliefs among rural Native American and White parents of young children. *Health Education Research, 20*(2), 175–184.
- Lindorff, K. (2002). *Tobacco: Time for action. National Aboriginal and Torres Strait Islander Tobacco Control Project*. Darwin: National Aboriginal Community Controlled Health Organisation (NACCHO).
- Manderson, L., Bennett, E., & Andajani-Sutjahjo, S. (2006). The social dynamics of the interview: age, class, and gender. *Qualitative Health Research, 16*(10), 1317–1334.
- Mathers, C. D., & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLoS Medicine, 3*(11), e442.

- Nichter, M. (2003). Smoking: what does culture have to do with it? *Addiction*, 98, 139–145.
- Penman, R. (2006). *Occasional Paper No.15. The 'growing up' of Aboriginal and Torres Strait Islander children: A literature review*. Canberra: Department of Families, Community Services and Indigenous Affairs.
- Poland, B., Frohlich, K., Haines, R. J., Mykhalovskiy, E., Rock, M., & Sparks, R. (2006). The social context of smoking: the next frontier in tobacco control? *Tobacco Control*, 15(1), 59–63.
- Roche, A. M., & Ober, C. (1997). Rethinking smoking among Aboriginal Australians: the harm minimisation-abstinence conundrum. *Health Promotion Journal of Australia*, 7(2), 128–133.
- Ryan, A., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, 15(1), 85–109.
- Scragg, R., Laugesen, M., & Robinson, E. (2003). Parental smoking and related behaviours influence adolescent tobacco smoking: results from the 2001 New Zealand national survey of 4th form students. *New Zealand Medical Journal*, 116(1187), U707.
- Shadel, W. G., Shiffman, S., Niaura, R., Nichter, M., & Abrams, D. B. (2000). Current models of nicotine dependence: what is known and what is needed to advance understanding of tobacco etiology among youth. *Drug and Alcohol Dependence*, 59(Suppl. 1), 9–22.
- Shenassa, E. D., McCaffery, J. M., Niaura, R. S., Swan, G. E., Khroyan, T. V., Shakib, S., et al. (2003). Intergenerational transmission of tobacco use and dependence: a transdisciplinary perspective. *Nicotine & Tobacco Research*, 5(6 Suppl. 1), 55–69.
- Smith, J. D., Margolis, S. A., Ayton, J., Ross, V., Chalmers, E., Giddings, P., et al. (2008). Defining remote medical practice. A consensus viewpoint of medical practitioners working and teaching in remote practice. *Medical Journal of Australia*, 188(3), 159–161.
- Stead, M., MacAskill, S., MacKintosh, A. M., Reece, J., & Eadie, D. (2001). "It's as if you're locked in": qualitative explanations for area effects on smoking in disadvantaged communities. *Health & Place*, 7(4), 333–343.
- Thomas, D. P., Briggs, V., Anderson, I. P. S., & Cunningham, J. (2008). The social determinants of being an Indigenous non-smoker. *Australian and New Zealand Journal of Public Health*, 32(2), 110–116.
- Thomson, D. F. (1939). Notes on the smoking pipes of north Queensland and the Northern Territory of Australia. *Man*, 39, 81–91.
- Unger, J. B., Cruz, T., Shakib, S., Mock, J., Shields, A., Baezconde-Garbanati, L., et al. (2003). Exploring the cultural context of tobacco use: a transdisciplinary framework. *Nicotine & Tobacco Research*, 5(Suppl. 1), S101–117.
- Vos, T., Barker, B., Stanley, L., & Lopez, A. D. (2007). *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003*. Brisbane: School of Population Health, The University of Queensland.
- Waters, A. J., & Sutton, S. R. (2000). Direct and indirect effects of nicotine/smoking on cognition in humans. *Addictive Behaviors*, 25(1), 29–43.
- Wood, L., France, K., Hunt, K., Eades, S., & Slack-Smith, L. (2008). Indigenous women and smoking during pregnancy; knowledge, cultural contexts and barriers to cessation. *Social Science & Medicine*, 66(11), 2378–2389.