Increasing delivery of smoking cessation treatments to Māori and Pacific smokers

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Thornley and colleagues, in this issue of NZMJ, report disappointingly low uptake of subsidised nicotine replacement therapy (NRT) among 15–64 year old people in Counties Manukau (CMDHB) during 2007—Few smokers in South Auckland access subsidised nicotine replacement therapy (http://www.nzma.org.nz/journal/123-1308/3943). They rightly suggest that there is vast room for improvement.

Several helpful smoking cessation policy and programme changes have been implemented since 2007:

- The New Zealand Smoking Cessation Guidelines1 revised in August 2007 introduced the ABC approach and led to updated training for an extended range of health professionals.
- The Ministry of Health’s (MoH) focus for cessation shifted to triggering more quit attempts and increasing the use of proven treatments at each quit attempt.2
- The Quit Group added NRT Online late 2007 and Txt2Quit mid-2008.
- All general practitioners (GPs), midwives, dentists, optometrists, and nurse practitioners were included in the Quit Card (NRT) programme from 2008.
- The nicotine lozenge was subsidised from September 2008.
- Zyban was subsidised from July 2009.
- The cost per 4–8 weeks per product type reduced to $3 from September 2009 when the subsidised NRT programme changed to allow practitioners to issue prescriptions as an alternative to Quit Cards.
- CMDHB developed a Living Smokefree Plan.3

In September 2009, CMDHB progress against the MoH’s health target to provide advice and help to 80% of hospitalised smokers by July 2010 was poor (10%, ranked 17th out of 21 DHBs).4 Clearly more needs to be done for CMDHB and other DHBs to achieve their targets.

Two main barriers need to be overcome to improve delivery of cessation to Māori and Pacific people in CMDHB: low health literacy and cost.

People are not going to use effective cessation methods if they don’t know about or trust treatments. Preliminary results from Keeping Kids Smokefree (an intervention trial in the CMDHB area targeting Māori and Pacific Island parents5) suggests that awareness of the nicotine patch and gum is high among smokers (93%), but few smokers think they are effective (28% patch, 21% gum). Awareness of other evidence based pharmacotherapies is low (32% Zyban, 28% nortriptyline, 44% inhaler, 40% lozenge).
Conversely, awareness of treatments that lack evidence of efficacy is high (75% hypnosis, 73% acupuncture, 71% Nicobrevin). Extending the range of subsidised cessation treatments is welcome, but smokers need to be better informed.

Cost of accessing treatments is a barrier for low socioeconomic smokers even when pharmacotherapies are subsidised. On top of the product charge it costs time and money to visit a GP and pharmacy. Access to cessation support and treatment needs to be as convenient as it is for people to buy cigarettes from their local convenience store.

Several innovative interventions for prompting quit attempts among Māori, Pacific, and low socioeconomic smokers address these barriers:

- **Quit & Win contests** at local and regional level can deliver quit rates above baseline community rates. In 2000, a successful Quit & Win contest was piloted in Hawke’s Bay with an indication that contests may be particularly appealing to low-income smokers. Keeping Kids Smokefree’s most effective strategy for prompting quitting among school students’ parents and whānau (family) has been an adapted quit and win contest—Sponsor To Win (see www.keepingkidssmokefree.org.nz).

Minister Turia’s Whānau Ora Taskforce is looking for whānau-centred initiatives that build on the strengths and capabilities present in whānau. An Iwi Whānau Ora Challenge that pits iwi (tribes) against each other in a race towards improved Whānau Ora for their people could have a stop smoking goal for 2010. Individuals who smoke could nominate which iwi ‘team’ they are ‘competing’ for and those who are successful could be entered for a whānau prize. National contests such as this, using an enduring cultural model of inter-iwi competition (e.g. the Aotearoa Māori Performing Arts Festival) have the potential to catapult Māori towards an urgently needed reduction in smoking prevalence.

Pacific groups could use similar models to encourage quit attempts, with teams based on affiliations with particular islands, villages, or churches.

- **A retail approach to cessation**—Keeping Kids Smokefree workers trained in a retail approach, set up a display in or outside shopping centres, attract the attention of passing shoppers, talk about and show NRT samples, and issue Quit Cards. Over 800 Quit Cards were dispensed over a 2-month period in 2009 using this method—10% of cards were redeemed. This proactive strategy has the potential to reach smokers unlikely to engage with ‘reactive’ services that advertise and wait for smokers to contact them. It shows that non-clinicians trained to deliver cessation treatments can target groups the health system has difficulty delivering to.

- **Proactive recruitment through cold-calling**—Quitlines, can also go out to the smoker. There is some evidence that a reasonable proportion of smokers would find an uninvited phone call from a quit support service acceptable, resulting in similar quit rates to those obtained among populations that initiate contact themselves. Priority populations such as Māori and Pacific can be targeted by calling areas with elevated smoking prevalence and high proportions of Māori and Pacific residents.
Most smokers want to quit. A suite of effective cessation treatments and services are now available at low cost in New Zealand. New approaches, such as those outlined above, need to be developed and rolled out to increase Māori and Pacific access to and use of NRT.

**Competing interests:** MG has delivered training for Novartis and sat on a Zyban Advisory Panel for GlaxoSmithKline NZ and a Varenicline Advisory Panel for Pfizer NZ.

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**References:**

This article was corrected on 5 March 2010 to reflect the Erratum at http://www.nzma.org.nz/journal/123-1310/4021