Tackling Indigenous Smoking Program

Final Evaluation Report

18 February 2022

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Developed by the Cultural & Indigenous Research Centre Australia 2022

All research conducted by CIRCA for this project was in compliance with ISO 20252:2019 Market, Opinion and Social Research

ACKNOWLEDGEMENTS

We acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters in which we work and the knowledge-holders of the oldest continuous cultures in the world. We pay our respects to Elders past and present.

CIRCA would also like to acknowledge the respondents who gave generously of their time to share with us their thoughts about the Tackling Indigenous Smoking Program and smoking in their communities, as well as the input of the Commonwealth Department of Health, the TIS National Coordinator, and the TIS National Best Practice Unit.

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1. EXECUTIVE SUMMARY

While smoking rates among Aboriginal and Torres Strait Islander peoples show evidence of declining,[1] tobacco use continues to be widespread among these populations, especially in remote regions, and remains a leading contributor to their burden of disease. The Tackling Indigenous Smoking (TIS) Program was established to improve the health of Aboriginal and Torres Strait Islander peoples by preventing their uptake of smoking and supporting smoking cessation. TIS is a multi-component program that employs evidence-based activities and focuses on tobacco reduction outcomes. Importantly, it promotes culturally tailored approaches designed for and by Aboriginal and Torres Strait Islander peoples.

The 2018-19 to 2021-22 TIS Program consists of:

- Regional Tobacco Control Grants (RTCG) and Remote Priority Group Grants (RPGG) funded by the Federal Department of Health (the Department) for tobacco control activities and enhanced activities targeting priority groups (such as pregnant women and remote communities)
- a range of national supports for implementation, including a National Best Practice Unit (NBPU) and a National Coordinator position
- performance monitoring and evaluation
- enhanced Quitlines and quit training for TIS staff
- leadership and coordination.

The TIS Program supplements Australia's broader national tobacco control measures, such as plain packaging, health warnings and excise duties.

For the evaluation of the 2018-19 to 2021-22 TIS Program, the Cultural & Indigenous Research Centre Australia (CIRCA) was contracted to assess the extent to which best practice and evidence-based interventions are in place and effectively implemented, explore the extent to which and how program objectives have been met, and to determine where program improvements can be made. For this evaluation of the Regional Tobacco Control Grants (RTCG), CIRCA has collected data from diverse stakeholders for analysis at two time points, once in 2020

[1] Greenhalgh, EM, Hanley-Jones, S & Winstanley, MH. 1.9 Prevalence of tobacco use among Aboriginal peoples and Torres Strait Islanders. In Greenhalgh, EM, Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2020. Viewed 7 February 2022 <http://www.tobaccoinaustralia.org.au/chapter-1-prevalence/1-9-prevalence-of-tobacco-use-among-aboriginal-peo>

and once in 2021. This evaluation report reports on the second of those two time points and represents the final evaluation.

To provide insights into the program, CIRCA has relied on the following data sources:

- in-person and virtual site visits to RTCG recipient locations (eight sites in 2020 and nine sites in 2021), involving consultations with TIS staff and community members and stakeholders
- semi-structured phone interviews with 28 RTCG recipients who were not the subject of site visits
- a comprehensive online survey distributed to all RTCG recipient staff, conducted in 2020 and 2021
- qualitative in-depth interviews with NBPU TIS, Quitline, Quitskills, National Coordinator, and Department of Health staff (12 interviews in 2020 and 11 interviews in 2021)
- RTCG recipients' Activity Work Plans (AWPs)
- RTCG recipients' Performance Reports (Jul-Dec 2019 and Jul-Dec 2020)
- Quitline referral data and Quitskills data.

Our findings regarding the appropriateness of the TIS Program

An implementation objective for the TIS Program is that it be culturally appropriate, evidence-based, and accessible to a diversity of Aboriginal and Torres Strait Islander peoples.

We have found that the **TIS Program is delivered in a culturally appropriate way**, from the top of the program's leadership down to TIS team staff working on the ground. That is, there appears to be community control and ownership of TIS, and evidence that the program embodies Aboriginal and Torres Strait Islander cultural values.

We have also found that **TIS Program activities are based on an evidence-based population health promotion approach for the most part**, largely through grant recipients' access to the NBPU and the range of resources and support it offers. However, while all RTCG recipients are drawing on evidence to justify their selection of activities, the nature and quality of that evidence varies considerably. Most evidence cited by grant recipients comes from academic/science journal-based knowledge and local or anecdotal knowledge, with the rest drawing from program-generated data or grey literature. For around a third of the activities included in AWPs though, the source of evidence used was unclear, indicating room for improvement among grant recipients. It may be that RTCG recipients have improved their ability to draw on the evidence base since they prepared their initial AWPs but without access to updated AWPs, we are unable to measure this for the final wave of the evaluation. Therefore,

it is recommended that the Department of Health and NBPU provide TIS teams with more guidance on valid evidence and how to source it, to inform activities selected for AWPs. It is also recommended that TIS teams annually update their AWPs and submit them to the NBPU and FAMs for external review and feedback.

The evaluation data collected to date clearly indicate that, as intended, **TIS teams have extended their reach to sizable populations outside their Aboriginal Community-Controlled health service's clientele**. This has been principally through social media campaigns and broad social marketing, distribution of resources, work with partner organisations (e.g. schools, sports clubs, prisons), community leaders, employers (i.e. around smoke-free policies), and through other activities. This level of reach, given the size of Aboriginal and Torres Strait Islander populations, suggests that the volume of messaging is high. The positive effect of these activities is being demonstrated through increases in the number of smoke-free workplace policies, public events, public and private transport, and homes; and in the number of referrals to Quitline and local quit support.

Our findings regarding improvements to the evidence base underlying the TIS Program

Given that the TIS Program takes an evidence-based population health promotion approach, it is expected that program activities are supported by evidence showing what may or may not work in local contexts. An implementation goal is for TIS grant recipients to use evidence to shape and improve their program design or implementation.

We have found that **TIS teams have gained a better understanding of an evidence-based population health promotion approach over time**, although some TIS teams initially struggled to understand this approach. Most teams have drawn on NBPU resources to source evidence and some have sought further training around this approach. Evidence that TIS teams have improved their understanding is in the quantitative and qualitative data provided in their Performance Reports.

Many RTCG recipients advised that they routinely modify their program activities, based on their monitoring of what does and does not work in their programs. They are using that information to review their practices. Modifications include adapting activity materials, adjusting their delivery medium or process, adjusting their targeting to specific groups, and tailoring activities and services to the needs of those groups.

Our findings regarding national support to the TIS Program

One implementation objective of the TIS Program is for the NBPU, National Coordinator, and key organisational leaders to support RTCG grant recipients and the program overall, by enhancing program implementation and outcomes.

The evaluation has found that the **NBPU and the National Coordinator provide considerable support to TIS grant recipients to facilitate their understanding and implementation of**

evidence-based population health approaches. A few TIS teams are very experienced with such approaches and have been working in this space for some time; these teams found the NBPU resources less useful. Aside from those few, we found that **the vast majority of TIS grant recipients value and find NBPU support useful for identifying and promoting best practice evidence-based approaches**. This includes the NBPU website, jurisdictional workshops, training, TIS Facebook page and Tackling Indigenous Smoking Resource and Information Centre (TISRIC) database, newsletter and Yarning Circles. However, the evaluation did find **scope for improvement in the ways in which NBPU provides support to TIS teams**, namely in its provision of more consistent communications to teams, supporting them to update their AWPs, as well as supporting them with the monitoring and evaluation of their activities. Some TIS teams could also improve their use of NBPU resources and support to remain up to date with developments and evidence in this field, and to ensure their use of good practice.

The National Coordinator provides direct support to RTCG recipients, for example, through tailored presentations at each jurisdictional workshop, contribution to training, circulation of regular TIS newsletters and organisation of Yarning Circles, as well as indirect forms of support through advocacy for tobacco control and cessation at various levels of leadership across the country. Despite this work, **TIS staff were limited in the extent to which they could actively and strongly cite the support and mentorship they receive from the National Coordinator**. This may be in part due to the part-time nature of the role, the impact of COVID-19 on the National Coordinator's capacity to travel to and visit teams, and his advocacy work being less obvious to TIS teams. We suggest the NBPU better promote the support and mentorship opportunities the National Coordinator can provide to TIS teams, as well as consider additional opportunities for him to engage with TIS staff (e.g. through online workshops).

The evaluation was unable to find evidence that key organisational leaders within the Aboriginal Community Controlled Health Organisations (ACCHOs) are leading or advocating for evidence-based population health approaches, given that TIS teams are part of their organisational structure. Of more concern, some TIS staff have raised issues with the NBPU and National Coordinator relating to impediments imposed by ACCHO management on TIS staff's ability to effectively deliver a population health program. These issues relate to: limits on travel expenses to communities even when TIS funding is available; limiting staff overtime or work outside of standard office hours; expectation to work with health service clients rather than wider Aboriginal and Torres Strait Islander populations, and restrictions on setting up social media forums for TIS.

Our findings regarding the achievement of short-term outcomes for the TIS Program

COVID-19 had a significant impact on the delivery of certain activities in 2020 and 2021. Restrictions on movement and in-person contact primarily curtailed TIS community engagement and education activities, and delivery was also affected in instances where service resources and TIS team members were redeployed to deal with the pandemic. Despite these

impacts, TIS teams do appear to have made good progress on the program's short-term objectives.

The TIS Program short-term outcome objectives and achievements on these are outlined below:

A. ***Outcome:*** **RTCG recipients are successfully delivering a range of evidence-based population health promotion approaches including to priority groups**

Our evaluation found that **TIS grant recipients are delivering a wide range of activities to community members and that these activities are largely evidence-based**. In terms of reach, **TIS activities connected with people across the country many times in the evaluation period: nearly 2.9 million times in the second half of 2019 and approximately 2.6 million times in the second half of 2020** (the 2020 figure is likely to be more accurate due to a change in instructions in the Performance Reporting template for that year). Community member interviews and focus groups suggest that TIS teams are making significant in-roads in reaching smokers and non-smokers, who can and do influence their colleagues, family members and friends. **In 2020, on average, TIS teams reported reaching 13.7% of their target populations.** We suspect this is an underestimate, however, as there were many missing data points across teams for this new element of reporting introduced in the July to December 2020 Performance Report.

RTCG recipients have been successful in reaching priority groups, although the groups reached vary between teams. **Children and young people are the priority group most engaged**, through schools, youth and sporting clubs, but TIS teams are also reaching pregnant women and new mothers, Elders and people in remote locations.

B. ***Outcome:*** **TIS activities are reaching their intended community members**

TIS activities reached people just over 2.9 million times in 2019 and just over 2.6 million times in 2020. The difference in reach between years may be due to RTCG recipients in 2019 generally slightly overstating their reach and/or due to the impact of COVID-19 restrictions on movement and gathering in 2020. For either period, it is unclear how many unique community members this reach represents.

In 2020, on average, TIS teams reported reaching 13.7% of their target populations. We suspect this is an underestimate, however, as there were many missing data points across teams for this new element of reporting introduced in the July to December 2020 Performance Report. In conversation with community members across the sites we visited, it was clear that many have been reached by TIS activities and are aware of TIS messages.

C. ***Outcome:*** **TIS activities are locally relevant and have community support**

In terms of local relevance, **TIS teams are effectively engaging with local organisations and individual community leaders and members to deliver activities that are locally relevant**

and have community support. This includes through the co-design of activities and production of local resources. Teams report feeling that their activities are working well alongside similar initiatives, such as healthy lifestyles or exercise programs. **Evidence of community support for many TIS activities was clearly articulated in most conversations with community members at different TIS sites**, and through community participation in and engagement with activities.

D. ***Outcome:*** **RTCG recipients have built strong collaborations and partnerships with external organisations and individuals to achieve the goals of the TIS program**

Almost all RTCG recipients are entering extensive partnerships and collaborations with a range of organisations and individuals. These arrangements help TIS teams to deliver activities, distribute smoking cessation messaging and resources, and to learn from and share information with a wider audience. The partnerships also support TIS teams to access priority populations and people outside of ACCHO clientele. The quality of these arrangements and joint activities indicates that they will be long-lasting, as long as the social and relational needs of partnerships are appropriately addressed.

E. ***Outcome:*** **There should be an increased focus on priority groups, particularly pregnant women**

RTCG recipients are directing activities at reaching various priority groups. These vary and include pregnant women, children and young people, people with chronic conditions, men, and women. **For the second half of 2020, grant recipients reported implementing 208 activities targeted at priority groups and 207 activities in the second half of 2019.** From July to December 2020, RTCG recipients implemented 120 priority group activities targeting children and young people, which was more than the 85 they had for the same period in 2019. A continued focus on priority groups, especially pregnant women who smoke, will help TIS teams build on their successes to date.

Our findings regarding the achievement of medium-term outcomes for the TIS Program

The TIS Program medium-term outcome objectives and progress on these are outlined below:

A. ***Outcome:*** **RTCG recipients have prioritised evidence-based population health promotion approaches with maximum reach within their identified TIS region**

To reach priority groups like pregnant women and children and young people, TIS teams are largely prioritising evidence-based population health promotion approaches. According to RTCG recipients' AWPs, most activities and approaches are evidence-based for population health promotion, suggesting grant recipients have prioritised these activities. What is of concern, however, is that a large percentage (44%) of activities listed in plans have no or unclear sources of evidence. Given that the TIS Program is supposed to be evidence-based, the AWPs demonstrate a significant deficit in grant recipients' capacity at the time of writing the

plans in 2018/2019 to identify reliable information to inform activities. It is likely that grant recipients' capacity has improved over time, with NBPU and peer support, but this should be an ongoing area of development for teams and their supports.

TIS teams are also undertaking a mix of approaches according to the diverse needs among different priority groups; for example, some approaches that maximise reach (such as a social media and social marketing campaign targeting pregnant women) and others that maximise depth of engagement (such as a healthy lifestyles course conducted with children over a school term).

B. ***Outcome:*** **RTCG recipients have successfully reached priority groups, particularly pregnant women**

Activities targeting priority groups reached people just over 240,000 times in the second half of 2019 and over 140,000 times in the second half of 2020. Through those activities, **between July and December 2020, TIS teams reported reaching, on average, 27% of young people, 8% of pregnant women, and 3% of Elders in their region.** These represent good in-roads to these priority populations, particularly to young people, but these figures also clearly show **room for improvement** to reach greater proportions of these populations.

C. ***Outcome:*** **RTCG recipients have successfully increased their geographical reach**

The data indicate that grant recipients are implementing many activities to reach community members across a broad geographic area, as well as people who do not attend ACCHOs, by way of community engagement, community education, social marketing, and social media. **In the last six months of 2019, 37 grant recipients reported conducting 130 activities to increase their reach, and in 2020, 32 grant recipients reported conducting 132 activities to meet this objective.** This included activities to extend the geographical reach of TIS programs, as well as activities to reach people who do not attend ACCHOs.

D. ***Outcome:*** **RTCG recipients have ensured that Aboriginal and Torres Strait Islander peoples who do not attend Aboriginal Community Controlled Health Organisations (ACCHOs) or Aboriginal Medical Services (AMS) are prioritised and reached**

Estimations for 2019 and 2020 indicate that TIS grant recipients have successfully reached community members across a wide geographic area, far beyond people who attend ACCHOs. Data for 2020 show that **grant recipients used various strategies like social marketing and social media to achieve this, with social media activities being the most successful** (in terms of reaching the most people). **In 2020, across 32 TIS teams, 100 activities were undertaken to extend reach to people who do not attend their ACCHO or AMS, which yielded over 910,000 engagements and interactions with people.**

E. *Outcome:* The TIS Program has increased community involvement and support of tobacco control initiatives

Our evaluation finds that **the program has increased community involvement and support of tobacco control initiatives in some areas**, as evident through involvement of community members in co-design of TIS activities, community attendance at activities, community feedback on activities via formal and informal data collection processes, regular participation in activities from some community members, and willingness of community members to become Ambassadors and champions for TIS messaging. The evaluation also finds, however, that this is not universal and challenges to building and maintaining community involvement and support include COVID-19 restrictions on travel, staff turnover, unexpected cancellation of events and internal community tensions. Despite these challenges, TIS teams continue to consult and plan activities with communities, tailor activities to be culturally and locally appropriate, conduct community engagement, maintain a regular presence in communities and use strength-based approaches.

Although community involvement and support for tobacco control initiatives has increased over time, the extent of the TIS Program's contribution to this is unclear. Grant recipients themselves differ in their appraisal of this aspect of the program.

F. *Outcome:* RTCG recipients have enhanced leadership and advocacy roles of community leaders in tobacco control

TIS teams are increasing community leadership and advocacy for tobacco control, albeit at varying levels. The greatest successes have been in encouraging young people, Elders and some community leaders to become TIS Ambassadors and spokespeople. Yet, despite partnering with many community members and leaders, TIS staff remain reserved about the extent to which they have encouraged community members to 'step up' on this issue. Hesitancy to take on advocacy roles often results from individuals not wanting to draw criticism from others for their position or concerns about their commitment to remain tobacco free, if they are a past smoker.

G. *Outcome:* RTCG recipients have contributed to an increase in the number of smoke-free homes, workplaces, and public spaces

The Performance Report data clearly indicate that **RTCG recipients are undertaking numerous activities to minimise community members' exposure to second-hand smoke**. These include sponsoring smoke-free events; helping organisations and employers develop, review and enforce smoke-free policies; and helping community residents make their homes smoke-free. Almost all of the grant recipients have been doing these types of activities and most have shared information about the harms of second-hand smoke with community members and organisations, providing them with resources and support to transition to being smoke-free.

We found evidence that grant recipients are contributing to an increased number of smoke-free homes, workplaces, and public spaces. **TIS teams assisted 163 organisations in the second half of 2019 and 67 organisations in the second half of 2020 to establish or review their smoke-free policies.** The decline in numbers over time is likely to reflect the impact of COVID-19 restrictions but may also be attributed to the initial success TIS teams had engaging with employers. **TIS teams supported a total of 896 events be smoke-free in the second halves of 2019 and 2020. TIS teams also assisted 6,483 homes to become smoke-free in the second half of 2019, surpassed in the second half of 2020 with a further 14,843 smoke-free homes.**

Evidence provided by organisations which host TIS teams suggests that compliance with no-smoking policies (e.g. no smoking indoors or in a work vehicle) can be quite high. Lower levels of compliance are found in other areas though (e.g. not smoking while wearing a work uniform).

H. *Outcome:* RTCG recipients have prevented uptake among community members

Our evaluation data around prevention of uptake of tobacco is relatively scant. We have some anecdotal, promising signs that prevention is being encouraged by TIS activities. The anecdotal reports from grant recipients suggest that prevention is most likely occurring via their work with children and young people, although challenges remain among this cohort. Measurement of this metric is important, particularly in some of the remote areas where we received reports of uptake among children and young people at very early ages.

I. *Outcome Mitigators:* The key enablers and barriers to achieving medium term and longer-term outcomes

Our evaluation identified the following factors that help and hinder TIS teams achieving impact.

Enablers
Collaboration and partnerships
Staffing of TIS teams by Aboriginal and Torres Strait Islander individuals
Taking an educational approach with community members
TIS teams funding smoke-free events for community organisations
Legislation that has come into effect that outlaws smoking around people in certain circumstances, like in cars where there are children present

Barriers
TIS-funded organisations (outside of the TIS team) restriction of TIS teams' ability to travel, their travel budgets, and their ability to work overtime
Distance
Bad weather conditions and poor infrastructure (road, accommodation)
Difficulties navigating community politics and reaching people who are not interested in the tobacco control messages
Measurement and reporting challenges

Enablers	Barriers
Creating opportunities for community members to step up into leadership and advocacy roles and be visible	Avoidance of antenatal checks by pregnant women
Actively seeking out community input and creating space for that involvement	Existence of other similar programs in the community
Engaging the right local leaders as Ambassadors – those who are well respected and can help bring more people into the TIS fold	Difficulties in enforcing smoke-free policies and spaces
Education sessions that cover new or novel information about harms of smoking	Sentiments from community members that they do not want to be told what to do and that they do not respect the message because they do not have a positive view of the messenger

J. ***Outcome:*** **RTCG recipients were given sufficient assistance and time to understand and make any changes required as a result of the key areas of focus of the forward TIS program**

There was no feedback in the Performance Reports, online survey, interviews, or focus groups that spoke to this as an issue, so **it appears that grant recipients did feel they had enough time to adjust to the new focus of TIS in this grant period**.

Our findings regarding improved access to quit support through the TIS Program

The TIS Program is expected to improve Aboriginal and Torres Strait Islander peoples' access to and uptake of services to help them quit smoking. A primary way that TIS teams do this is by educating groups and individuals about quitting and making direct referrals of smokers to local quit support services and the Quitline. TIS teams facilitate referral processes by forging partnerships and collaborations with quit support services, and by increasing quit support skills among health professionals who engage with Aboriginal and Torres Strait Islander peoples.

Our evaluation found that RTCG recipients are referring people to local quit support services and, to a lesser extent, to the Quitline. The reasons for more referrals to local quit support than to Quitline included: perceived or actual language and cultural barriers with Quitline staff; telecommunication challenges and cost of phone credit; and time differences. Community members also expressed some reluctance to contact Quitline due to a lack of awareness of Quitline support; once contacted, Quitline staff not getting back to them; or simply finding that the service did not work for them. Despite these barriers, Quitline does employ Aboriginal and Torres Strait Islander staff and makes other provisions to provide culturally appropriate support. We note that more successful state Quitline services have their staff make frequent community visits, allowing community members to connect their faces and voices with the service, and adjust their branding to make it clear that their service is there for Aboriginal

and Torres Strait Islander audiences. This approach could be emulated by Quitline services more widely.

Overall, Quitline data indicates a total of 6,296 referrals of Aboriginal and Torres Strait Islander peoples were made to Quitline between June 2019 and May 2021, which does not only reflect written referrals from TIS teams (i.e. it also includes self-referrals, including those encouraged by TIS teams, and referrals from other sources). This is not a particularly high figure and **RTCG data show that TIS staff written referrals to Quitline fell from 425 referrals in July to December 2019 to only 167 referrals in July to December 2020** (the decline being possibly due in part to COVID-19 restrictions on travel to communities). Significantly, Queensland referrals far outnumber all other states and territories combined, for a variety of possible reasons.

In addition to Quitline, our evaluation found evidence that **TIS teams are forming effective collaborations to improve access to culturally appropriate quit support**. They are achieving this by partnering with organisations and individuals, such as GPs, chemists and health workers, to improve referral processes, access to nicotine replacement therapies and psycho-social support. The development of partnerships appears to be an ongoing process as grant recipients continue to identify opportunities for promoting quit support.

All the TIS staff we spoke with have heard of Quitskills and most have already undertaken or plans to undertake the training. Many other people outside TIS teams also appear to have or are planning to undertake the training, sometimes promoted or organised by TIS staff.

While TIS staff found Quitskills training useful in gaining skills and confidence to speak with community members about quitting, particularly staff who are newer to the program, criticisms of the training were also raised. These centred on the training's focus on one-on-one support to clients rather than population health approaches that underlie a TIS approach; a perception that the material is somewhat dated; and the length of time required for the training and impost on TIS teams (three days plus travel time). These criticisms suggest there is scope for NBPU to consult with grant recipients to identify the ongoing training needs for TIS teams around supporting quitting. Any training should be offered with options around flexible delivery (e.g. in person or online, breaking down training into modules that can be taken at different times, option for recognition of prior training).

Our findings regarding the overarching TIS program

Overall, our evaluation has concluded that **the TIS Program is positively impacting Aboriginal and Torres Strait Islander communities through the promotion of smoking cessation and by encouraging smokers to access local and culturally appropriate quit support**. This suggests that the program is achieving successful outcomes and merits continuation and ongoing funding, with some improvements.

Recommendations

Our evaluation has revealed that in many ways the TIS Program is operating as intended and is having desired outcomes. The evaluation did shed light on some aspects of the program that are critical to its continued success and aspects that could use some reconsideration that, if addressed, could further enhance its impact. Our recommendation overall is for the program to continue with some improvements.

- We recommend improving the planning and reporting processes for TIS teams:
  - Improve the linkage and connection between NBPU, the National Coordinator and the Department of Health to the FAMs Community Grants Hub, to allow the **NBPU, the National Coordinator, and the Department quicker access to AWPs and Performance Reports**. This will allow NBPU and the National Coordinator to provide more concrete and quicker guidance to TIS teams, while offering the Department greater insight into program delivery.
  - **Encourage teams to formally review and update their AWPs** annually, with support from NBPU, and to submit these to FAMs. This will enable teams to reflect on what is and what is not working and make adjustments. It would provide teams an opportunity to cite sources of evidence more clearly in their AWPs, learn from new evidence and adjust their plans accordingly, and re-engage with the established evidence base to improve the effectiveness of activities.
- We recommend continuing to encourage TIS teams to gather evidence, and suggest some adjustments to increase their capacity to do so:
  - **Encourage TIS teams to monitor** what works and what does not, either through formal or informal monitoring systems and processes through the ongoing requirement for performance reports and reiteration of the importance of evidence to inform and justify activities.
  - **Offer teams a range of supports to develop monitoring and evaluation frameworks and data collection tools** so they can create their own evidence for effective population health promotion approaches. This may involve developing standardised data collection tools and frameworks for distribution to TIS teams.
  - Encourage TIS teams to design and implement improved **data storage and data analysis systems.**
  - **Consider an array of indicators of community support** including, but not limited to, partnerships and requests to co-host events.
  - **Review the process of making and tracking Quitline referrals by TIS teams** to ensure that data is secure and readily available for appropriate use.

- We recommend continuing the current support provided to TIS teams to understand and use evidence-based approaches, with consideration of some improvements to that support:
  - **Supporting and encouraging TIS teams to access information from the National Coordinator and NBPU** to undertake evidence-based activities to promote smoking cessation and prevent smoking**, accentuated through additional targeted workshops/trainings and information sharing forums**.
  - **Continue offering training and education** to TIS team staff members in evidence-based population health promotion approaches, and **conduct assessments of knowledge gained** as a result of these trainings.
  - **Continue to develop or host programs or activities or make available on the NBPU website** various tobacco control topics for TIS teams to access.
- We recommend continuing the current support provided to TIS teams to enable their understanding and use evidence-based approaches by:
  - **Support and encourage TIS teams to access information from the National Coordinator and NBPU in order to undertake population health promotion approaches, and be mindful of the barriers or challenges**, so they can plan and strategise to leverage those opportunities and mitigate those challenges
  - **Encourage TIS teams to reflect on the approaches that seem to be working and assess an appropriate balance of activities to maximise reach and impact**: using social and traditional media, making messaging clearly visible, active enforcement of no-smoking areas at events, educating youth about harms of smoking, utilising hands-on tools to convey messages, distributing incentives, and working through TIS Ambassadors
  - **Offer ongoing training and education to TIS team staff members in evidence-based population health promotion approaches**, and conduct assessments of knowledge gained as a result of these trainings
  - **Continue to develop or host programs and activities or make available on the NBPU website various tobacco control topics** for TIS teams to access
  - **TIS teams, DOH, National Coordinator, Quitline, Quitskills, and NBPU should reflect on ways to mitigate and navigate challenges**: limited coordination and connections between TIS teams and Quitline, limited abilities of TIS teams to monitor and identify longer-term impacts on people they interact with, difficulties addressing smoking among young women and pregnant women in remote areas, and challenges influencing the wider community to understand and adopt a population health promotion approach

- **Continue jurisdictional workshops**, in a two-day in-person format, and if in-person meetings are not possible, consider **adjusting the NBPU online forums slightly to allow more peer-to-peer learning opportunities**.

- We recommend improving processes and approaches to achieving TIS program outcomes:
  - The NBPU and the TIS National Coordinator should **continue directly educating ACCHO management about evidence-based population health approaches to tobacco control and encourage them to show leadership** in their organisations and communities to openly advocate for the approach. In addition, they might explore ways to empower and equip TIS teams to also educate and encourage ACCHO management to take leadership in this area.
  - TIS teams should **continue to work with communities to identify their priorities and involve community members in designing and developing relevant TIS activities**
  - TIS teams should **continue their partnership efforts and identify ways to navigate the challenges associated with staff turnover** and its effect on partnership formation and sustainability
  - TIS teams should continue to **monitor community engagement (and further develop measurement tools and indicators where needed)** to gauge the extent of community involvement and support, and **strengthen their presence in some communities** to extend their messages to a larger audience
  - To better identify community members for leadership and advocacy roles, TIS teams should **create opportunities for Elders, young people and community members who are already strong advocates for tobacco control to share TIS messages;** TIS teams should try to overcome leadership stereotypes by **engaging and supporting ex-smokers as TIS role models** who can speak honestly and genuinely about the quit journey

- We recommend improving the TIS Programs' ability to provide access to and create pathways to culturally appropriate quit support
  - Given the success of one Queensland health service in making a very high number of referrals to Quitline, we recommend the **successes of that relationship between Quitline and that particular health service be explored and replicated, as possible, to encourage TIS teams nationwide to promote and make written referrals to Quitline**
  - Overcome the challenges and negative perceptions of Quitline among TIS teams, by **enabling Quitline and TIS teams to work together to build confidence and capacity**

to assist remote community members to receive quit support that is culturally appropriate accessible

- **State Quitline services to be encouraged to engage directly with communities more**, for example, through community visits
- **Continue to support and encourage TIS teams to make referrals to a variety of quit support providers**, in accordance with their community's needs
- For communities which lack sufficient and culturally appropriate local quit support and where access to telecommunications and internet is limited, **TIS team staff to continue playing a significant role in helping community members access local quit support** (e.g. AMS's, ACCHOs, hospitals, pharmacists, GPs or support groups).
- **NBPU should consult with grant recipients to identify the ongoing training needs for TIS teams around provision of quit support.** Where possible, flexible options for training delivery should be offered (e.g. in person or online, module based, recognition of prior learning).

2. INTRODUCTION

2.1 Background

While smoking rates among Aboriginal and Torres Strait Islander peoples show evidence of declining,[2] tobacco use continues to be widespread among these populations, especially in remote regions, and remains a leading contributor to their burden of disease. The Tackling Indigenous Smoking (TIS) Program was established to improve the health of Aboriginal and Torres Strait Islander peoples by preventing their uptake of smoking and supporting smoking cessation. TIS is a multi-component program that employs evidence-based activities and focuses on tobacco reduction outcomes. Importantly, it promotes culturally tailored approaches targeted for Aboriginal and Torres Strait Islander peoples. The program supplements broader tobacco control measures, such as plain packaging, health warnings and excise duties.

The Federal Department of Health has delivered the TIS Program since 2010 to reduce smoking rates among Aboriginal and Torres Strait Islander peoples. Following a review in 2015, the 2015-16 to 2017-18 TIS Program emphasised a region-specific population health approach to tobacco control and on reducing tobacco smoking in Aboriginal and Torres Strait Islander communities. The Australian Government provided $116.8 million for the program from 2015-16 to 2017-18, with a significant proportion of the funding ($93.4m) allocated to regional grants. The 2015-16 to 2017-18 program consisted of several components, including grant funding for regional tobacco control activities, a range of national supports for implementation (including the National Best Practice Unit [NBPU] and a National Coordinator), performance monitoring and evaluation, innovation grants, enhanced Quitlines and training, and leadership and coordination.

The Cultural and Indigenous Research Centre Australia (CIRCA) was contracted to evaluate the 2015-16 to 2017-18 TIS program, in collaboration with the Incus Group, Renee Williams and Professor Shane Hearn. A preliminary evaluation report was published in June 2017, with a final evaluation report released in March 2019. This evaluation concluded that the TIS Program had been successful in meeting its short-term outcomes and was on track to achieving its medium-term and long-term outcomes. The evaluation recommended that the TIS Program continue. Considerations and changes for the future implementation of the program were also recommended.

[2] Greenhalgh, EM, Hanley-Jones, S & Winstanley, MH. 1.9 Prevalence of tobacco use among Aboriginal peoples and Torres Strait Islanders. In Greenhalgh, EM, Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2020. Viewed 7 February 2022 <http://www.tobaccoinaustralia.org.au/chapter-1-prevalence/1-9-prevalence-of-tobacco-use-among-aboriginal-peo>

In February 2018, the Minister for Indigenous Health and for Aged Care, announced funding of up to $183.7 million to continue the TIS Program for four years from 2018-19 to 2021-22. The key components of the 2018-19 to 2021-22 program remain very similar to the previous iteration, with the addition of enhanced activities targeting priority groups (pregnant women and remote communities) and ceasing funding for innovation grants. CIRCA was contracted to evaluate the 2018-19 to 2021-22 program (Part A) and the Department has also contracted the Australian National University for enhanced data collection and analysis (Part B of the national evaluation), to assess impacts and outcomes from TIS Regional Tobacco Control Grants (RTCG).

The TIS Program objectives are to reduce the uptake of smoking and increase sustained cessation of tobacco use among Aboriginal and Torres Strait Islander peoples, and to reduce exposure to second-hand smoke. Table 1 outlines the program's overall objectives, along with its specific immediate objectives.

Table 1: Objectives of the TIS Program

Overall objectives of the TIS Program
Minimise harm related to tobacco use among Aboriginal and Torres Strait Islander peoples, through reductions in the uptake of smoking and an increase in sustained cessation.
Reduce exposure to second-hand smoke in cars, homes, workplaces, community areas and events.
Component/immediate objectives of the TIS Program
Population health tobacco control initiatives
1. Increase community involvement and support for tobacco control initiatives by including communities in the design and delivery of programs.
2. Increase use of multi-component and evidence-based intervention approaches that include elements such as community education, quit support groups, and youth-based interventions.
3. Build positive attitudes and social norms around reducing tobacco use.
4. Increase understanding of health impacts of smoking and pathways to quitting.
5. Increase quitting intentions and number of quit attempts among Aboriginal and Torres Strait Islander peoples, especially among pregnant women.
6. Reduce exposure to second-hand tobacco smoke.
Access to quit support
7. Increase uptake of services supporting quitting through partnerships and collaborations built through TIS.
8. Increase in specific tobacco control skills among those professionals in contact with Aboriginal and Torres Strait Islander peoples.
Capacity development for tobacco control initiatives
9. Improve capacity and capability of local services to provide accessible and appropriate tobacco control support and services.

Use and promotion of innovation and best practice

10. Identify and promote use of evidence to enhance quality and relevance of tobacco control approaches.
11. Promote innovation in tobacco control initiatives and contribute to evidence base.

Coordination, leadership and advocacy

12. Improve leadership and advocacy in tobacco control at the national and regional level

This final report presents findings from the current CIRCA evaluation of the TIS Program, based on data collected between July 2020 and October 2021. It explores the extent to which and how TIS Program objectives have been met.

2.2 Methodology

This evaluation assesses the extent to which the TIS Program incorporates and effectively implements best practice and evidence-based interventions, to explore the extent to which and how program objectives have been met, and to determine where program improvements can be made. Critical areas for investigation include: assessing the fit between the TIS Program and the needs of local Aboriginal and Torres Strait Islander communities, other stakeholders and the policy context (appropriateness); the extent to which evidence-based and best practice population health approaches are being implemented (implementation); and progress against the short and medium-term outcomes (outcomes).

Data collection and analysis have centred around answering the following evaluation questions (Table 2):

Table 2: Evaluation Questions and sub-questions

Evaluation domain	Key evaluation question	Sub questions
Implementation **Appropriateness**	1. Is the local population health promotion approach appropriate as a supplementary effort to reduce the high smoking rates among Aboriginal and Torres Strait Islander peoples?	a. Does the current TIS program support activities based on an evidence-based population health promotion approach? b. Were the funded organisations able to reach and influence a larger population than their health service clients? c. To what extent were the delivery strategies utilised in TIS RTCG recipient programs evidenced based? d. What were the key successes and barriers to

		implementing the population health promotion approach as part of the 2018-19 to 2021-22 program? e. Are the approaches and activities delivered through the TIS Program culturally appropriate?
Outcomes **Localised population health promotion approaches to reduce the uptake of smoking, increase sustained cessation and reduce exposure to second-hand smoke.**	2. To what extent have short term outcomes been achieved for RTCG recipients population health promotion?	a. To what extent are RTCG recipients successfully delivering a range of evidence-based population health promotion approaches including to priority groups? b. To what extent and how are these activities reaching their intended community members? c. To what extent and how are activities locally relevant and have community support? d. To what extent and how have RTCG recipients built strong collaborations and partnerships with external organisations and individuals to achieve the goals of the TIS Program? e. To what extent and in what ways is there an increased focus on priority groups, particularly pregnant women? f. What have been the key successes and barriers to RTCG recipients achieving their short-term outcomes? How have these differed for remote communities?
	3. To what extent have the medium-term outcomes of the TIS Program been achieved?	a. To what extent and how have RTCG recipients prioritised evidence-based population health promotion approaches with maximum reach within their identified TIS region? b. To what extent and how have RTCG recipients been successful in reaching priority groups, particularly pregnant women? c. To what extent and how have RTCG recipients been successful in increasing

		their geographical reach? d. To what extent and how have RTCG recipients ensured that Aboriginal and Torres Strait Islander peoples who do not attend Aboriginal Community Controlled Health Services (ACCHOs) or Aboriginal Medical Services (AMS) are prioritised and reached? e. To what extent and how has the program increased community involvement and support of tobacco control initiatives? f. To what extent and how did the RTCG recipients enhance leadership and an advocacy role of community leaders in tobacco control? g. To what extent and how have RTCG recipients contributed to an increase in the number of smoke-free homes, workplaces and public spaces? h. What evidence exists from the evaluation about if and how the RTCG recipients have prevented uptake among community members? i. What have been the key successes and barriers to achieving medium and longer-term outcomes? How have these differed for remote communities? j. Were RTCG recipients given sufficient assistance and time to understand and make any changes required by the key areas of focus of the forward TIS program?
Implementation **National support for RTCG recipients**	4. To what extent did the support of NBPU TIS and the National Coordinator enhance the program implementation and outcomes?	a. To what extent have RTCG recipients increased their knowledge and implementation of evidence-based population health approaches through the support provided by NBPU TIS and the National Coordinator? b. To what extent did NBPU identify and promote best practice evidence-based

		approaches by RCTG recipients to tobacco control? c. To what extent did the National Coordinator successfully support and mentor RCTG recipients? d. To what extent has there been increased leadership and advocacy by ACCHO management for evidence-based population health approaches to tobacco control? e. To what extent and how have RCTG recipients improved their monitoring and reporting systems in line with Performance Reporting guidelines and through the support provided by NBPU TIS? f. To what extent has the monitoring data collected by RCTG recipients about the performance of TIS improved since the previous evaluation?
Outcomes **Access to quit support**	5. To what extent have outcomes been achieved in relation to access to quit support?	a. To what extent and how have RCTG recipients continued to form effective collaborations and partnerships to improve access to culturally appropriate quit support and have new partnerships been built? b. To what extent and how has Quitline been promoted throughout the TIS Program and what evidence exists from the evaluation about the extent to which there are increased referrals and uptake of the service by Aboriginal and Torres Strait Islander peoples? c. How well are referrals made to supports such as Quitline, social media tools and local community Quit support groups? d. To what extent do Aboriginal and Torres Strait Islander peoples have improved access to

		culturally appropriate Quit support? e. To what extent has there been an increase in TIS staff and relevant health professionals receiving Quitskills training and to what extent are they better equipped to provide culturally appropriate quit support as a result? f. To what extent and how has the program increased community understanding of the health impacts of quitting and pathways to quitting?
Implementation **Improved evidence base**	6. To what extent are RCTG recipients using evidence to improve program design and/or implementation?	a. Have RTCG recipients gained a better understanding of evidence-based population health promotion approaches? b. Are RTCG recipients able to provide a rationale based on evidence for their strategies and activities? c. What is the quality of the evidence used to influence program design, implementation and improvement? d. Are RTCG recipients modifying their work based on new data, either from their own data sources or from others? e. Is the program revealing a better understanding of what works and what does not and in what circumstances?
Outcomes **Overarching TIS program**	7. Is the program as implemented worth maintaining?	a. Overall does the evidence collected through this evaluation suggest that the program as implemented is worth maintaining? b. What changes or refinements are required for the program going forward?
	8. What are the barriers and enablers for the development and delivery of appropriate and effective evidence based TIS health	a. How does the implementation of the TIS program differ between remote and non-remote settings (inclusive of all TIS sites)?

	promotion services in remote areas?	b. How do the challenges to implementation differ between remote and non-remote settings (inclusive of all TIS sites)? c. How do the successes in implementation differ between remote and non-remote settings, and how do the factors that contribute to success differ (inclusive of all TIS sites)?
	9. What is the benefit of implementing the TIS program in remote areas?	a. How has the TIS program addressed barriers to health promotion in remote areas? b. How has the TIS program activated and leveraged enablers to health promotion in remote areas? c. How has the TIS program created unique value for the remote communities in which it has been embedded?

2.2.1 Data collection methods

CIRCA has analysed data collected for this evaluation at two time points. This evaluation report represents the second of those time points and is referred to as the final evaluation. We have used a range of data collection methods, as outlined below.

In-person and virtual site visits to nine Regional Tobacco Control Grant recipient locations. In 2020, CIRCA conducted site visits to eight of the 37 TIS sites (in 2020, COVID-19 restrictions prevented our access to a planned ninth site) and in 2021 conducted visits to the same eight locations, plus the additional ninth site. The second round of visits allowed for an in-depth review of progress at these sites over time. Selected sites included a mix of urban, regional and remote locations. Each site visit was arranged in close consultation with RTCG recipients to ensure that the approach for each location was appropriate and reflective of the local context and needs.

During site visits, qualitative consultations were held with RTCG recipients, stakeholders, relevant service users and Aboriginal and Torres Strait Islander community members. All interviews and focus groups were conducted by our team of Aboriginal and Torres Strait Islander Research Consultants. Recruitment of community members was typically undertaken through a mix of methods (i.e. through recommendations from TIS teams and via the network connections of CIRCA's Aboriginal and Torres Strait Islander Research Consultants). Participants were diverse across gender, age and roles in the community.

Semi-structured interviews with Regional Tobacco Control Grant recipients who are not the subject of site visits. CIRCA's Aboriginal and Torres Strait Islander Research Consultants interviewed 14 RTCG recipients in 2020 and interviewed a different 14 RTCG recipients in 2021. This ensured that all 37 RTCG recipients were involved in either a telephone consultation or a site visit during the evaluation.

Comprehensive online survey of all RTCG recipients. An online TIS staff survey was administered at two time points (mid-term and final phases of the evaluation). The survey collected data on the TIS Program progress against its performance indicators and to gather staff perspectives on enablers and challenges to implementation. Because CIRCA did not have access to the names and contact details for all TIS staff at all 37 sites, TIS Coordinators were asked to distribute the survey link to all their staff. CIRCA subsequently sent out three reminders to encourage responses. The online survey resulted in responses from multiple TIS staff across different sites.

In 2020, the survey was distributed to 146 grant recipient staff across all 37 sites. In total, 56 responses were received across 29 sites from: TIS Managers (26%); Regional Coordinators (19%); Educators (16%); Project Officers (14%); and staff serving another role in TIS (25%). In 2021, the survey was distributed to all 37 grant recipients. In that year, 64 responses were received from: TIS Managers (22%); Regional Coordinators (20%); Educators (18%); Project Officers (14%); and staff serving another role on TIS (25%). Responses in that year came from all states and territories, except for ACT, and represented 31 postcodes.

RTCG recipients' Activity Work Plans (AWPs). We received and analysed 35 AWPs submitted since 2019, to explore the evidence-based nature of TIS program activities. Note that two RTCGs did not submit AWPs and no updated AWPs were provided to CIRCA for the years 2020 or 2021.

RTCG recipients' Performance Reports. We received and analysed 37 RTCG Performance Reports covering the period from July to December 2019, and 32 RTCG Performance Reports from July to December 2020, to explore progress over time against the program's six performance indicators.

Qualitative in-depth interviews with NBPU TIS, Quitline, Quitskills, National Coordinator and Department of Health. In 2020, we conducted 12 interviews with these stakeholders and a further 11 interviews in 2021 (one fewer from the Department of Health).

Quitline and Quitskills data. Aggregate data on Quitline referrals were provided by Quitline services from approximately May 2019 to May 2021. Quitskills evaluation results from 1 July to 31 December 2019 were also provided and analysed.

The analysis in this final evaluation report is based on the datasets outlined in Table 3, representing the perspectives of all program stakeholders.

Table 3: Evaluation datasets

Datasets	Jurisdictions	TIS Stakeholder Perspective
Site Visits		
Grand Pacific TIS	NSW	TIS staff; Community members
Wellington TIS	NSW	TIS staff; Community members
Sunrise TIS	NT	TIS staff; Community members
IUIH TIS	Qld	TIS staff; Community members
Nganampa (APY Lands) TIS	SA	TIS staff; Community members
Nunkuwarrin Yunti TIS	SA	TIS staff; Community members
VAHS TIS	Vic	TIS staff; Community members
KAMS TIS	WA	TIS staff; Community members
Wheatbelt TIS	WA	TIS staff; Community members
Phone interviews with TIS managers/coordinators at 28 RTCG recipients not site-visited	ACT, NSW, NT, Qld, SA, Tas, Vic, WA	TIS staff
RTCG online survey	NSW, NT, Qld, SA, Tas, Vic, WA	TIS staff
AWPs	ACT, NSW, NT, Qld, SA, Tas, Vic, WA	TIS staff
Six-month Performance Reports	ACT, NSW, NT, Qld, SA, Tas, Vic, WA	TIS staff
Implementation stakeholder interviews	National	DOH, National Coordinator, NBPU, Quitline, Quitskills

Quitline data	NSW, NT, Qld, SA, Tas, Vic, WA	Quitline
Quitskills evaluation data	National	Quitskills

2.2.2 Data analysis methods

Interview and focus group data All interview and focus group data from the nine site visits, phone interviews with 28 RTCG recipients, and phone interviews with national implementation stakeholders were analysed with NVivo software to identify themes and patterns across the dataset.[3] The themes primarily centred on the evaluation questions and objectives of the program, and also emerged from the analysis.

Data from the 2021 online survey of all RTCG recipients were analysed quantitatively using STATA software to generate descriptive statistics. Responses to open-ended sections of the survey were analysed using a thematic approach.

RTCG recipients' AWP data submitted since 2019 were analysed using Excel software to enable the calculation of aggregated descriptive statistics. No AWPs were available for 2020.

RTCG recipients' Performance Report data for the two time periods were analysed using Excel software to enable the calculation of aggregated descriptive statistics. Responses to open-ended questions in the TIS Program six-month Performance Reports were analysed for themes using NVivo software.

Quitline data were analysed using Excel software to produce trend charts of referrals for the period May 2019 to May 2021.

Quitskills evaluation report from 1 July to 31 December 2019 was reviewed and insights from it were added to our analysis of the relevant evaluation questions about capacity to provide culturally appropriate quit support.

2.2.3 Limitations

Some limitations relating to the data used in this report need to be noted:

Limitations related to site visits to nine RTCG recipient locations

- In each site, we interviewed approximately ten community members. The purpose of these interviews was to gain an in-depth understanding at each site of Aboriginal and Torres Strait

[3] Judith C. Lapadat, 'Thematic Analysis', in *Encyclopedia of Case Study Research*, ed. Albert Mills, Gabrielle Durepos, and Elden Wiebe (Thousand Oaks, CA: SAGE Publications, Inc., 2012), 926–27, https://doi.org/10.4135/9781412957397.

Islander community member perceptions of: tobacco use; its harms; tobacco control measures; and avenues and barriers to quitting. Interviews also sought to investigate community member engagement with program activities and any resulting changes in attitudes, knowledge, social interactions or behaviours. These interviews are not representative of the entire community at each site. Rather, they are intended to ground the research by generating inductive findings about the lived experience of Aboriginal and Torres Strait Islander community members, their relationship to tobacco and interaction with the TIS Program.

- The focus groups we held with TIS staff were open to all staff, including managers. This arrangement may have led some staff to being less open about some of the challenges they have experienced in their work – particularly if these challenges related to organisational constraints, such as restrictions on work outside of standard business hours.

Limitations related to data from the online survey of all RTCG recipients

- Data collected via the surveys represent the perceptions of grant recipient staff and, as such, may not always be representative of actuality. This is particularly important with respect to staff perceptions of community impact and outcomes.

Limitations related to data from the AWPs

- We did not receive AWPs from two grant recipients, therefore their data are not included in our analysis.

- To analyse the data from the AWPs, we coded the rationales that each grant recipient reported for each activity. Our coding may have misinterpreted some of those rationales, so ours are estimates of the evidence-based nature of the TIS Program activities.

RTCG recipients' Performance Report limitations

- We did not receive Performance Reports from a number of grant recipients: two recipients in 2019; and five recipients in 2020. Information about their activities and performance are, therefore, not included in our analysis.

- Activities reported should be recorded once under either Indicator 1, 5, or 6, depending on the activity's focus. In some instances, however, the same activity was reported under multiple indicators. Where duplicates were identified, they were only recorded once – generally under the first Indicator in which the activity appeared, unless enough information was provided to determine otherwise. Where potential duplicates were identified, the activities were recorded separately and labelled as such. This may have led to some overreporting of number of activities and number of times people were reached.

- Activities reported could be classified under six types: 1) Social Marketing Campaigns; 2) Social Media Activities; 3) Development & Distribution of Resources; 4) Community Education; 5) Community Engagement; and 6) Other. This classification was at the discretion of RTCG recipients. As such, similar activities were reported differently across RTCG recipients (e.g. radio commercials were reported by some under Social Marketing Campaigns and by others as Social Media Activities).

- Grant recipients varied in measures (e.g. attendees, posts, followers) they used to estimate the "number of community members reached by activities" and likely included multiple interactions with the same community members. As such, these figures are reported as the number of times people were reached. Additionally, there has been a change in how recipients report the number of people reached, so the comparison between years is not equal. The current template looks to be generating a more realistic estimate of reach but will still inevitably have a double- or multiple-count of people.

- It was apparent that grant recipients completing the Performance Report did not understand the intent of the question asking for a count of the "*total* population targeted by the TIS intervention". Instead, TIS teams often reported a *subset* of the total population. To provide a more accurate estimate, we adjusted the data in these cases so that the total now represents the largest population value TIS teams recorded if activities were directed at the General Population. In the cases where teams gave an impossibly low number (i.e. for the Priority Group population), we then deleted that figure and reported the data as missing.

- Not all activities targeting Priority Groups were provided to "end beneficiaries" (e.g. an activity where the Priority Group identified is "pregnant women" may have actually been delivered to midwives) and the numbers of people reached were reported as the intermediaries (i.e. a smaller figure) instead of the end beneficiaries. While the delivery of TIS to intermediaries reflects the systems approach of population health promotion, reporting on and assessing the numbers of people reached by these activities gets muddied when intermediaries and end beneficiaries are targeted.

3. FINDINGS

3.1 Implementation

This section provides evidence from the analysis of data relating to the extent to which evidence-based and best practice population health approaches are being implemented, as well as their appropriateness to the local context.

3.1.1 Appropriateness

This sub-section addresses key evaluation question 1: *Is the local population health approach appropriate as a supplementary effort to reduce the high smoking rates among Aboriginal and Torres Strait Islander peoples?* As per the evaluation strategy[4], the evidence provided in this sub-section is based on Indicators 1, 2, and 6.

3.1.1.1 Does the current TIS program support activities based on an evidence-based population health promotion approach?

Summary of our findings

For the most part, the current TIS program appears to support activities based on an evidence-based population health promotion approach. Grant recipients frequently draw on the NBPU and its resources for evidence to support their selection of activities and for guidance around implementation. The extent to which grant recipients use the NBPU's resources and support is affected by each TIS team's need for that support, as well as by grant recipient's and the community's capacity to gather evidence themselves through reviews of the literature or efficacy of their own activities. Grant recipients share evidence on their own activities with other TIS teams via the Tackling Indigenous Smoking Resource and Information Centre (TISRIC) database, TIS Facebook page, jurisdictional workshops, TIS newsletter and in informal discussions. TIS teams are also informed about evidenced-based population health approaches through their networks with other health workers using similar approaches. Despite these opportunities and efforts of grant recipients, there is some scope for improvement. That is, around increased NBPU support for TIS teams to source research and evidence, and around TIS staff sharing their experience and findings.

Evidence to support our findings

TIS teams' Performance Report data indicate that they are implementing a wide range of population health-type activities. Additionally, in interviews and focus groups, many grant

[4] CIRCA, 'Draft Monitoring and Evaluation Framework for the Tackling Indigenous Smoking Program 2018-19 to 2021-22', May 2019.

recipients pointed to the support they receive from the NBPU website and staff to develop activities that are evidence-based. The NBPU website provides access to research papers, conference presentations, evidence-based activities and resources that TIS staff can directly use in their programs or that they can adapt. To a lesser degree, grant recipients talked about the support they received coming via NBPU reviews of their original AWPs and Performance Reports.[5] NBPU feedback is often centred around the quality of the activities TIS teams are proposing and the evidence they use to support implementation. NBPU staff are also available to answer grant recipients' questions or discuss approaches via phone, email or in-person visits. TIS teams identified this as another important form of support:

> … we definitely, I myself, use the [NBPU] website quite often to get inspiration and ideas of how we can better deliver our services out here, and if there's any tips on there that we can use in doing that. (Grant recipient, interview/focus group, regional)
>
> I think NBPU have been really helpful. They support with reviewing our activity plans, once we've developed the draft and provide feedback for that and I think the report too. (Grant recipient, interview/focus group, regional)

TIS teams themselves can and do support each other around the data they collect about their program activities. They do this by uploading their evidence to the TISRIC database, sharing information via the TIS Facebook page, in TIS jurisdictional and other workshops, via the TIS newsletter and in TIS Yarning Circles. In interviews and focus groups, TIS teams spoke of how much they value these opportunities for peer learning about what works and what does not in program implementation. This is particularly so on a state basis where different approaches to managing COVID-19 encouraged collaboration by teams on what could work in that state. It has also been evident from discussions at the jurisdictional workshops that there is scope for intensification of peer support, through teams more diligently uploading information about strategies, successes and challenges to the TISRIC database.

Some TIS teams also spoke about receiving information, guidance and support from their health organisation or wider organisational network (e.g. within a health promotion network), that helps them align their activities with evidenced-based population health approaches.

TIS teams can and do generate their own evidence as to what works well in their communities and then adapt their work accordingly. For example, TIS staff spoke about reviewing the

[5] The mid-term evaluation report identified a need for the NBPU be able to request AWPs and Performance Reports after they have been approved by FAMS to be able to better advise support TIS teams. This approach has since been improved.

implementation and performance of their activities to assess what works, and conducting their own scans of the literature for evidence of efficacy:

> So for the last couple of activity plans, we did [planning] as a team … We spend at least two days all together sharing our ideas, what things that worked last time that we might want to repeat, what things didn't really work, maybe we could try something else. (Grant recipient, interview/focus group, regional)
>
> So we've actually enlisted a PhD person who's doing a lit review and collating all the evidence for us around what works and what doesn't in social marketing and behaviour change and health promotion for Aboriginal people. (Grant recipient, interview/focus group, regional)

In the 2021 online survey of TIS staff, 58% of respondents strongly agreed with the statement, "*The TIS Program encourages my organisation to develop TIS activities that are based on evidence regarding Aboriginal and Torres Strait Islander smoking behaviour and motivations to quit*". Interestingly, this represents a decline in positive sentiment from the 72% of respondents who strongly agreed with this statement in the 2020 survey. We can speculate that this change in response has something to do with a shift with the NBPU, such as a decline in service to teams, or that as teams become more familiar with the TIS Program, that they are looking at the evidence-base of their work more critically – but we cannot be certain of the reason.

Respondents to the online survey in 2021 consistently ranked spending the greatest financial and non-financial resources in the prior six months on *Performance Indicator 1: Implementation of evidence-based population health promotion activities aimed at preventing uptake of smoking and supporting the promotion of cessation*. As Table 4 shows, the average ranking of this indicator was 2.0 out of six for spending the greatest financial resources on this indicator (a slight decline from 2020) and as Table 5 shows, the average ranking of this indicator was 1.4 out of six for spending the greatest non-financial resources on this indicator (a slight increase in prioritisation from 2020).

Table 4: Ranked budget allocations for individual TIS performance indicators, according to 2021 online survey respondents (on a ranked scale of 1 being greatest allocation and 6 being the smallest)

Average budget allocation rank	Obs	Mean
Performance Indicator 1: Implementation of evidence-based population health promotion activities aimed at preventing uptake of smoking and supporting the promotion of cessation.	64	2.0
Performance Indicator 5: Increased focus on priority groups, e.g. pregnant women.	64	3.4
Performance Indicator 4: Reduced exposure to second hand smoke.	64	3.4
Performance Indicator 3: Increased access to Quit support through capacity building.	64	4.0
Performance Indicator 6: Increased reach into communities	64	4.1
Performance Indicator 2: Partnerships and collaboration facilitate support for tobacco control.	64	4.1

Table 5: Ranked non-financial resource allocations for TIS performance indicators, according to online survey respondents (on a ranked scale of 1 being greatest allocation and 6 being the smallest)

Average non-financial resource allocation rank	Obs	Mean
Performance Indicator 1: Implementation of evidence-based population health promotion activities aimed at preventing uptake of smoking and supporting the promotion of cessation.	64	1.4
Performance Indicator 6: Increased reach into communities	64	3.1
Performance Indicator 5: Increased focus on priority groups, e.g. pregnant women.	64	3.8
Performance Indicator 2: Partnerships and collaboration facilitate support for tobacco control.	64	3.9
Performance Indicator 4: Reduced exposure to second-hand smoke.	64	4.0
Performance Indicator 3: Increased access to Quit support through capacity building.	64	4.4

Taking all this data into account, it would appear that grant recipients do have access to and in many cases are receiving support to implement evidence-based population health activities.

Recommendations

- NBPU should continue to identify ways to streamline and institutionalise TIS teams' access to and use of research and evidence to inform their development of population health activities. Part of this may involve developing standardised data collection tools and frameworks for TIS teams, as well as further training.
- Where possible, TIS teams should intensify their use of and access to jurisdictional workshops, TISRIC, the TIS Facebook page, TIS Yarning Circles and other mechanisms to facilitate data gathering and information sharing across teams.

3.1.1.2 Were the funded organisations able to reach and influence a larger population than their health service clients?

Summary of our findings:

The aims and objectives of the TIS Program require RTCG recipients to adopt a population health approach working with broader Aboriginal and Torres Strait Islander populations, rather than their AMS clients (although AMS clients may be included in TIS activities coincidentally). While the evidence demonstrates that RTCG recipients are reaching populations outside of their health service clientele, this could be reinforced by the Minister, Department of Health and NBPU to RTCG recipients and TIS staff.

There were significant differences between 2019 and 2020 in the way teams reached community members, principally due to the impact of COVID-19 and associated restrictions. In 2019, TIS activities largely focussed on community engagement, partnerships, and promoting smoke-free events and spaces. In 2020, however, TIS teams greatly expanded their social media and social marketing activities, while limiting their community engagement. This change in emphasis opened up new opportunities for communicating with communities and resulted in new skills for some teams.

The Performance Report data indicates some weaknesses in the way that data is reported on reach of activities. There is Performance Report data that the program is influencing populations, including data on development of smoke-free policies, organisation of smoke-free events and establishment of smoke-free homes and referrals to quit supports. We note that Quitline data on referrals are relatively small numbers and not only attributable to TIS teams, so alone are not indicative of a strong TIS Program influence on quitting behaviour.

Evidence to support our findings:

TIS program performance data captured in the corresponding six-month periods for 2019 and 2020 indicate that, as intended, RTCG recipients have been able to reach and influence a larger population than just their health service clients. We know that the number of Aboriginal and Torres Strait Islander peoples accessing ACCHOs is less than half their total Australian population[6] of 798,400 people.[7] From July to December 2019, RTCG recipients were estimated to have implemented 762 activities and reached Aboriginal and Torres Strait Islander people more than 2.9 million times; for the same period in 2020, RTCG recipients were estimated to have implemented 690 activities and reached this cohort over 2.6 million times.[8] Given the size

[6] Australian Institute of Health and Welfare 2018. *Australia's health 2018*. Australia's health series Number 16. AUS 221. Canberra: AIHW.
[7] Figure is based on the Australian census and accurate at 2016. Australian Bureau of Statistics 2017. *Australian Demographic Statistics, March Quarter.* Canberra: ABS (cat. Number 3101.0).
[8] As explained in detail in Section 3.2.1.2 of this report, the original figure for reach provided by RTCG recipients in their Performance Reports for 2019 was over 32 million. This high figure was proved to be

of the Aboriginal and Torres Strait Islander population, this represents a good volume of TIS messages over time.

It is worth noting that the estimate of reach from Performance Report data for 2020 is likely to be more accurate than for 2019, due to possible confusion over the wording in the 2019 Performance Report template. Our review of the Performance Reports indicated two data weaknesses leading to some TIS teams miscalculating the extent of their reach for activities:

A. Some TIS teams when estimating the *targeted reach of an activity* gave the figure as the population of that entire region or state or territory, when the likely reach might be smaller (e.g. for a radio advertisement, giving the figure of the entire population of the region rather than the size of the listening audience for the station).

B. Some TIS teams did not understand the intent of the Performance Report question that asked for a *count of the population targeted by the TIS intervention*, referring to the total number of Aboriginal and Torres Strait Islander peoples living in the TIS service area. In this case, some TIS teams only reported a subset of the total population (e.g. reporting on the number of midwives at working at the hospital where an activity took place, rather than the total number of pregnant women as their target).

To improve the accuracy of these figures, CIRCA: (i) replaced notably low target population numbers for General Population activities with the largest population value the team had reported; and (ii) deleted notably low target population numbers for Priority Population activities and reported these as missing.

What is demonstrably evident from the Performance Report figures and reported by TIS teams themselves is that their capacity to reach communities and individuals in 2020 was significantly compromised by the COVID-19 pandemic and corresponding restrictions. In both 2019 and 2020, RTCG recipients used diverse means to extend their reach beyond their health service clientele but were forced to change their emphasis on certain strategies in 2020 to compensate for restrictions on travel and face-to-face interaction.

To illustrate, in 2019 RTCG recipients mostly conducted community engagement activities, including organising and attending many community events (e.g. comedy events, sporting events, Colour Runs, festivals, NAIDOC events, bingo and film nights). They also engaged in partnerships with organisations like mainstream health services, sporting clubs, schools, and Departments of Corrections to reach those organisations' clients, as well as communities or groups who often miss out on such services in the region:

skewed by 2 outlier reports, one which greatly over-estimated the TIS team's reach and one in which the team mis-interpreted the question. CIRCA has corrected for these outliers and presented a more realistic figure for 2019, of TIS activities reaching people 2,978,667 times.

> I think those partnerships with other organisations are critical because, like I said, we have a lot of people that don't attend our AMS and that are outside [region]. So for us, those places such as Baptist Care, AC Care, AFSS, the Department of Education, even the Community Legal Justice Centre is another one, children's centres, day care centres, anywhere like that that we have put out information, we are reaching community that are not necessarily coming here. (Grant recipient, interview/focus group, regional)

Aside from community engagement, in 2019 RTCG recipients focussed on community education activities (e.g. through information stalls and health education sessions to various community groups), developed and distributed resources (e.g. fact sheets, posters, stickers, hats, T-shirts, bags and videos), conducted social marketing campaigns (e.g. production and airing of television, radio, newspaper and billboard advertisements) and social media activities (e.g. via Facebook, Instagram, Twitter or TikTok). Some RTCG recipients were able to support activities like smoke-free sporting events and smoke-free prisons, and work with organisations to establish or review their smoke-free policies.

In contrast, in 2020 in response to the changed conditions imposed by COVID-19, many TIS teams innovated by stepping up their community education (including online public events or education sessions), developing and distributing resources, greatly expanding their social media activity, investing in social marketing/campaigns (including contracting professional communications staff and paying for television, radio, newspaper and billboard advertisements), or working to increase their local TIS Ambassador program. All these activities allowed teams to extend their reach despite COVID-19 restrictions.

Despite the impacts of COVID-19, there is performance data to indicate that the program is not only reaching but also influencing populations. This includes data which demonstrates the establishment of smoke-free workplace policies, smoke-free community events and smoke-free households, as well as referrals to a range of quit supports. Complementing this evidence, smoking rates data from the Mayi Kuwayu study indicate that TIS areas are associated with significantly higher prevalence of smoke-free homes (15% higher) and lower nicotine dependence (21% lower) than non-TIS areas.[9]

The shift in emphasis of activities since the pandemic has had benefits and limitations for reach and influence of the program. As Australian jurisdictions emerge from COVID-19 restrictions, TIS teams may find they want to reconsider the weighting of different activities in their

[9] Cohen R, Maddox R, Sedgwick M, Thurber KA, Brinckley M-M, Barrett EM, Lovett R. Tobacco Related Attitudes and Behaviours in Relation to Exposure to the Tackling Indigenous Smoking Program: Evidence from the Mayi Kuwayu Study. *International Journal of Environmental Research and Public Health*. 2021; 18(20):10962. https://doi.org/10.3390/ijerph182010962

programs going forward, to both maximise their reach to populations and level of impact. The NBPU may be able to assist in an assessment of the best balance of activities for these objectives.

Recommendations

- NBPU should continue providing assessment and guidance to TIS teams as to an effective balance of activities to both reach and influence a larger population than their health service clients.
- NBPU should continue working with CIRCA to provide guidance and enhance support to TIS teams to improve their accuracy in reporting reach of activities and to improve Performance Report consistency across teams.

3.1.1.3 To what extent were the delivery strategies utilised by RTCG recipients evidence based? Are RTCG recipients able to provide a rationale based on evidence for their strategies and activities? What is the quality of the evidence used to influence program design, implementation and improvement?

To promote readability and limit repetitiveness in this evaluation report, this section examines three evaluation questions together.

Summary of our findings:

All 36 grant recipients which provided AWPs for analysis listed rationales for their planned delivery strategies. The nature and reliability of evidence for these rationales varied greatly. Most rationales drew on academic and scientific research (40%) or local consultation or anecdotal information (24%), with the remainder relying on TIS program-generated evidence (18%), grey literature (14%) or needs assessments (4%). Of concern though, the source of evidence for a third of rationales (33%) was unclear. We acknowledge that the AWPs we reviewed were developed in 2018 and that TIS teams may have well increased their understanding of reliable sources of evidence since then and revised their plans accordingly. However, without access to updated AWPs, we cannot be sure.

We conclude that the support for TIS teams to plan for and undertake evidence-based activities is working and should be continued. Yet, there is scope for the Department of Health and NBPU to intensify their guidance to TIS teams towards reliable sources of evidence to inform their selection and development of activities, including through peer-to-peer learning. We support the decision of national implementation stakeholders to encourage TIS teams to write their AWPs themselves. We note that people completing and updating the AWPs should be the TIS Manager or Coordinator, in consultation with TIS team members.

Evidence to support our findings:

The template for AWPs requires grant recipients to provide a rationale and source/s of evidence for their planned activities, to demonstrate both a need for and the efficacy of actions to be implemented. According to their AWPs, all 36 grant recipients for which we have data were able to provide rationales for the delivery strategies they were planning for 2020 and 2021. However, the nature and reliability of evidence for these rationales varied greatly in quality. There were also instances where grant recipients did not specify any evidence for the rationales for activities. We categorised these rationales as having "unclear sources".

Most grant recipients used evidence-based strategies from clear sources (34 of the 36 who submitted AWPs). However, two recipients based all their activities on rationales with unclear sources of evidence. Instead, they only gave broad justifications for activities, such as:

> Activity: Development and delivery of specific programs to engage identified TIS priority group's children, young people and pregnant women.
> Rationale: Tailored/Specific programs are more successful than a generic or one size fit [sic] all approach. (RTCG, AWP, remote)

It is possible that the rationales for these activities are based on externally or internally gathered evidence, but a lack of information about the evidence underpinning them make it impossible to categorise them or gauge their quality. While only two RTCG recipients were unclear about the evidence for *all* their activities, most of the other RTCG recipients were also unclear about the evidence for many of their activities. In fact, only five RTCG recipients consistently provided clear sources of evidence for all the rationales for their TIS activities.

Based on the rationales that RTCG recipients gave for their activities, we could categorise activities according to the types of evidence they relied upon. Across all 36 AWPs, RTCG recipients listed 745 activities, 729 of which listed a rationale (16 activities gave no rationale). Across those 729 activities, 942 rationales were provided (sometimes multiple rationales were given for an activity). Approximately 631 (67%) of the rationales given for activities clearly stated the type of evidence they drew on but 311 rationales (33%) were unclear about their sources of evidence.

Of the 631 rationales that were clear about their source of evidence:

- 255 (40%) were based on academic/science journal-based evidence, for example:

> Activity: Provide interactive health education sessions to children (8-15 yrs) about the risks and harms of smoking as part of healthy lifestyles, sports and life skills programs
> Rationale: Adolescents are more susceptible to nicotine addiction than adults and school based health promotion has been shown to reduce smoking rates. Reference: Harvey and Chadi Preventing Smoking in children

> and adolescents: RecoPaediatri Child Health. 2016 May; 21(4) (RTCG AWP, remote)

- 153 (24%) were based on local knowledge, community consultation and anecdotal-based evidence, for example:

> Activity: Use the data from community consultation to design and deliver regional anti-smoking campaigns within the region.
> Rationale: Evidence from last six years suggests that the program will be more successful if team – builds a long-term relationship of trust, respect and honesty with community members; maintains ongoing communication and assess community health needs; engages community members in decision making and ownership of the program. (RTCG AWP, regional)

- 113 (18%) were based on TIS program data, evaluation, assessment, publication, or promoted publication-based evidence, for example:

> Activity: Education, awareness and ongoing support of women on the impacts on smoking before, during and after pregnancy
> Rationale: National research (Scollo & Winstanley 2018) and our own data collection between 2017 and 2018 suggests that high levels of stress, lack of knowledge and misconceptions were associated with smoking tobacco during pregnancy. (RTCG AWP, remote)

  - No mentions were made of grant recipients using the Yarning Circle online forum hosted by the NBPU on the TIS website as a source for evidence to support programming decisions, as this was not yet available when grant recipients wrote their AWPs.

- 86 (14%) were based on grey literature evidence (e.g. policy briefs, program reviews), for example:

> Activity: Conduct regular follow ups with smoking cessation support services to ensure we are consistently and effectively referring participants to these services
> Rationale: Less than 1% of smokers will quit without help. Like most smokers, people from at risk groups need reminders, encouragement and support to help them quit smoking (Cancer Council Western Australia, 2016). Talking to people about their smoking has been shown to increase the likelihood of people making a quit attempt, opposed to non-personal

> approaches such as putting brochures or posters in a service which have shown to have limited impact. "Chronic diseases are the leading cause of illness, disability and death in Australia, accounting for 90% of all deaths in 2011…Of the risk factors considered by the study, dietary risks, high body mass index and smoking were the leading risk factors" (Australian Government Australian Institute of Health and Welfare, 2014) (RTCG AWP, Remote)

- 24 (4%) were based on needs assessment data from statistical agencies, that justified the targeting of a particular population but not necessarily the specific activity, for example:

> Activity: …Youth Services staff implement activities in their programs that supports awareness or risks and benefits of cessation of smoking
> Rationale: Elders, community leaders and SHSAC Board members have identified these high-risk groups and verbally stated their own observations that there is indeed a normalisation of smoking in peer groups and families, including pregnant women. (RTCG AWP, remote)

These findings show that academic and anecdotal/local knowledge types of evidence were most commonly cited by grant recipients when they first wrote their AWPs. Correlation analysis revealed no relationship between location of the TIS team (i.e. remote, regional, or urban) and the type of evidence used. It was not clear from the data available what factors contribute to teams being more or less likely to use different types of evidence to justify their activities.

The breakdown of evidence used also suggests that grant recipients carefully navigate the spaces they occupy. That is, recognising the community-based nature of their work, they are open to and use local knowledge, and recognising the situation of their work in a broader scientific discourse, they use academic and scientific evidence, as well. As one recipient put it:

> The local evidence is treated with equal respect and consideration along with the current evidence base around working in this space, either be it tobacco cessation or population health-based approaches. There is quite an amount of different perspectives in this space, so treating them equally and with consideration is essential. (Grant recipient, interview/focus group, regional)

It does appear that the support and encouragement TIS teams receive to base their activities on an evidence-base is working and should be continued. However, the fact that so many (33%) of the listed rationales in the AWPs were unclear about their sources of evidence, and drawing on

our conversations with national implementation stakeholders, there appears to be considerable room for improvement in the AWP writing process.

Although not mentioned in interviews or focus groups with grant recipients, it has emerged in the jurisdictional workshops and elsewhere that in some cases TIS team members do not write their AWPs themselves. As a result, the rationales provided for activities sometimes lack detail or come from poorer quality sources (e.g. may be more anecdotal). We support the decision of national implementation stakeholders to encourage TIS teams to update their AWPs themselves. In addition, some TIS teams have submitted their AWPs to the Department of Social Services' FAMS Community Grants Hub without review by the NBPU, which could have advised them on quality evidence to use and activities that have demonstrated positive outcomes.

We know from the interviews and focus groups with TIS teams that many review their AWPs regularly to assess what is working and what is not, and modify their plans accordingly. However, no updated AWPs were available for CIRCA to review. An annual review of AWPs with guidance and advice from the NBPU would ensure TIS teams are learning from new evidence, adjusting plans accordingly, and re-engaging with the established evidence base. This process will enhancing the likelihood that activities will be effective.

Recommendations:

- The Department of Health and NBPU should continue to provide guidance to TIS teams on sources for reliable evidence for TIS teams to be drawing on to develop activities and plans.
- In order to support ongoing monitoring and review of strategies based on new evidence, TIS teams should be required to review their AWPs annually and submit them to NBPU and FAMS for review and feedback.

3.1.1.4 What were the key successes and barriers to implementing the population health promotion approach as part of the 2018-19 to 2021-22 program?

Summary of our findings:

Grant recipients reported a range of key successes to implementing a population health promotion approach, the most prominent being: targeting priority groups of children and young people and pregnant women; engaging in community consultation and culturally resonant approaches (e.g. community events); using partnerships and collaborations to facilitate access to communities and groups; focusing on smoke-free policies, spaces and events; and use of social media and social marketing (particularly with the advent of COVID-19 and associated restrictions). Key enablers were cited as: having a full complement of staff to focus on planning and delivery of activities; drawing on NBPU and other TIS teams for information and support; community consultations to develop programs and activities, partnerships with organisations,

workers and community leaders; and having strong, trusted individual counselling options that allow TIS teams to concentrate on a population health approach.

TIS staff also identified key barriers to the implementation of a population health approach, the most significant being: COVID-19 severely curtailing community engagement and education activities (although shifts in activities have opened new access points to communities and allowed staff to develop new capabilities); gaps in staffing; acclimatising new TIS staff and communities to the value of a population health promotion approach; lack of access to local data and time and effort required for TIS teams to collect their own data; unexpected cancellations of events and activities in regional and remote areas; unfounded community perceptions of TIS workers and of smoking (including that it is not a priority). These continuing barriers suggest a need for additional workforce development in a new round of TIS funding. It should be noted that the NBPU has already developed an induction pack for new TIS staff.

Evidence to support our findings:

Grant recipients reported a range of successes or avenues to implementing a population health promotion approach. The most prominent among these were:

- Having strong, trusted individual counselling options available to community members allows TIS teams to focus on population health activities and make referrals as appropriate:

> We think that the ability to focus on a particular outcome [through the population health approach] is really beneficial, and that we can reach a lot more people. It would not be so if you didn't have the opportunity for individual counselling, however, through your Aboriginal health workers in the clinic. (Grant recipient, interview/focus group, regional)

- Being able to recruit and sustain a full complement of staff placed some TIS teams in a better position to focus their effort on the planning and delivery of population health activities, particularly amongst local staff who know their communities well.

- Engaging in partnerships and collaborations with other workers (e.g. maternal health workers, dieticians, General Practitioners [GPs]), organisations (e.g. schools, drug rehabilitation centres, prisons) and people (e.g. community leaders) helped facilitate TIS staff access to new communities or target groups to deliver population health messages:

> So [our TIS program] … recently signed an MOU with…a queer organisation that advocates for and supports Aboriginal and Torres Strait Islander LGBTQ+ community members, and our team worked very closely in the workshops leading up to [a large local event] helping community members and [the queer organisation] building the floats and helping with the costumes, which basically broke the ice and led to an MOU

being signed and this afternoon – no, yesterday – we had a focus group run by [the queer organisation] with Aboriginal and Torres Strait Islander queer community to develop messaging by that community for that community. And that's ongoing now, so that's a strong relationship, and a group with which we haven't actually worked closely with before, and smoking rates are higher in that community, so there's another example. (Grant recipient, interview/focus group, urban)

[The school program is] probably one of our most effective programs. We target the schools with the highest Indigenous population, so the ones with the most number of Indigenous students, we try and hit. (Grant recipient, interview/focus group, regional)

- Community consultation on the development of TIS activities and community engagement (e.g. in community events) was an effective way for teams to deliver population health messages and activities. For example:

What's worked well with the health promotion stuff is that that's where we see a lot of our clients, or a lot of our community members, who wouldn't ordinarily come into our clinic. So that's always been a strength for [our TIS team], is attending the community events and having those health promotion stalls around. (Grant recipient, interview/focus group, regional)

- NBPU information and support, and opportunities for TIS team peer support (e.g. through meetings with other teams, jurisdictional workshops, TISRIC database and TIS Facebook page) helped TIS teams to develop effective population health promotion approaches and activities and plans
- Quitskills training, despite having a more individualised approach, was described as giving TIS staff greater confidence to speak with smokers about quitting
- Having the option and capacity where available to increase focus on social media, social marketing, electronic communications and online education, which has led to the development of new capabilities for TIS staff and opened up different avenues for connection with communities (although barriers persist for community members without access to telephone or electronic communications). For some remote workers, online learning for staff has actually increased their accessibility to training:

COVID-19 was a big challenge in itself because we were in the office, however we did come up with new means of communication, which was fantastic, and opened a whole range of avenues, such as TV ads, billboards, Facebook videos and Ambassador clips. (Grant recipient, interview/focus group, regional)

Alongside these successes and avenues, TIS staff identified key barriers to implementation.

- Many TIS staff identified COVID-19 and accompanying restrictions as severely curtailing their planned community engagement and education activities, as well as impacting on travel for staff training and staff recruitment. For some workers, TIS health staff were also redirected to responding to the pandemic for a period of time:

> So our biggest challenge has been COVID-19 because, in the region we're in, we have a lot of remote communities that we could just not go out to last year, because we weren't allowed out there. (Grant recipient, interview/focus group, regional)

While acknowledging these COVID-19 impacts on implementation, as mentioned above, quite a few TIS staff also observed their increase in social media and marketing and electronic communications.

- Gaps in staffing, either through slow initial recruitment, staff turnover or both had inevitable impacts on program delivery and resulted in pockets of underspend:

> I think we've lost three [staff] in the last month. And they're going on for other opportunities or family reasons. But that impacts your delivery, that impacts your management or your coordination. (Grant recipient, interview/focus group, urban)

We note that uncertainty surrounding ongoing funding for programs means that often individual staff do not have security of tenure, which can drive staff turnover.

- TIS teams spoke of challenges in acclimatising new staff to the value of a population health promotion approach. The education process may be affected by budget restrictions limiting capacity to source training or supports in project management or planning. Some teams also reported a lack of support from community leaders, organisations and event partners for their shift to a population health approach (more so in the first wave of data collection in 2020), and community members themselves expressed their concerns about this change:

> [A key challenge has been] Community acceptance of new "population health approach" – that is, community [was] previously used to ongoing one-on-one support from [our] TIS worker and accessing funded allied health services. [Our ACCHO] and the TIS team has continued to inform the service providers and community of these changes through social media, newsletters and referrers workshops (Grant recipient, Performance Report, urban)

> … the TIS workers, they don't go door to door. They expect us to read pamphlets and go, do you know what I mean? It's our own individual decision, but if they're so adamant in getting it done, come and see the people. (Community member, interview/focus group, regional)
>
> I cannot still for the life of me understand why they have moved so sharply away from cessation support when they acknowledge the importance of it. The last … report if I remember correctly, advised more community base support for people to quit smoking. And they certainly acknowledge the importance of support, one of the measures of success is referrals to Quitline and other support services. And despite that most areas find themselves with a whole bunch of people who, because of the program, think okay quitting's a great idea, and then they haven't any support to do it. So I think that's just a hugely problematic direction that people have gone in (Community member, interview/focus group, regional).
>
> Look, I would say [a priority for the TIS Program should be] definitely support individuals more, individually. And whatever they need, whether it's one on one, that one on one support person to help them quit. (Community member, interview/focus group, urban)
>
> In terms of preconditions for success, I guess what's needed going forward is probably a stronger relationship and more concerted effort into how we can ascertain what community need to be able to quit… Where I would like to continue our focus is back connecting with our regions, making sure that we're on the right track, and making sure that if we're not on the right track, then getting on the same path together so that we can actually influence organisations and communities to really adopt the population health model around attacking the smokes, rather than the individual. (Grant recipient, interview/focus group, urban)

- A few teams spoke about lacking local data (including on the effectiveness of prevention), as well as the time and effort involved in their own data collection for monitoring and reporting:

> And so that has also been a barrier in itself, accessing data. So smoking data or clinical presentations and stuff like that, we have no access to any of that data. That would actually support us a lot in our reporting. (Grant recipient, interview/focus group, urban)

- Unexpected cancellations of events and activities in regional and remote areas, brought about by poor or seasonal weather conditions, community closures (e.g. for Sorry Business, community meetings or events), or program partners cancelling, had subsequent delays or impacts on delivery

- TIS staff stated that some community members are reluctant to engage with them due to perceptions of TIS workers as the "smoking police" who are there to shame or lecture smokers. To counter this perception, TIS workers strive to be non-judgemental, educational and inviting of questions rather than lecturing about the harms of tobacco and the benefits of quitting:

> A lot of people mistakenly think that, if they're not a smoker, they have no reason to engage with us. And if they are a smoker, they don't want to engage with us because they think we're going to, I guess, pressure them to quit or overload them with information on that. And so, for us, we have worked really hard to try and break that barrier down and have them come along and learn about all these effects of smoking. (Grant recipient, interview/focus group, regional)

- TIS staff and community members also spoke about problematic perceptions that some community members have about smoking itself. These included: smoking being seen as cool; smoking seen as alleviating stress; smoking during pregnancy being seen as benign; quitting being seen as likely to lead to weight gain or illness; quitting being seen as too late (i.e. too hard or of no benefit) for older adults; and smoking not being seen as a priority issue:

> I think the biggest challenge that we come across is smoking isn't the priority here. And when we're talking about smoking, we, it's hard to not, it's hard to keep the conversation just on tobacco. There's some pretty, pretty complex substance use up here. … the healthy lifestyles approach, I think, allow for a broader conversation. (Grant recipient, interview/focus group, remote)

- Some grant recipients spoke about non-Aboriginal and Torres Strait Islander peoples wanting to participate in TIS activities, raising challenges when program resources are targeted and limited:

> One of the challenges with a population health approach targeted to Aboriginal and Torres Strait Islander peoples is that some non-Indigenous people want to participate. Regional Managers and Statewide Development Officers have reported that in some schools the non-Indigenous students want to sign up because they say the topics are interesting (Grant recipient, Performance Report, urban)

One TIS team noted bureaucratic processes as slowing down their approvals for spending and implementation. This team requires approvals through various levels of state government up to Department of Premier and Cabinet, for all activities (e.g. travel and development of brochures).

Recommendations:

- NBPU and grant recipients themselves should continue to share information about enablers and barriers to population health promotion approaches, so that TIS teams can strategise to leverage opportunities and mitigate the challenges.
- The NBPU's induction pack should be used with all new TIS staff.

3.1.1.5 Are the approaches and activities delivered through the TIS Program culturally appropriate?

Summary of our findings:

From the top of the program's leadership down to TIS staff on the ground, the TIS Program appears to be delivered in a culturally appropriate way. That is, in terms of leadership and staff, prioritising the employment of Aboriginal and Torres Strait Islander staff for TIS teams and NBPU, and having an Aboriginal Advisory Council advising some recipient organisations and TIS teams. TIS teams consult and sometimes co-design programs and activities with communities. TIS teams sometimes partner with Aboriginal community leaders and groups, and incorporate local individuals, languages, concepts and values in program materials and messaging.

Evidence to support our findings:

Community control and community ownership of the TIS Program is demonstrated through the leadership roles of the NBPU (whose leadership and staff are Aboriginal and Torres Strait Islander) and the National Coordinator (Professor Tom Calma, who is a well-known and respected Aboriginal academic and human rights and social justice campaigner), and by prioritising employment of Aboriginal staff on TIS teams. Some organisations and TIS teams are advised by an Aboriginal Advisory Council, including Elders. TIS teams also commonly invite community consultation and co-design on activities and their implementation:

> Yeah, so we always work with community leaders and Elders and like I said, that's through our health action teams where they could be either leaders or Elders. We also work really closely with the local Aboriginal community councils and [our organisation, an ACCHO] always has buy-in from them, because we do what they ask us to do and we do it in such a way as that we provide sustainability of messaging once we've finished. (Grant recipient, interview/focus group, regional)

In addition, TIS teams report embedding cultural values and culturally aligned representations into the activities and materials they develop and implement. For example, in the six months covered by the 2020 Performance Reports, 84% of RTCG recipients (27 - two fewer than in 2019) reported having produced at least one tobacco control poster/banner featuring an Aboriginal or Torres Strait Islander person or artwork. Other examples cited by RTCG recipients included: translating resources and signs into local languages; using the local Aboriginal seasonal calendar; partnering with Indigenous organisations for program delivery; holding Elders' Olympics and Aboriginal Spirit Colour Fun Runs; organising walks on country; and digital storytelling.

One community member explained what cultural safety looks like in an ACCHO that delivers TIS and that it is the thing that they considered the ACCHO is doing right to change attitudes:

> I can tell you; cultural safety. When you walk into [ACCHO] you see Aboriginal health workers everywhere. You see culturally appropriate posters. And that's what I was trying to say before, the posters that they put up are targeted at Aboriginal people, and they're funny. So you might see a poster about something, and it might use a bit of a, a Koori phrase. So it gets your attention. And I guess they approach it at the community level, grassroots level, and not in a patronising way. So that's really good. [The ACCHO] in itself, you've got a kitchen there that anyone can just go there, make yourself a cuppa and have a conversation with each other. It's like a community meeting place. A lot of Elders go there. There's a lot of Elders programs, that go there. Like, if you go to a mainstream health service, you see a doctor, you only talk about what you're there for. But when you go [to ACCHO], like I said, the health worker takes you first, they take all your blood pressure and everything, they have the conversations with you, then they move you onto the doctor. Even when you get into the doctors, that doctor don't just ask you why you're here and rush you out the door. That doctor asks you about your full health. Then refers you onto dieticians, other programs within the [name of ACCHO], and that includes that smoking program. (Community member, urban)

Recommendations:

- We recognise that TIS teams and implementation stakeholders are already delivering a culturally appropriate program and recommend that they continue their current approaches.

3.1.2 Improved evidence base

This sub-section addresses key evaluation question 6: *To what extent are RTCG recipients using evidence to improve program design and/or implementation?* As per the evaluation strategy[10], the evidence provided in this sub-section is based on Indicators 1, 2, 3, 4, and 5.

3.1.2.1 Have RTCG recipients gained a better understanding of evidence-based population health approaches?

Summary of our findings:

Some RTCG recipients were already familiar with a population health approach adopted in the TIS Program but others have struggled to adjust from the provision of one-on-one support. To gain a better understanding, some teams report receiving training in a population health approach and others report turning to NBPU resources on evidence-based approaches. While the 2019 TIS AWPs demonstrate some substantial evidence gaps in the plans from most teams, the 2020 Performance Reports indicate teams' use of diverse population health strategies. As we did not receive updated AWPs for 2020 or 2021, it is difficult to be conclusive about the level of improved understanding of evidence-based population health across the entire program. Additionally, given the level of staff turnover, there is a need to continue to promote these approaches to new staff.

Evidence to support our findings:

For some teams, the evidence-based population health approach adopted in TIS was familiar to begin with:

> So population health is a clinical as a national and state indicator for our clinics as well. … So I think, if from a from a kind of macro level, the actions of the [TIS team] are really contributing into our reporting across the organisation, not just in TIS. (Grant recipient, interview/focus group, regional)
>
> I think this renewed emphasis on population health promotion fitted really well with [state's] tackling smoking approach anyway. (Grant recipient, interview/focus group, regional)

However, this was not true for all RTCG recipients, at least when they were first established or when new staff have been appointed. One grant recipient (regional, ACCO) noted in their 2019 Performance Report that identifying whether they were "meeting the funding guidelines around population health and meeting our six KPI's" was a challenge, suggesting they do not have a

[10] CIRCA, 'Draft Monitoring and Evaluation Framework for the Tackling Indigenous Smoking Program 2018-19 to 2021-22', May 2019.

good understanding of what population health approaches entailed. On the other hand, a different grant recipient (regional, ACCO) reported that seven of its staff had received population health promotion training, suggesting they now have an improved understanding of the approach. We note that the NBPU has also been offering this kind of training to teams since 2019.

Other grant recipients we spoke with described how they compiled their AWPs and explained how their understandings have changed and why. One organisation suggested that having access to NBPU resources improved their access to evidence-based approaches:

> In terms of coming up with that plan, it was really about reviewing and reflecting on past activity, and past partnerships and past expectations that we knew about the regions, and it was about ensuring that we could build upon the last activity plan. Definitely, I reviewed all the evidence, having the TIS portal was really useful, and also having the opportunity to see what other TIS programs across the country were doing. (Grant recipient, interview/focus group, urban)

Another organisation explained that improving the understanding of their staff members has been critical to helping them engage in the TIS Program:

> I guess with the evidence base, it's getting our workers to understand the reasons behind why we do the things that we do. So that's just been about increasing our education as to what that means and how that evidence has actually come about, has helped that understanding. And then also improving the acceptance of reporting and data collection so that we're able to also build our own local evidence. So that when it comes to our internal review times, we can see how our activities have worked or haven't worked and why that is. (Grant recipient, interview/focus group, regional)

These quotes indicate that some grant recipients are clear that their teams' understandings of population health promotion approaches have improved, and they are readily able to articulate this improvement.

Our review of the 2020 Performance Reports indicates that most, if not all, TIS teams seem to understand what constitutes a population health approach and are implementing such activities. The evidence for activities can definitely be strengthened, however, given the identified gaps in credible evidence underpinning selection of activities listed in the AWPs, as previously discussed.

One possible way to better gauge these gains may be to compare the evidence cited in the original AWPs to that cited in any updated versions. We have not been provided with updated AWPs but this is something that could be explored by the NBPU or in future evaluations.

Recommendations

- NBPU should continue to offer training and education to TIS team staff members in evidence-based population health promotion approaches (including findings from this evaluation), especially for new staff. They could also conduct assessments of knowledge gained as a result of these training opportunities.

3.1.2.2 Are RTCG recipients modifying their work based on new data, either their own or from others?

Summary of our findings:

Many RTCG recipients report that they are modifying their work based on new evidence, either from their own data or data from others. The types of modifications they are making include adapting activity materials, adjusting the delivery medium or process, adjusting their targeting and tailoring activities and services to their communities, adjusting their emphasis on specific strategies and making efforts to complete or follow up activities. Without updated AWPs, however, we are unable to systematically review and assess the extent to which modifications have formally been made.

Evidence to support our findings:

From the qualitative interviews and focus groups, many TIS teams indicated that they are modifying their work based on new data. For example:

> So for the last couple of activity plans, we did it as a team and it's been a real big team aspect of we spend at least two days all together sharing our ideas, what things that worked last time that we might want to repeat, what things didn't really work, maybe we could try something else. … So we usually do, after any event or anything that we have, we do a post survey too that aligns directly with questions that are asked in the [performance] reporting … And really just picking up on different things that community members say, so even if it's like, "Okay, that event that you did last time was really good. We'd like another one," or something like that. (Grant recipient, interview/focus group, regional)

One type of change RTCG recipients identified making, based on data collected or received, related to the delivery of activities. This included adapting the activity material – in terms of the language used and content– as well as creating new documents for internal purposes:

> Two of the 12 to complete the evaluation form stipulated that they were unclear on the step-by-step process of case management and practicing tobacco support as only no previous experience in the field of tobacco management. These concerns actioned by

> the development of new process documents and the practical mentoring aspect of capacity building. (Grant recipient, Performance Report, remote)

RTCG recipients also identified making changes to the delivery medium and process (for example, changing from in-person delivery to videos or offering more activities) for three reasons: 1) to better meet demand; 2) to capitalise on successes; and 3) to address challenges, as illustrated in the following quotes, respectively:

> Referrals for NRT [nicotine replacement therapy] were made and, due to a high amount of interest, we produced a resource to provide education and information on what NRT was available and how to use this, using one of our clinical nurses to explain in a video. This video was shown on our social media channels, TVs in the clinics and preschools (Grant recipient, Performance Report, urban)
>
> Linking community members who are interested in quitting, to either the clinic or Quitline can at times be difficult as they expect the team to be able to assist them then and there to be able to quit. To try to mitigate this, the team have worked to develop clear referral pathways so that the interested community member is not lost through the system (Grant recipient, Performance Report, remote)
>
> The ad was released to critical acclaim in the region with feedback being unequivocally positive. People have contacted the TIS team to start their quitting journey as a direct result of seeing the ad. [Our ACCO] augmented this media presence by tying the side of bus campaign in to the TVC by utilising an image from the ad and the slogan "smoking takes away more than just time" (Grant recipient, Performance Report, regional)

Grant recipients also reported making or planning changes to activities based on new information they either collected or received from groups their activities targeted. That information highlighted shortcomings in current strategies, as illustrated below:

> In our 2018-19 Activity Work Plan, the TIS team focused on one event to target each priority population- people with chronic condition, [local Aboriginal pregnant women], young people and men. These events were well received, however, [it] meant that some populations in other regions were missing out. For the 2019-2020 Activity Work Plan we have [identified] it as a priority to get out into the community to deliver group education locally and in our surrounding communities (Grant recipient, Performance Report, regional)
>
> For our clients who were on their quit journey, closed online support groups and teleconferences were established to try and provide continuity of programs and

> services. Many of our quitters advised they had increased smoking when in lockdown and when working from home, many advised an increase in anxiety and mental health issues... [Our TIS team] developed a targeted approach using our social media channels to provide weekly messaging around the concerns raised by our enquiries, providing solutions-based content that was well received and has provided avenues for further exploration into program delivery. (Grant recipient, Performance Report, urban)

Lastly, some RTCG recipients identified tailoring their activities and services to better meet individual, organisational, and community needs:

> We find that [monitoring data] quite useful. We can go back and do comparisons for the previous six months. We can see what activity numbers look like; where things might be having a bit of a slide, so we're not getting the numbers in certain communities. And an example of that is one of the towns we visited in the last period, we had zero attend one of the programs. So we changed the way we pre-pre-programmed. So we put flyers in the local town newspaper; we ended up holding the next one at the community library because it's such a small town with no facilities. So that helped increase numbers. (Grant recipient, interview/focus group, regional)

Without updated AWPs from TIS team, we were unable to systematically assess the extent to which RTCG recipients are formally modifying their work based on new data; instead, we are reliant on self-reports. Although teams are encouraged by the NBPU and National Coordinator to update their AWPs, they are not required to submit these to the NBPU or FAMS. As previously suggested, the practice of requiring updated plans may help encourage TIS teams to review and refine programs and activities as new data emerges. We note that the NBPU has conducted training with TIS teams on continuous quality improvement, particularly in 2021, and we support this work.

Recommendations

- TIS teams should be encouraged to review and update their AWPs annually, and to submit them to the NBPU and FAMs for review and feedback.

3.1.2.3 Is the program revealing a better understanding of what works and what does not and in what circumstances?

Summary of our findings:

Individual TIS teams are monitoring what works and what does not in each of their programs, and they are putting that information to use in their practices. The things that appear to be working for the TIS teams on the ground include: promoting smoke-free policies, increasing

visibility of smoke-free zones and active enforcement of no-smoking areas at events; educating youth about harms of smoking; utilising props and tools to convey messages; using social and traditional media; distributing incentives; and identifying community Ambassadors and spokespeople for the program. The things that appear not to be working so well include: limited coordination and connections between TIS teams and Quitline; limited access to local quit support; and limited abilities of TIS teams to monitor and identify longer-term impacts on people they interact with.

Increasingly, TIS teams are recording and sharing this information through their Performance Reports; on TISRIC and TIS Facebook page; at jurisdictional workshops; and NBPU Yarning Circles, Town Halls, and trainings.

Evidence to support our findings:

Because all teams must complete six-monthly Performance Reports, we could observe that they are clearly tracking the achievement of process and performance against outcome indicators. In their Performance Reports and in our interviews and focus groups, TIS teams identified the strategies that are working and not working so well.

Establishing smoke-free policies, zones and events was identified as an area of success, particularly as these strategies continue to have an impact even when teams are not in communities and is a reminder to the community about the harms of tobacco. Many teams were able to work with other organisations to establish or review their smoke-free policies. However, TIS teams have reported that concerted effort is sometimes needed to ensure that smoke-free zones and policies are enforced. TIS teams have noted at community events, for example, a need for good signage, active enforcement by TIS team staff and support from the event organisers to ensure that smoke-free zones are respected:

> Ensuring major community events and activities become and remain smoke-free remains an ongoing challenge, despite adequate signage and announcements. Our team continues to maintain a strong presence during all community events where we disseminate appropriate information on the risks of smoking and quitting tobacco, gently reminding current smokers of the impact their smoking has on non-smokers, as well as encouraging them to move to designated smoking areas or outside of localities (Grant recipient, Performance Report, remote)

Having TIS teams on site at smoke-free events and in communities to provide education messages and disseminate resources about tobacco and to changing smoking behaviours, has also proved successful:

> After the families received the packs, there was a:
> - 28% increase in homes being smoke-free.

> - 15% drop in smoking inside the car
> - 8% increase in their desire to seek help from the Quitline.
>
> Majority of resources were designed to be useful and visible within the home. This may be the reason why there was a greater shift in behaviour inside the home compared to the car (Grant recipient, Performance Report, urban)

Delivering education about the harms of second-hand smoke for others, including to children and smokers themselves, was identified by some RTCG recipients as contributing to changed smoking behaviours, such as reducing or stopping smoking in particular spaces. This education can have mixed reactions. For some smokers, having other community or family members warn them about the harms of passive smoking may feel shaming and increase their resistance to change. For others, it can become a powerful incentive to change their smoking habits or quit altogether:

> Can I just say, I think one of the bigger impacts that I've seen since starting would be when we target the stage three kids, like Year 5 and Year 6 kids, kids are kids and they, they just tell it how it is. So, they're getting your message and they're going home to the parents and just saying how it is like, "that's bad for you, you shouldn't be smoking," that sort of stuff. So, we've had a lot of feedback from community, you know, "you guys must have been at the school because my kid come home and said I shouldn't be smoking in the car". (Grant recipient, interview/focus group, regional)

TIS teams spoke about the effectiveness of using engaging content and interactive delivery mechanisms when conducting community education. Some teams have developed games (e.g. versions of Bingo, Snakes and Ladders, the Amazing Race) for use with children and young people, visual props (e.g. models of a pregnant women or movement of smoke around a neighbourhood), and interactive tools (e.g. Smokerlyzer® to measure levels of nicotine in a person's lungs) to physically demonstrate the harmful effects of smoking and passive smoking:

> As a direct result of our passive smoking workshop delivered to residents and staff members, the residents were empowered to successfully request that the smoking area be moved to a more isolated area on the grounds. The request was made when non-smokers were consistently getting high Smokerlyzer readings (Grant recipient, Performance Report, remote)

TIS teams identified the use of traditional media (e.g. television, radio, newspaper, cinema and billboard advertisements) and social media (e.g. Facebook, Twitter, Instagram, TikTok, vodcasts) as successful strategies for disseminating messages about the harms of tobacco and benefits of quitting to a large and diverse audience. Teams made greater use of traditional and

social media in 2020 and 2021, given COVID-19 restrictions on travel and community engagement. Social media messaging is often used to complement traditional media campaign messages and also provides a way of connecting and communicating directly with community members. Some teams sought out professional support to inform their use of social marketing and social media to be more effective:

> It's quite good to assess what worked and what didn't work. So when I mentioned the TV commercials that we did, we did monitoring data on that. So that enabled us to see the reach of it. Was the health message understood? Were they clear and well received? Which they were. (Grant recipient, interview/focus group, remote)

> During the reporting period, there are twenty [20] episodes of social media/marketing, which resulted in a total of 6590 people being reached. In October 2020, [TIS team] sought support to create and implement a communication plan/strategy that incorporates a much stronger professional focus, providing tobacco education and cessation support to encourage and empower the target groups via digital technology and build the TIS team's capacity to roll out the social marketing strategy. (Grant recipient, Performance Report, regional)

TIS teams found engaging facilitators or Ambassadors with connections to the local community to be effective in supporting the delivery of activities. One team spoke of focusing on identifying and supporting local Ambassadors during COVID-19 lockdowns to ensure messages were still being communicated locally. Feedback from the interviews and focus groups with both TIS staff and community members emphasised that local (rather than more famous) Ambassadors tend to resonate more strongly within communities. Through our interviews and focus groups with community members, we identified many individuals who are already strong anti-smoking advocates among their family members, peers and colleagues. They could potentially be drawn upon and supported by TIS teams to be Ambassadors and spokespeople for the program.

Incentives were noted by some RTCG recipients as an effective way to encourage community engagement with TIS activities or to quit smoking, although it was highlighted that this may not translate to enabling RTCG recipients to better achieve their goals:

> The incentive-based activity was implemented to encourage TIS Facebook page followers initially and not focused on specifics such as smokers, Indigenous or ACCHOs attendees (…) The anti-smoking posts received some "likes" from followers but zero anti-smoking message posts were shared, and this is something to look at [if] the target of 500 followers is working to be reached (Grant recipient, Performance Report, regional)

Many RTCG recipients spoke about the importance of preventing people from taking up smoking in the first place and a need to reach children and young people with messaging about the harms of tobacco. TIS teams found working in schools, for example, running healthy lifestyle workshops over a series of sessions to be effective, as well as using games, models or exercise-based events to engage the interest of children and young people.

Some community stakeholders in an urban area spoke about their local TIS team's use of empowering and respectful strategies to engage people as having a positive influence on quitting behaviour.

TIS grant recipients also spoke about the things they think are not working so well in their programs. A few grant recipients felt they did not have enough access to local information about long-term impacts of their work. Specifically, these staff wanted better data and better way to understand longer-term impacts on people they interact with. This suggests that some teams need to improve their current data collection, monitoring, and analysis systems:

> I would like to see more focus on the collection of data, and that matching up against the reporting and having more support around that. And again, which has been my common theme throughout this whole conversation, having another aspect of the TIS Program, which would be the client individual support and follow-up, so that we can capture data around original quit attempts and whether we're making any sort of headway on individual behaviour change and attitudes around smoking. (Grant recipient, interview/focus group, urban)

Other grant recipients noted that their connections to quit support are not working as well as they could be. They suggested a need for better connections to or relationships with Quitline, as well as a need for better-equipped local quit supports and making a range of nicotine replacement therapies more widely available:

> We haven't quite got a great relationship with the Quitline, so we haven't really actively promoted that service at the moment. … But to overcome that, we are building up our clinicians to be able to deliver a brief intervention, and being to follow up those who need support to come into the clinics... (Grant recipient, interview/focus group, remote)
>
> Yeah, the main one I feel like we need to improve in areas is our referral pathways to our – especially to the Quitline. I have noticed this through going over our reporting and just finding our weaker areas and a few of those is what it was. (Grant recipient, interview/focus group, regional)

> I think improving in our tobacco cessation support from clinics, being able to provide that one-on-one quit support from clinics would be very helpful… All they [the TIS staff] can do is, I guess, refer to the clinic and so, then we need our clinic staff to be able to provide that support on the ground as well. At the moment, I guess with acute disease needs that potentially quit support isn't being done as well as we'd like to, so I think more support from clinical and also our staff development. (Grant recipient, interview/focus group, remote)

Recommendations:

- TIS teams should continue to monitor what works and what does not, either through formal or informal monitoring systems and processes.
- TIS teams and the national implementation stakeholders should continue to document, promote and reflect on approaches that seem to be working: promoting smoke-free policies, increasing visibility of smoke-free zones and active enforcement of no-smoking areas at events; educating youth about harms of smoking, utilising props and tools to convey messages; using social and traditional media, distributing incentives, and working through Ambassadors.
- TIS teams and the national implementation stakeholders should also continue to document and reflect on ways to mitigate and navigate challenges that are impeding the program: limited coordination and connections between TIS teams and Quitline, limited abilities of TIS teams to monitor and identify longer-term impacts on people they interact with, and challenges influencing the wider community to understand and adopt a population health promotion approach.

3.1.3 National support

3.1.3.1 To what extent have RTCG recipients increased their knowledge and implementation of evidence-based population health approaches through the support provided by NBPU TIS and the National Coordinator?

Summary of our findings:

RTCG recipients report that the TIS Program has supported them to learn about and implement an evidence-based population health approach. This has been achieved primarily through the National Coordinator, who is seen as a highly respected Aboriginal leader, and NBPU which is a source for guidance for grant recipients. However, it is clear that there are knowledge gaps among some TIS teams and that not all teams are aware of or make full use of NBPU resources and avenues of information. This may be in part due to staff turnover in teams or a perception among teams that they do not need this support. The COVID-19 pandemic changed the way in

which grant recipients accessed national support (e.g. shifted from in person to online jurisdictional workshops) and the types of knowledge gained. These adjustments may have lessons for the program going forward. There is no indication that the pandemic impeded the support provided by these resources to TIS teams.

Evidence to support our findings:

It should be noted that a few RTCG recipients with more resources than other smaller or remote TIS teams were clear that they had been doing evidenced-based practice for a long time and were not always supportive of the NBPU feedback or resources. However, the large majority of RTCG recipients report that the TIS Program has valuably supported them to learn about and implement an evidence-based population health approach.

The role of the National Coordinator was viewed as highly important and successful in this regard. The National Coordinator has provided high-level leadership and direction in terms of evidence-based population health approaches for RTCG recipients. When visiting RTCG host organisations, the National Coordinator has run small workshops for allied health staff around interventions for Aboriginal and Torres Strait Islander peoples and has promoted the support available to all staff through Quitskills in delivering a brief intervention program:

> …Responsibility for tackling smoking is everybody's responsibility and particularly in any primary health care setting, because it's a single biggest contributor to ill health. And so, they all have a responsibility, so I talk a lot about that. (National Coordinator, interview)

The National Coordinator is a figurehead who is Aboriginal, approachable and well-versed in and passionate about the issue of tobacco control. As such, he provides valuable guidance to non-Indigenous staff on how to deliver a smoking program for Aboriginal and Torres Strait Islander peoples. He has authority and the trust and respect of ACCHOs, which means he is able to get the attention of busy CEOs. One of the important aspects of this is the work of the National Coordinator, supported by the NBPU, with managers of organisations to emphasise the focus of TIS teams in working with people outside of ACCHO clientele.

Responses to the online staff survey in 2020 and 2021 suggest that overall, RTCG recipients feel they are focused on outcomes, which is part of being evidence-based and population health focused. However, from 2020 to 2021 there was a slight decline in the perceived effects of the TIS Program on staff and their organisations. Of respondents to the online survey in 2021, 61% strongly agreed with the statement “the TIS Program has encouraged a population health promotion approach”, down from 2020 when 75% strongly agreed with the statement. In 2021, 41% of survey respondents strongly agreed with the statement, “The TIS Program has encouraged a stronger focus on outcomes within my organisation” and a further 39% slightly

agreed[11]; again reflecting a shift in sentiment from 2020 when 59% of online survey respondents strongly agreed with the statement and 23% slightly agreed. Whatever the cause of this decline, there appears to be a need for greater support for TIS teams to implement a population health approach and stronger focus on achieving outcomes.

In their AWPs, 18% of the evidence cited by RTCG recipients came from TIS program sources, such as TISRIC (hosted by the NBPU) and HealthInfoNet, which is heavily promoted by the NBPU and National Coordinator. This suggests that both are influencing RTCG recipients' consideration and implementation of the evidence-based population health approach. RTCG recipients also spoke about the value of NBPU resources as usefully informing them about evidence-based approaches and tools:

> We have used [NBPU] as a reference and as a best practice guideline, as well for the information and the content. (Grant recipient, remote)
>
> Yeah, so we use them and more so recently when we do a review or refresh of some of our processes or even some of our evaluation measures and the questions that we ask. Of recent, we've just gone on there and reviewed all their documents that's been on the TIS portal and use them just to make sure that the questions that we're asking are in line with that, that they're maybe not missing anything around the indicators and those sorts of things. (Grant recipient, interview/focus group, urban)

The COVID-19 pandemic forced all aspects of the TIS Program to shift and adapt, and the support from the NBPU and National Coordinator was no exception. As a result of movement and gathering restrictions to curb the pandemic, the support from both could no longer take the form of in-person gatherings. Through this period, grant recipients appear to have still felt supported and valued the continued accessibility to NBPU via online meetings and over the phone. It appears that the accessibility of the support teams for direct communication was what grant recipients appreciated and relied on most during the pandemic. Interestingly, one participant mentioned that during COVID-19, they have been turning to the TIS Program website areas that post information about other teams' activities and resources to get ideas for their own work, because "*there's not much going on, on there*" while everyone is managing the pandemic (Grant recipient, remote). Another grant recipient suggested the jurisdictional workshops (which had to be shortened from previously two days in-person, to half day online sessions during COVID-19), offer more of an opportunity for grant recipients to "*yarn about our*

[11] Interestingly, in 2021 there appeared to be some state differences in these responses. In particular, a greater proportion of NSW respondents than WA respondents indicated they strongly agreed with the statement "The TIS Program has encouraged a stronger focus on outcomes within my organisation". 62.5% of NSW respondents strongly agreed and 31.2% slightly agreed, while only 25% of WA respondents strongly agreed and 58.3% slightly agreed.

programs and so forth,…[to see] what's working, what's not" (Grant recipient, interview/focus group, regional).

According to these reflections, it appears that TIS teams were still supported during COVID-19 to increase their knowledge and implementation of evidence-based population health approaches via direct communication with NBPU. However, teams felt they had less opportunity to do so via learning from each other. This will likely adjust again now as the COVID-19 pandemic is being brought under control in Australia and as the NBPU is able to resume in-person meetings and workshops.

Recommendations:

- The National Coordinator and NBPU should continue being accessible to give support to TIS teams around the implementation of evidence-based population health approaches.
- Until NBPU staff can freely travel to TIS teams again, they might consider adjusting their online forums to allow more peer-to-peer learning opportunities.

3.1.3.2 To what extent did NBPU identify and promote best practice evidence-based approaches by RTCG recipients to tobacco control?

Summary of our findings:

The NBPU identifies and promotes best practice evidence-based approaches to RTCG recipients using a variety of means. This includes providing review and feedback on AWPs and Performance Reports. The NBPU hosts and maintains a website and a resource portal for RTCG recipients that provides access to evidence-based resources and reports on the efficacy of various approaches. The NBPU hosts jurisdictional workshops, training sessions and Yarning Circles with TIS teams to help them identify and understand evidence-based approaches, and NBPU staff make themselves available to grant recipients via phone, email, and online meetings to help. To update TIS teams on new developments in the tobacco control space, the NBPU also publishes a regular newsletter that includes contributions from TIS teams.

Evidence to support our findings:

The NBPU encourages RTCG recipients to gather evidence specific to their program activities via focus groups, surveys, interview responses from general community, social media analytics, and other means. TIS teams are also encouraged to provide qualitative and quantitative data from various interventions back to NBPU around positive and negative outcomes, to inform the evidence base for future program delivery:

> We ensure that activities that the TIS teams are doing are evidence based and ensuring that they do have the evidence that they're working or not working. To be able to also

> get that evidence around them not working, isn't necessarily a bad thing. At least it's been tried and tested in that particular area. (NBPU stakeholder interview)

According to most RTCG recipients, they get regular helpful support from NBPU staff and they turn to the website resources when they need them – perhaps one or two times per year. Some RTCG recipients reported not needing the NBPU's assistance so much because they felt they have a firm grasp of the evidence-base and evaluation and monitoring, but others reported getting a fair amount of assistance from NBPU:

> I did have a role in developing the TIS Activity Work Plan. A lot of the stuff had just been carried over from previous plans and I guess just putting extra activities in that we had not previously done. All in partnership and close collaboration with the previous evaluators through the National Best Practice Unit and support from them to make sure that we're on track and we're actually being able to obtain our data and evidence, that it was measured across when it was coming to evaluation times. (Grant recipient, interview/focus group, urban)
>
> Yeah. I guess, as I mentioned, there's portal and it's a really useful website and beneficial to be able to see in your own time. Sometimes, it's not so easy to organise a meeting or you might just want a snapshot of information then and there when you're working on something, and so that's where that's been really helpful. And there's still the online, face-to-face support there as it's needed and been offered through undertaking jurisdictional workshops as an opportunity to share information and ensure that – as an example, the most recent monitoring and evaluation training was really beneficial for us to develop our team's skills in capturing information and just its relevance and importance within the TIS Program. (Grant recipient, interview/focus group, urban)
>
> [To prepare our Activity Work Plan] the reflection was basically done through our report and through team meetings just to see what we thought worked and what didn't work, and then looking at the evidence mostly through the HealthInfoNet website. And then also looking [to staff at] NBPU to finalise it and make sure that the activities that we decided were successful would still be - were still relevant and had that broader evidence base, not just our culture in our local context. (Grant recipient, interview/focus group, regional)
>
> They're really useful to tap into around case studies and good news stories. So you can flesh out some – what we might think is a standard kind of process for doing things, I think what best practice says, well, actually, no, that's a really good example of how to do things different. (Grant recipient, interview/focus group, regional)

Most RTCG recipients reported using the NBPU website resources to help them with monitoring and evaluation, and many also used the resources posted by other RTCG recipients as a source of inspiration for activities they might run in their own communities or as a benchmark for themselves. Some really engage with those resources and adapt what other teams are doing to fit their local context, while others simply consider it good information to know:

> Yeah, definitely we've used the portal on HealthInfoNet as prepared by the National Best Practice Unit, they have been very helpful and, I think, it's in that data collection tools and the monitoring and evaluation, is what we predominantly use them for. I think, a lot of the other resources around, you know, I mean we look at them just in terms of to see what other organisations are doing, but in terms of what [we] specifically [use it for] it would be more around reporting and monitoring, and evaluation. (Grant recipient, interview/focus group, regional)
>
> When we look at some of the games and stuff [on the NBPU website], and we get some of their ideas and things from them and just put together our own stuff, really. So it's just stealing ideas. We don't actually use the same resources that they have on there, because we are quite culturally driven in the [community]. (Grant recipient, interview/focus group, remote)
>
> … we also upload all our campaigns to their HealthInfoNet now, so it's been a really great way to use the HealthInfoNet to share our resources, because we don't have a dedicated website. And then someone from _____ last week called me saying, "I saw this on the HealthInfoNet. Can I use it too?" So that's been really great to share. (Grant recipient, interview/focus group, regional)

To update TIS teams on new developments in the tobacco control space, the NBPU also publishes a regular newsletter that includes contributions from TIS teams, runs training workshops and hosts online yarning circles with updates and opportunities for discussion with the National Coordinator and NBPU staff.

A few teams were less positive about the NBPU, indicating areas for improvement, particularly around communications from the unit and organisation of its website. One person spoke about a lack of support from NBPU, which they attributed to staff turnover:

> Yeah, it's sometimes you really have to dig deep to try and find what you're looking for. It's not the most easiest website to navigate. (Grant recipient, interview/focus group, urban)

> We got offered to have regular catch-ups, more informal and yarning on Teams and that, and that hasn't really happened. It happened once and then they said, "Oh, we'll organise another one with the Project Officer," and they never did. So I think that just accountability, like if you say you are going to support us and catch up regularly, outside of our reporting or if us coming to you, then just reaching out and doing that. (Grant recipient, interview/focus group, regional)
>
> The one thing I'll say is that sometimes the feedback hasn't always been consistent and that can sometimes cause confusion, but we managed to work our way through that. (Grant recipient, interview/focus group, urban)

There is scope for TIS teams themselves to better engage with NBPU resources to keep updated about changes and developments in tobacco control. In the following quote, for example, one TIS staff member complained about not being informed about the changes in national vaping legislation, despite this information being circulated widely by the NBPU through its website, newsletter and at each jurisdictional workshop:

> [A TIS colleague] just sort of mentioned that [from] 1st October, that vaping - you have to have a script and I thought well, why haven't we heard something from the National Best Practices about that? Why hasn't that information come out like as an alert to all teams that this is happening? Because that is going to have an effect on our GPs and in our service delivery. …. And they should have had templates of evaluations or templates of social media, for social media designs or social media content or something. (Grant recipient, interview/focus group, urban)

Some TIS staff wanted more information from NBPU on specific topics, like engaging in social marketing, advocating for smoke-free spaces, as well as resources on smoking in pregnancy, chewing tobacco and vaping. A few TIS staff said they did not make much use of NBPU resources due to a lack of time and staff available in their teams.

Over time, there appears to have been some change to the type of support TIS teams have needed from the NBPU. According to NBPU stakeholders, when teams were first introduced to the idea of using evidence-based approaches and doing their own monitoring and evaluation, some struggled with this. It took them some time to get used to and to engage in monitoring and evaluation. At that point, the NBPU's role was to support teams to understand the new approach to tobacco control and why evidence is important. Since then, the NBPU's role has evolved to providing more in-depth support and information that teams are now eager to request.

As grant recipients are becoming more independent and confident in using evidence-based approaches, the NBPU's role will likely continue to shift towards facilitating cross-team

evidence sharing, oversight of team plans and reports, and provision of dynamic resources to new staff members. There will still be a need for training for some sites and new staff but, hopefully, as other teams continue to mature in this area, time and resources will be freed up for greater investment in those sites that are still early in their evidence-based approach journey.

Overall, RTCG recipients appear to be mostly appreciative of the NBPU – the work they do, information they provide and the way they provide support, although there is some scope for improvement.

Recommendations:

- The NBPU should continue identifying and promoting best practice approaches to RTCG recipients as it has been, with the following improvements:
  - Improve timeliness of Performance Report and AWP feedback turnaround from NBPU to RTCG recipients
  - Ensure there is ample cross-team learning at jurisdictional workshops if they are held online due to COVID-19 restrictions
  - Improve communications with TIS teams to ensure consistent advice is given and notifications circulated in a timely fashion about changes affecting tobacco control
  - Provide more guidance or support around navigating the NBPU website.
- The NBPU itself has also identified some areas for improvement to better support grant recipients:
  - Encourage teams to update their AWPs regularly so they can reflect on what is working and what is not, and make adjustments
  - Improve support around monitoring and evaluation of remote TIS program activities.

3.1.3.3 To what extent did the National Coordinator successfully support and mentor RTCG recipients?

Summary of our findings:

The National Coordinator role provides some direct support to RTCG recipients and more indirect support by advocating for tobacco control and cessation at various levels of leadership across the country. The National Coordinator attends and presents at each jurisdictional workshop, attends and contributes to trainings where relevant, and hosts online yarning circles with updates and opportunities for discussion with the National Coordinator and NBPU staff.

The extent to which all RTCG recipient staff are currently able to actively and strongly cite the support and mentorship received by the National Coordinator is limited.

Evidence to support our findings:

The role of the National Coordinator is to:

> "provide strategic and policy direction to the Department of Health on tackling Indigenous smoking… act as a mentor and guide to the TIS Workforce, the national workforce, and that entails visiting organisations… interface with politicians, both government and non-government or opposition, to keep them informed about the program and generally on side… [and be] a general advocate for the Tackling Indigenous Smoking program and smoking cessation with the general population" (National Coordinator interview).

According to the RTCG online staff surveys conducted in 2020 and 2021, sentiments were mixed in both years regarding the extent to which support of the National Coordinator and the NBPU helped teams deliver their program and activities. Of the 41 respondents to the 2021 survey, the majority said they strongly agree (44%) or slightly agree (34%) with the statement that "Over the last six months, the support of the NBPU and the National TIS Coordinator has enhanced the effectiveness of the TIS Program and TIS activities within my organisation"; only 5% slightly disagreed with the statement (see Figure 1). This is a considerable improvement on responses to the 2020 survey, in which only 26% strongly agreed and 35% slightly agreed with the statement, and 9% slightly disagreed.

Figure 1: Enhanced TIS effectiveness through support of NBPU and National TIS Coordinator, 2021 RTCG survey

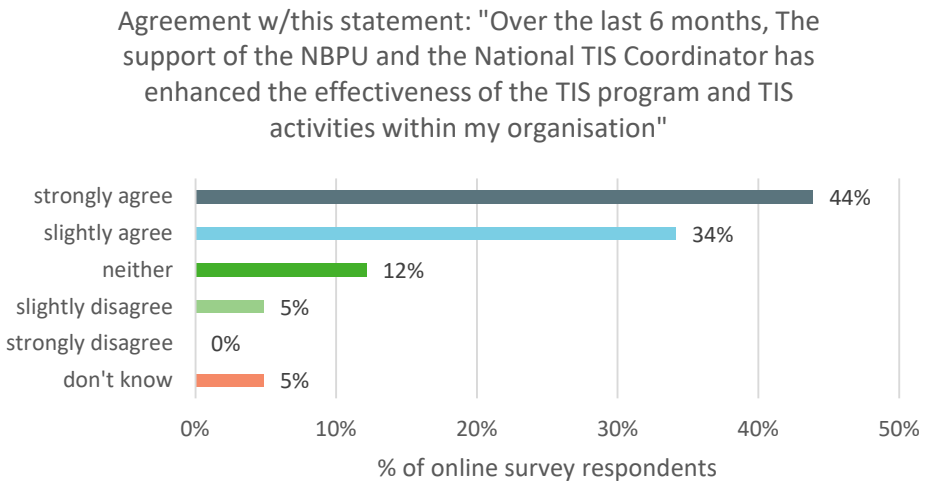
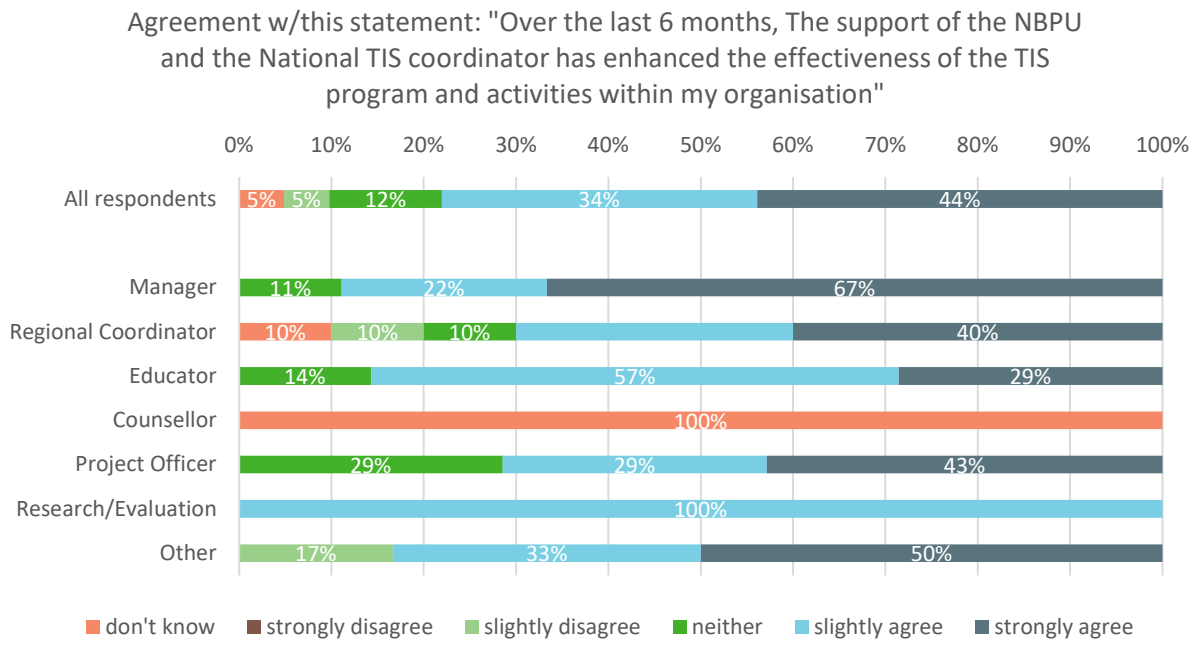


Figure 2 breaks down responses by people's roles, revealing some differences. Managers, Regional Coordinators and Project Officers were more likely to strongly agree that NBPU and National Coordinator support had enhanced their program effectiveness, while Educators and Research and Evaluation Officers were less likely to strongly agree but were more likely to agree overall.

Figure 2: Enhanced TIS effectiveness through NBPU and National TIS Coordinator support by role, 2021 RTCG survey



Some of the lower levels of agreement with this statement may be due to the impacts of COVID-19. Since March (and in some cases since early February) 2020, instead of visiting RTCG recipients in-person, the National Coordinator was only able to interact with them via online jurisdictional workshops organised by the NBPU. Another contributing factor may be related to the fact that when TIS teams are asked about what they want in NBPU trainings and Yarning Circles, if they do not request information that the National Coordinator can provide, then he does not contribute.

Lower levels of agreement with the statement could also be partly due to the National Coordinator role being part time, so that TIS teams do not get full time access, and partly due to the National Coordinator's role including advocacy and strategic support within government. Although that support may be crucial to RTCG recipients, they may not be regularly informed of it or aware of how it ultimately serves or influences them. As one national implementation stakeholder explained, the National Coordinator has exercised significant influence on the direction of RTCG programs, particularly the early iteration of TIS around 2018:

> Professor Calma's ability to influence decision makers about this [shifting from one-on-one intervention approaches to population health promotion approaches], and I have to also put it in context, Tom had noticed that some of the organisations had started moving in that direction or putting some of their funding towards that [one-on-one intervention approaches]. Not all of them, it was only some. So it was an opportunity to make sure the message got out to everybody, and that's what happened is that there was a Ministerial direction that there had to be a focus on population health approaches. I can say that very clearly. (National Implementation Stakeholder)

When the National Coordinator is able to visit RTCG recipients across the country, this allows TIS staff and other host organisation staff to "*put a name to a face and not feel out on their own*". At these visits, the National Coordinator can learn what is and what is not working (National Coordinator, 2020).

> [The TIS team] have found Dr Tom Calma a great resource and support. He's been accessible, he's been open to being approached. The team members feel like he's a great advocate for their work. (Grant recipient, interview/focus group, regional)
>
> There has never been "Oh no, no, no, you can't be doing those activities" or whatever and Tom Calma is a real driver of that as well. He is in attendance at a lot of the meetings that you go to and this is regularly, so he is not just a figure that does a bit of a five-minute talk at a workshop or a conference or whatever. He is heavily involved on a first name basis with people, which is great and he is very flexible around that. He loves hearing about what people are doing… (Grant recipient, interview/focus group, remote)

During visits to RTCG recipients, the National Coordinator will talk with the host organisation's CEO or Practice Manager to clarify the role of TIS staff ,so they are clear the TIS team is there to "*serve the population who don't come to the AMS*" and the team is not there to service the AMS staff (National Coordinator, 2020).

> And the last visit I did [before COVID-19]…was to a [regional, ACCHO] where I went through and I was very impressed with the way all the nurses and midwives all do brief interventions, with not only the mothers but the partners. And so that I saw as a very good practice but that's not common for sure. (National Coordinator)

One of the key challenges in being able to support and mentor TIS teams, aside from COVID-19 movement restrictions, between 2018 and 2021 was the lack of information the National Coordinator received about what teams are planning. He only had access to the national

program evaluation results, not AWPs or Performance Reports, so his ability to comment and encourage certain types of activities was limited by this. This was due to a bureaucratic process that limits access – namely submission of AWPs and Performance Reports to the FAMs Community Grants Hub. The FAMs Community Grants Hub sits outside the Department of Health and there was not an automatic piping of those reports to Department of Health staff or the National Coordinator. Requests for reports could be made but they take time to process and was not automatic. In 2021 steps were made to address this so that the National Coordinator and the NBPU could have easier access to AWPs and Performance Reports.

If the NBPU and the National Coordinator would like to improve the extent to which TIS teams feel that they are supported by those roles to make their work more effective, it will be important for further consultations to be held to more deeply understand what is driving some of the less positive perceptions among TIS Managers and Coordinators.

Recommendations:

- Continue improving the National Coordinator's and the NBPU's access to AWPs and Performance Reports, so they can provide more concrete and quicker guidance to TIS teams.
- NBPU and National Coordinator should hold discussions with TIS Managers, and TIS Coordinators about how they can be better supported or mentored to increase program effectiveness, to reveal unmet needs. It may also help for TIS teams to be better informed about the role of the National Coordinator.
- National Coordinator should consider promoting and holding more yarning circles with TIS teams to discuss different topics of interest.

3.1.3.4 To what extent has there been increased leadership and advocacy by ACCHO management for evidence-based population health approaches to tobacco control?

Summary of our findings:

Very little of the data spoke to whether ACCHO managers are leading or advocating for the promotion of evidence-based population health approaches as a result of TIS teams being part of their organisations.

Evidence to support our findings:

TIS teams are implementing evidence-based population health approaches and may, in effect, be role modelling these approaches to other health workers. In some locations, they are also working closely with other health teams engaging in population health promotion, enabling an exchange of ideas and mutual support. Across the interviews, focus groups, surveys, and Performance Reports, no grant recipients mentioned that their or other ACCHO's management were leading or advocating for evidence-based population health. This makes it difficult to

speak to the extent to which their leadership and advocacy in this area has increased, if at all. However, feedback from the National Coordinator and Department of Health indicates that there is a difference between medical-based grant recipients and non-medical grant recipients in terms of the latter being more inclined to be active in population health activities because they are less confined to clinical practices. This suggests that the type of host organisation matters to implementation of the program. It also suggests that medical/clinic-based grant recipient organisations need to be held accountable to implementation of a population health approach to TIS.

Recommendation:

- The NBPU and the TIS National Coordinator should continue educating ACCHO management about evidence-based population health approaches to tobacco control and, if they understand and agree with them, encourage them to show leadership in their organisations and communities and openly advocate for these approaches. In addition, they might explore ways to empower and equip TIS teams to also educate and encourage ACCHO management to take leadership in this area.

3.1.3.5 To what extent and how have RCTG recipients improved their monitoring and reporting systems in line with Performance Reporting guidelines and through the support provided by NBPU TIS?

Summary of our findings:

It appears that monitoring and reporting systems for some RCTG recipients have improved as a result of reporting guidelines and NBPU TIS support (including through data collection workshops). The Performance Report template and performance indicators set benchmarks, guide teams' data collection efforts and have helped teams to identify activity shortcomings and where approaches may need to be changed. However, it is not clear if and how grant recipients have changed their broader systems, such as data entry and storage processes or data analysis procedures and tools, beyond the collection of data. In future, as teams put better data collection systems in place, they may then focus on improving their data storage and analysis components.

Evidence to support our findings:

It appears that monitoring and reporting systems for some RCTG recipients have improved as a result of reporting guidelines and NBPU TIS support (including through data collection workshops). Of the grant recipients who responded to the 2021 online survey, 39% strongly agreed with the statement, "I am confident that we have the monitoring capabilities required to report accurately on how the TIS Program is performing", and 29% slightly agreed. While a clear majority of grant recipients feel that they are encouraged to use evidence, only a minority strongly feel that they can create their own evidence. This is an area where more or different support may be important. It is also important to note that respondents from Western Australia

were more likely to only slightly agree with the statement, while respondents from New South Wales were more likely to strongly agree. One national stakeholder did point to more work needing to be done around monitoring and evaluation among the remote and very remote grant recipients:

> I must say, one of our downfalls is probably getting the remote and very remote. (It's a bit of a hard nut to crack in the way of how – because monitoring and evaluation for our remote teams, it's something that they don't really think about too much). So it's all about getting that message out in the activities. But we've made some tools, but I don't think it's still working too much. I think overall that we've been pretty good in the monitoring and evaluation, but I think we could probably just do a little bit better, particularly for the remote and very remote. (NBPU stakeholder interview)

Some RTCG recipients spoke to the ways the reporting requirements of the TIS Program have helped to improve monitoring of their activities. The Performance Report template and performance indicators set benchmarks, guide teams' data collection efforts, and have helped teams to identify activity shortcomings and where approaches may need to be changed:

> I find them [Performance Reports] helpful, because I think it provides the team with a service standard … and that's aligning our programs with our performance indicators. (Grant recipient, interview/focus group, regional)
>
> Having the [Performance Report] template there has helped guide on what types of data we want to be collecting and, if we're not collecting it, how we can better collect data. So, I guess it has helped in just being really clear on the types of data that people are wanting to see and it has helped us to obviously monitor our performance internally around our targets and measurements that we put in place for ourselves. (Grant recipient, interview/focus group, urban)
>
> So it highlights things that we can use to look back on and the same sort of thing for recognising gaps. We might go, "Oh, look, we've done a lot of stuff with pregnant women this year. But gees, our men are missing out." You know? So that's where we can go, "Well, what's happening with the men because we need to be engaging them as well." (Grant recipient, interview/focus group, regional)

Grant recipients valued the provision of examples of data collection tools and ways to document success stories, in the Performance Report template:

> The part that I find the most useful, is the data collection tools examples, particularly when we're looking at delivering a strategy. What's the best way to measure its

> outcomes, and working out what's the best tool to use? And then, the documents on success stories and case studies, that document in the portal is quite helpful when it comes to doing our performance review reports. (Grant recipient, interview/focus group, remote)

Grant recipients also spoke about NBPU support around data collection, for example, through workshops on data collection tools:

> So the National Best Practice Unit, they have a role in reviewing our activity plan. They also have a role in providing information on how to use data collection tools. What are the best tools to use for your particular activity that you have down in your activity plan? I do find their support helpful, particularly when we do our jurisdictional workshops. In the past we've done data collection tool workshops around how to best use a focus group. How to best use interviews. How do you best use a yarning circle? Yeah. What questions or resources do you need to have a best practice data collection method? (Grant recipient, interview/focus group, remote)
>
> Monitoring and evaluation, I found [the NBPU] particularly helpful there at the times that we needed them. They were able to come out and provide probably a two-day workshop. (Grant recipient, interview/focus group, regional)
>
> I think the Tackling Indigenous Smoking reporting template, I really like it. It is very nice. It collects a lot of quantitative data, which I love reporting on. Whenever we are stuck or confused, we just simply ask NBPU. (Grant recipient, interview/focus group, remote)

A few TIS staff indicated that they would like more support from NBPU on development of their AWPs, planning for KPIs and writing up case studies. It should also be noted that some grant recipients found the updated template more difficult to use than the previous one and a number TIS staff spoke about the indicators overlapping and finding it difficult to not repeat activities under different indicators.

It was not clear in our discussions with grant recipients how their broader systems have changed beyond the collection of data. Grant recipients rarely went into detail about the rest of their data systems, such as data entry and storage processes or data analysis procedures and tools. These other systems and procedures may or may not have changed as a result of TIS reporting requirements. We suggest that the TIS reporting requirements have led grant recipients to focusing on improving their data collection componentry. This is an important aspect of any monitoring and reporting system but not the only one. As teams put better data collection systems in place, they may move on to improving other aspects of data management.

Some RTCG recipients did recognise a need for more data on level of impact, including gathering that from other health clinics (e.g. around quitting smoking). For example:

> We achieve a lot of great output-based activities, which is great, but again, there is that missing link of the outcomes and what actually is working. There's not as much data [as] collected from any other programs and so that's something that we've identified we need further guidance with, as being able to work with other clinics to collect data, just not reported data that happens through the TIS community workers and our TIS team and I guess, because it is output-based and it is self-collected, it's hard to use it as a quality improvement method. (Grant recipient, interview/focus group, remote)

Some grant recipients spoke about there being state data available on smoking rates but not regional or local data, which could help TIS teams track the level of impact they are having on smoking rates. One team has tried collecting local data through a GP but this is not comprehensive nor necessarily up to date. Other suggestions were for access to AMS and Quitline data about numbers of people who have quit smoking as a measure of impact.

A final point is the value to TIS staff around guidance and simple data collection and analysis tools, given that workers may not be very familiar with these processes:

> I guess the other thing is in small orgs, our focus is employing people who can exemplify non-smoking behaviour and connect to their community. So, they're not epidemiologists or public health, they don't have a Master's in Public Health in their back pocket. So having some tools, some straightforward tools can sort of say well, if you're delivering X, try this. (Grant recipient, interview/focus group, regional)

Recommendations:

- The NBPU should continue requiring reports from grant recipients and educating them about the importance of evidence to inform their activities and to justify their approaches in community
- The NBPU should encourage TIS teams to consider putting better data collection, data storage, and data analysis systems into place for any future round of funding.

3.1.3.6 To what extent has the monitoring data collected by RCTG recipients about the performance of TIS improved since the previous evaluation?

Summary of our findings:

The Performance Report template has changed over time to encourage standardisation and higher quality data collection. As a result, the data now captured in the template is more precise than what was captured by previous templates. However, this means a direct comparison of quality is not possible because the data captured are now somewhat different. There still remains room for some improvement in the template, particularly around recording reach and reducing duplication of activities under different indicators.

Evidence to support our findings:

The 2016 and 2017 TIS Performance Report templates asked grant recipients to provide narratives describing their activities that addressed each TIS indicator, the measures of their success in the indicator, and any challenges they encountered working toward the indicator. This report template yielded many types of varied responses for any given indicator because each grant recipient would interpret the task differently. As a result, the 2015-2018 TIS evaluation team found many inconsistencies in the reports and high variability in the quality of data provided by the teams. That team formally assessed the quality of the report data and found the quality so variable across reports that they judged that data aggregation was not possible. That evaluation recommended refinement of the Performance Report template toward more standardised questions.

The Performance Reports issued to TIS teams in 2019 for use was quite different from that in 2016 and 2017, to improve the consistency of reporting across grant recipient teams and to provide them with greater clarity about what they should report. Now there are more closed-ended questions and more instructions on how to complete the report, both of which are written in the report template itself. The NBPU also communicates these to grant recipients during training on reporting.

As a result of changes to the Performance Report template implemented in 2019, the data are much more consistent and of higher quality. Due to the prescribed nature of the questions in the 2019 Performance Report template, it was not necessary to do a quality assessment as was done for the prior version of the report. Analysis of the 2019 report data did reveal some further room for improvement to the template around estimations of reach and avoidance of duplication, which should help improve the quality of data collected and its analysis, particularly in relation to the evaluation strategy.

Recommendations for adjustments to the Performance Report template:

- **Activities**
  - At the start of the TIS funding round, provide the evaluation team with a **clear picture of the data needed from grant recipients**, so that the Performance Report template can be written and finalised early, limiting the need for changes within the funding period.

- The current Guidelines at the back of the template indicate that **activities should not be duplicated – it is worth making this information more visible**.

- **Provide additional information regarding the 'Types' of activities**: Activities reported could be classified under six types: 1) Social Marketing campaign category; 2) Social Media activities; 3) Development & Distribution of Resources; 4) Community Education; 5) Community Engagement; and 6) Other. However, this classification is at the discretion of RTCG recipients and similar activities were reported differently across RTCG recipients (e.g. radio commercials were reported by some under Social Marketing campaign, and by others as Social Media activities). It is recommended that further information is provided around how to classify activities under the different types to ensure consistency in reporting.

- **Clarify the type of measures that can/should be used to report Estimated *number* of community members reached by the activity**: At present, the measures for reported estimated number of community members reached by activity is varied (e.g. attendees; posts; followers; end beneficiaries; attendees instead of end beneficiaries) and likely included multiple interactions with the same community members. It is recommended that guidelines are provided regarding the type of data that should be used for each type of activities.

  It might also be worth referring to 'number of times people were reached' rather than 'estimated number of community members reached by activity', if it is not possible to record unique interactions.

Open-ended questions

- Clarify what information should be recorded in the open-ended questions – Case study or success story, and Challenges and mitigation: At present, the information provided in these open-ended questions varies across RTCG recipients and is not always relevant to answering the evaluation questions. It is recommended that the purpose of the questions is streamlined to the evaluation questions, and that the information required is made clear to RTCG recipients.

Number of partnerships

- **Clarify whether Total number of partnerships should include Number of partnerships established in the last six months:** One RTCG recipient did not include the partnerships formed in the last six months as part of the total number of partnerships. While this was evident because they reported no total partnerships, it raises the question whether other RTCG recipients also did not include the partnerships formed in the last six months as part of the total number of partnerships.

- **General**

  - **Use a different software for the Performance Reports**: Given the quantitative nature of many of the questions in the Performance Reports, Excel (or another database software) would be more suited than Microsoft Word. This would allow the data to be analysed more easily and efficiently; quantitative data capture in Word has to be manually inputted in Excel for analysis, which creates opportunities for errors.

  - **Build in 'validation safeguards' for questions**: For data with multiple options, there were a few instances where more than one option was selected, making the data unusable. It is recommended that validation safeguards are built into the form, like only allowing one option to be selected.

    An additional validation measure that could be considered includes only allowing a particular type of content. For example, allowing only numbers for 'estimated number of community members reached' (to avoid RTCG recipients reporting 'thousands') or only allowing postcode data for 'location'.

3.2 Outcomes

3.2.1 Localised population health promotion approaches – short-term outcomes

This sub-section provides evidence in relation to key evaluation question 2: *To what extent have short term outcomes been achieved for Regional Grants Population Health Promotion?* As per the evaluation strategy,[12] the evidence provided in this sub-section is based on Indicators 1, 2, 4 and 5.

3.2.1.1 To what extent are RTCG recipients successfully delivering a range of evidence-based population health promotion approaches, including to priority groups?

Summary of our findings:

Grant recipients are delivering a range of activities to the general population, priority groups, and populations that are representative of 'increased reach'. For the most part, these activities map onto those proposed by grant recipients in their AWPs, thus are largely evidence-based. In addition, grant recipients are forging partnerships, promoting smoke-free events and spaces, and promoting Quitline and other quit support services – all of which are supported by different types of evidence articulated in their AWPs. There has been a definite shift in focus of activities, largely due to the pandemic. This has seen, unsurprisingly, fewer community engagement activities in 2020 and more focus on social media and development and distribution of

[12] CIRCA, 'Draft Monitoring and Evaluation Framework for the Tackling Indigenous Smoking Program 2018-19 to 2021-22', May 2019.

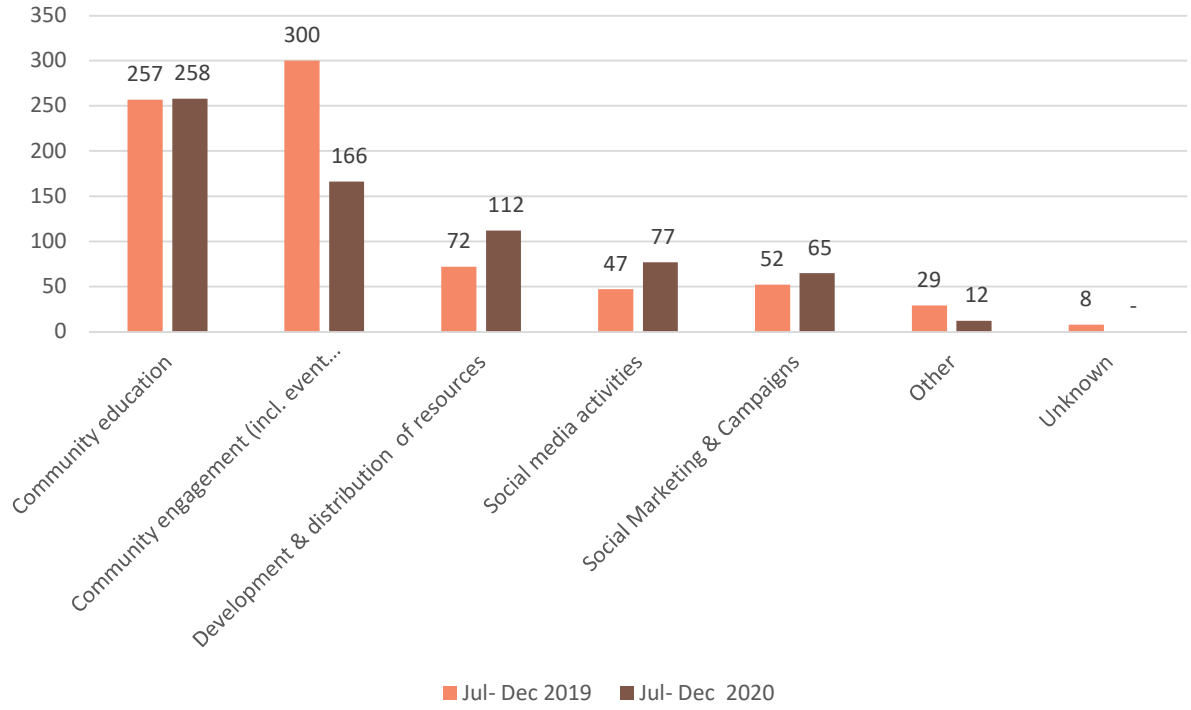
resources, as well as less focus on smoke-free policies and events, but more focus on establishing smoke-free households. There were a similar number of partnerships for the same six-month period in 2019 and 2020, but less than half the number of referrals to quit support services in 2020.

Evidence to support our findings:

The TIS Performance Reports received for July to December in 2019 and 2020 indicate that RTCG recipients rely on a wide range of activities to deliver TIS messages. A total of 690 TIS program activities were implemented by 33 grant recipients in the six-month period for 2020. This represents fewer activities than the 765 reported by 32 RTCG recipients in the previous year for the same period. The decline in number of activities for most RTCG recipients is most likely to be due to the impact of COVID-19 restrictions on travel and face-to-face contact. In a few sites, grant recipient staff were also redeployed to assist with COVID-19 community education, testing and vaccination, which left them less time to implement TIS activities.

Additionally, the impact of COVID-19 resulted in a shift in emphasis on certain activities. In 2019, community engagement was the most common activity implemented by TIS teams but in 2020 was the second most common, with teams implementing roughly half the number of activities than in the previous year. In 2020, the number of community education activities remained high, but teams also used their time that year to focus more on the development and distribution of resources, social media and social marketing, than they had in 2019 (see Figure 3).

Figure 3: Total number of activities by activity type (Jul-Dec 2019 & Jul- Dec 2020)



These activities were spoken to in RTCG recipients' AWPs, where they were justified with reference to academic/scientific and grey literature, health statistical data, TIS program findings, needs assessments, local knowledge and anecdotal information.

The TIS Performance Reports requires teams to report on activities under six indicators:

- Indicator 1 - General population health activities
- Indicator 2 - Forging partnerships
- Indicator 3 - Promoting Quit support among community members
- Indicator 4 - Promoting smoke-free spaces and events
- Indicator 5 - Priority group activities (e.g. for pregnant women and children)
- Indicator 6 - Increased reach.

Of particular interest to this evaluation is how many RTCG recipients are delivering evidence-based population health promotion activities to a range of population groups, including priority groups, and whether they are working to extend their reach. Table 6 presents data on the number of activities and number of RTCG recipients that implemented at least one activity type

in the two periods from July to December in 2019 and 2020 for Indicators 1 (general population), 5 (priority groups) and 6 (increased reach), as discussed below.[13]

Table 6 shows that RTCG recipients are delivering evidence-based population health promotion activities to a range of population groups, including priority groups. Under *Indicator 1, General population health*, 2020 saw fewer activities overall than in 2019 but a significant increase in the number of RTCGs developing and distributing resources, and two more recipients conducting community education activities.

Under *Indicator 5, Priority groups*, 2020 saw roughly the same number of activities as in the previous year, but more RTCG recipients developing and distributing resources, and conducting social media activities. At the same time, fewer recipients conducted community engagement, education, social marketing or other activities targeting priority groups.

In terms of *Indicator 6, Increased reach*, the numbers of activities remained roughly the same over the two time periods but the number of RTCGs conducting social marketing doubled and almost a third more were engaging in social media in 2020. In 2020, fewer than half the number of RTCGs were conducting community engagement activities to increase reach than in the previous year.

In addition to the activities targeting Indicators 1, 5 and 6, RTCG recipients also forged partnerships, promoted smoke-free spaces and events, and promoted quit support among community members. These activities are evidence-based, according to the rationales provided in the AWPs.

[13] Some activities were reported under more than one indicator. Where possible, duplicates have been removed. However, potential duplicates are included in figures reported here. This may lead to the number of activities being overestimated.

Table 6: Number of RTCG recipients that implemented at least one activity by focus and activity type

Focus	Activity type	# of activities 2019	# RTCG recipients implemented at least one activity 2019	# of activities 2020	# RTCG recipients implemented at least one activity 2020
General Population activities	Social marketing campaigns	27	15	27	15
	Social media activities	24	17	40	17
	Development & distribution	34	16	72	21
	Community education	122	26	116	28
	Community engagement	203	30	95	24
	Other	14	9	0	0
	Unknown	1	1	0	0
	TOTAL POPULATION	**425**		**350**	
Priority Groups activities	Social marketing campaigns	11	7	8	6
	Social media activities	7	6	11	9
	Development & distribution	27	12	23	16
	Community education	95	29	115	26
	Community engagement	54	22	43	15
	Other	12	8	8	5
	Unknown	1	1	0	0
	TOTAL PRIORITY GROUPS	**207**		**208**	
Increased Reach activities	Social marketing campaigns	14	8	30	16
	Social media activities	16	11	26	15
	Development & distribution	11	9	17	9
	Community education	40	12	27	13
	Community engagement	43	24	28	11
	Other	3	3	4	4
	Unknown	3	2	0	0
	TOTAL INCREASED REACH	**130**		**132**	

According to Performance Report data for *Indicator 4 – Promoting smoke-free spaces and events*, grant recipients assisted many organisations and households to promote smoke-free environments (see Table 7). Throughout the AWPs, grant recipients provided numerous sources of evidence for the efficacy and importance of promoting smoke-free spaces. For July to December 2019, of the 35 RTCG recipients for which we had data, 26 assisted 163 organisations to establish or review their smoke-free policies. For the same period in 2020, only 11 of 33 RTCG recipients were able to assist 67 organisations to make progress on becoming smoke-free. COVID-19 restrictions are likely to have played a major role in this outcome but the decline might also reflect that teams achieved significant success on this metric in the previous year.

Table 7: Smoke-free organisations, events, and homes that RTCG recipients encouraged in a six-month period

Activity	# that TIS teams assisted Jul-Dec 2019	# that TIS teams assisted Jul-Dec 2020
Organisations established smoke-free policies	77	24
Organisations reviewed their existing smoke-free policies	86	43
Events in service delivery area are smoke-free	532	364
Homes in service delivery area have become smoke-free	6,483	14,843

Between July and December 2019, RTCG recipients assisted 532 events to be smoke-free (only one grant recipient did not provide this type of assistance). Amongst barriers to creating smoke-free spaces in their community, some event coordinators consider it to be too much effort in creating and enforcing a smoke-free event.

For July to December 2020, fewer smoke-free events were reported (only 364 events), which likely reflects limits on events held due to COVID-19 restrictions. Five teams did not provide this type of assistance. However, there was a welcome sharp increase in the number of smoke-free households established. In the last six months of 2020, 22 RTCG recipients supported 14,843 homes to become smoke-free; more than double the 6,483 smoke-free homes supported by 26 TIS teams for the same period in 2019. TIS staff spoke about abandoning large scale community-based activities during COVID-19 restrictions in favour of working with families and households. Additionally, both TIS staff and community members observed a growing concern among parents, grandparents and other adult family members about second-hand smoke affecting children. One community respondent also considered that young people are becoming better educated about the harms of smoking and passive smoking, and are being more forward at home with sharing the quit message with their families.

Grant recipients cited evidence in their AWPs that to form stronger connections in communities and make headway to prevent uptake of smoking and promote cessation, it is important to forge partnerships and collaborations with trusted organisations and community leaders. In Performance Reports for July to December 2019, grant recipients reported forging 684 partnerships with organisations and leaders, and gave a similar figure of 683 partnerships for the same period in 2020.

Finally, grant recipients identified referrals to quit support services as important to their approach and cited academic and grey literature for their rationales. In Performance Report data for referrals of community members to quit support (i.e. Quitline, medical service or quit support group): 35 RTCG recipients made 2,205 referrals from July to December 2019, with only three teams making no referrals; in contrast 33 RTCG recipients made only 856 referrals in July to December 2020, and 21 RTCG recipients made no referrals. This significant decline in referrals may reflect the difficulty for teams to engage directly with communities in 2020 due to the pandemic and associated restrictions. A number of TIS staff also reported community feedback about heightened stress and/or boredom during COVID-19 restrictions and lockdowns that led to increased levels of smoking among community members.

With the (admittedly slow) COVID-19 vaccination rollout in Aboriginal and Torres Strait Islander communities and eventual easing of restrictions around the country, we anticipate that TIS teams will be able to engage more with community members, at least to the levels seen in 2019. Some TIS teams themselves acknowledge that a shift in emphasis among the different types of activities in 2020 has led to new opportunities to reach communities and other organisations, and new capabilities among teams. Going forward as COVID-19 restrictions ease, TIS teams may want to evaluate their balance of activities to maximise both reach and effectiveness of their programs. The NBPU may be able to assist with this assessment of activities for maximum reach and effectiveness.

Recommendations

- Given that shifts in activities across the two years has allowed for new ways of connecting with communities and organisations, and new capacities for TIS teams, we recommend that RTCG recipients, with the assistance of NBPU, consider the best balance of activities going forward to maximise program reach and impact. That is, that builds on new staff capacities, resources developed and connections forged with communities, partners and organisations.

3.2.1.2 To what extent and how are these activities reaching their intended community members?

Summary of our findings:

Reports on reach of TIS activities showed a very large discrepancy between 2019 and 2020 – which was due to a drastic over-estimation by one TIS team and a misinterpretation of the question by another team in 2019. Correcting for these outliers, the figures are more similar for

the two six-month periods, with activities reaching people almost three million times in 2019 and just over 2.6 million times in 2020. The difference in reach between years (333,000 times) may be due to RTCG recipients in 2019 generally slightly overstating their reach and/or due to the impact of COVID-19 restrictions on movement and gathering in 2020. For either period, it is unclear how many unique community members this reach represents. In 2020, on average, TIS teams reported reaching 13.7% of their target populations. We suspect this is an underestimate, however, as there were many missing data points across teams for this new element of reporting introduced in the July to December 2020 Performance Report. In conversation with community members across the sites we visited, it was clear that many have been reached by TIS activities and are aware of TIS messages.

Evidence to support our findings:

From July to December 2019, RTCG recipients reported implementing 762 activities, reaching people over 32 million times,[14] in stark contrast to figures for July to December 2020, during which time TIS teams implemented 690 activities, reaching people over 2.6 million times (see Table 8). On deeper investigation, the significant difference in these figures was largely driven by a drastic over-estimation by one TIS team and a misinterpretation of the question by another team in 2019.[15] Removing those outlier values from the data brings the total number of times people were reached down to 2,978,667 in 2019, which is more realistic and much closer to the 2020 estimate of 2,645,438. The smaller but persistent difference between the two years may still be due to other RTCG recipients in 2019 slightly overstating their reach,[16] and/or it could be due to the impact of COVID-19 movement and gathering restrictions in 2020. We did not find any common characteristics across TIS teams which are struggling with data reporting around reach and duplication of activities.

[14] It is important to note that there were 57 activities reported for which we have no information about the estimated number of times people were reached.
[15] One TIS team reported doing 1,855 radio spots in the six-month period, incorrectly, as a social media activity, and they estimated each spot reached 14,900 people, yielding a total of 27,000,000 listeners reached, which they incorrectly reported as the 'number of people reached'. The other TIS team incorrectly reported receiving 2,007,473 impressions (views) of their fact sheets on Facebook as the 'number of people reached'.
[16] In 2019, we suspect teams were reporting on the *number of times people are reached* instead of the *number of people reached*. Changes to the Performance Reporting template in 2020 may have made it more explicit that reporting should focus on the *number of people delivered to* – that is, the number of people attending each activity (and in the case of a multi week class, attendees would only be counted once). We suggest that the 2020 Performance Report template continue to be used, as revised in 2020, to enable a comparison of results with population figures for Aboriginal and Torres Strait Islander peoples.

Table 8: Estimated number of times people were reached (Jul–Dec 2019) and number of people reached (Jul-Dec 2020), by activity type

Activity type	No. of activities Jul-Dec 2019	Estimated Number of times people were reached Jul-Dec 2019	No. of activities Jul-Dec 2020	Estimated Number of people reached Jul-Dec 2020
Social marketing	52	2,257,795	65	1,048,381
Social media activities	47	29,309,166	77	1,354,157
Development & distribution of resources	72	219,435	112	121,768
Community education	257	47,444	258	69,781
Community engagement	300	149,231	166	48,963
Other	29	17,958	12	2,388
Unknown	5	200,548	0	-
Total	**762**	**32,201,577**	**690**	**2,645,438**
Total, corrected for data outliers		2,978,667		2,645,438

The data given above do not reveal the number of unique people reached through these activities or their characteristics, so we have limited insights into the extent to which all intended community members have been reached. Indeed, RTCG recipients in remote areas report challenges with covering large geographic regions and most TIS teams spoke of significant limitations on community engagement and activities due to COVID-19 restrictions in 2020 and 2021. Despite these challenges, Performance Report data indicate that RTCG recipients continue to reach large numbers of Aboriginal and Torres Strait Islander community members.

On the July-Dec 2020 Performance Report, grant recipients were asked for the first time to report the total number of Aboriginal and Torres Strait Islander community members in their TIS service area and the total number of priority group members in their TIS service area, so that we could calculate the proportion of the population reached by various activities. Based on their reporting and our calculations, on average, TIS teams reported reaching 13.7% of their target populations. We suspect this is an underestimate, however, as there were many missing data points across teams for the total populations. Also of note, the 2020 number of activities for social media, social marketing and development and distribution of resources is higher than in 2019, but the estimated number of times people are reached is significantly lower than for 2019.

RTCG recipients use a wide variety of methods to engage with their target audiences and, as previously discussed, these have been modified substantially in response to changing conditions brought about by the COVID-19 pandemic. The Performance Report data displayed in Table 8 show that in the second half of 2019, social media activities had the largest reach while making up only 6% of total activities, followed by social marketing campaign activities. RTCG recipients also relied on community education, community engagement, the development and distribution of resources, as well as other activities, and partnered with internal and external stakeholders to extend and reinforce their reach. Table 8 also shows the change in number of activities and emphasis on types of activities for 2020, with far greater weight placed on development and distribution of resources, social media and social marketing campaigns.

In conversation with community members across the sites we visited, many have been reached by TIS activities, even if they were initially unaware of TIS or had trouble initially recalling it:

> I was only aware by someone else that I – actually it was [a non-TIS Aboriginal Health Service] that told my mum who told me, but apparently the program's been running two years, other than I've been doing it, and I was unaware of it. But it was [that Aboriginal Health Service] that made me aware of it. (Community member, urban)
>
> *Q: Are you familiar with the role of the TIS Program?*
>
> A: No, I'm not. Not at all.
>
> *Q: Okay, so we will go into a few questions.*
>
> A: Do they do the [name of the TIS] program? Is that them?
>
> *Q: Yes*
>
> (Community member, interview/focus group, regional)
>
> At a lot of the community events I've been to, they've always had big signs out the front saying drug and alcohol, smoking-free as soon as you get in there, as you rock up to the entry gate, which is good. And then usually, when you get in there, you've got a stall or something with the no smoking thing, Tackling Indigenous Smoking stuff and [local TIS team] will usually have their own stall with activities and information and stuff like that. (Community member, interview/focus group, urban)

While some community members were not aware of the TIS Program, most could identify TIS activities and could identify TIS staff from their activities, as well as through their branded uniforms or vehicles. Community members recalled:

- TIS staff presence at and participation in sports events and community events (e.g. stalls)
- organisation of TIS events that included cultural or exercise activities (e.g. for World Tobacco Day)

- seeing or hearing advertising on television, radio or billboards
- being aware of TIS activities being run in schools or youth groups
- seeing signage about quit support services on cars, at clinics and elsewhere
- seeing TIS social media posts
- being aware of TIS sponsorship of sports teams
- hearing about TIS Ambassadors.

A few community members had themselves been invited to participate in the production of TIS resources (e.g. videos, posters, Facebook posts).

Based on the data available, we see no reason for changes to the TIS Program to better achieve reach to communities, other than for each team to consider the best balance of activities for them to maximise both reach and impact going forward.

Recommendations:

- TIS teams and implementation stakeholders should continue their current approaches and consider the best balance of activities to maximise reach to and impact on communities.
- NBPU continue to provide guidance to TIS teams about completing their Performance reports, particularly around estimating reach.

3.2.1.3 To what extent and how are activities locally relevant and have community support?

Summary of our findings:

TIS teams are employing a range of strategies to make their activities locally relevant and enlist community support. These include: consulting with community members in planning and designing program activities; forging partnerships with local organisations and groups; including local languages, places, people and art in program materials and advertising; working with local people as TIS Ambassadors; and being welcoming and inclusive in their activities, rather than shaming people about their smoking habits.

Some community members at different sites expressed criticism, wanting more community involvement in design and implementation of activities, targeting of priority groups and having TIS resources focused in their community. All of this suggests a need for better communication and management of expectations between TIS staff and community leaders and members.

Evidence to support our findings:

TIS teams reported in interviews, focus groups and Performance Reports ways to ensure their activities are relevant to local communities and have local support. Key strategies identified are to: consult with community members in planning and designing program activities; forge partnerships with local organisations and groups; include local languages, places, people and art in program materials and advertising; work with local people as TIS Ambassadors; and be welcoming and inclusive in their activities, rather than lecturing or shaming people about their smoking habits. These strategies are discussed in greater detail below.

A number of RTCG recipients spoke about keeping TIS activities locally relevant and gaining community support by consulting with community members in the design and testing of activities before they are rolled out. This includes collaborating with community members on the development of television and radio advertisements, writing up good news stories, and design work for smoke-free homes. For example:

> So, I think the consumer feedback, every time we make a resource, we take it out to the community, ask a couple of people. Not like having a big group of people come in, but just maybe five different people to run their eyes over the resource or even ask questions. We recently went out to ask the community if they would rather use a website or an app, because we were looking to create interactive tool and wanted to know what to put it on. And a lot of the community said they don't own laptops and computers and stuff, so they'd have to access it more on a phone or iPad or something. So, the original plan for an interactive tool was to have it for those people for chronic illness and a little bit older on the spectrum, but then realised, after our talks with the community, that it probably would need to be shifted down as older people didn't have the right phones. A lot of them still have flip phones or no phone at all, or just the house phone. So, we were like, okay, so maybe we'll change the age range to the ones that would actually use the app and then have the app on iPads for when people came into the health service for clinics and stuff like that. So yeah. So, they've been a very fundamental part of all the resources that we make … (Grant recipient, interview/focus group, regional)

Another way RTCG recipients ensure local relevance is to forge partnerships with other organisations and groups in the community to plan or implement TIS activities. As Table 9 shows, for July to December 2019, the 35 RTCG recipients for whom we had Performance Report data, reported a total of 3,395 partnerships; 684 of which were established in the last six months of that year. In the following year, the 32 RTCG recipients for whom we had Performance Report data, reported a total of 3,484 partnerships (which would include ongoing partnerships from the previous year); 641 of which were established in the last six months of 2020.

Table 9: Partnerships and collaborations to plan and/or implement TIS activities, July – December, 2019 & 2020

Organisation/community leaders	Total Number of partnerships Jul-Dec-2019	No. of partnerships established in the last six months Jul-Dec-2019	Total Number of partnerships Jul-Dec-2020	No. of partnerships established in the last six months Jul-Dec-2020
Mainstream health services	353	59	352	56
Other ACCHOs	145	34	131	18
Schools	463	118	838	153
Community organisations	587	124	451	74
Government	163	49	253	66
Individual community leaders	1,408	226	1,091	242
Networks or interagency groups	255	70	190	24
Other parts of RTCG organisation or programs the organisation runs			155	42
Other	21	4	23	8
Total	**3,395**	**684**	**3,484**	**683**

The large majority of partnerships in both years were with individual community leaders, with a strong showing in 2020 of partnerships with schools. Local support for TIS activities as a result of these partnerships is evidenced through reported positive community feedback, as well as community members' endorsement of TIS activities.

> We received positive feedback from our bus signage that call for people to "never smoke around us" with a picture of a young child in a car. (Grant Recipient, Performance Report, regional)
>
> We are working with some of these people to put together a campaign that will incorporate posters, radio and TV advertising. These people are very proactive in encouraging other members of the community to attempt to quit by word of mouth and having smoke-free cars and homes. (Grant recipient, Performance Report, regional)

In addition, 44% of respondents to the 2021 online RTCG staff survey strongly agreed with the statement that "In the last six months, TIS activities are working well alongside other related initiatives" (down only slightly from 47% in 2020) and 34% slightly agreed (down from 38% in 2020), meaning the majority (78%) in 2021 still feel the program is meshing well with other community initiatives.

TIS teams, particularly in regional and remote areas, spoke about the effectiveness of localising their resources and advertising materials through the use of local languages, images of local people and places, using community artists to produce artwork (e.g. for posters, discarded car bonnets and merchandise) and, in one case, using the Aboriginal seasonal calendar as a way to connect with the key client group. Some RTCG recipients spoke about how having local people captured in advertising and resources resonated the most with community members and were more likely to impact their recall of messages (for example, if participants had a family member in a local campaign targeting youth about not smoking). RTCG recipients also spoke about the value of TIS community Ambassadors in gaining involvement and support of the community.

Both grant recipients and community members spoke about TIS activities being more likely to gain local support if they are inclusive and interactive. That is, if activities welcome people whether they smoke or not, are interactive and invite questions from participants, rather than having TIS staff lecture at people who smoke. Community members and grant recipients most seem to enjoy and engage in activities involving entertainment (e.g. film or comedy nights), exercise (e.g. Colour Runs) or fun (e.g. games). For example, one community member said, "*Probably just putting the humour into it…is as effective as anything, and when you see those kids giggling around and dancing and singing with [TIS campaign spokesperson], the whole family's involved all of a sudden*" (Community member, interview/focus group, urban).

Community members did not always indicate a level of support for the local TIS activities. Some were unaware of the TIS Program or activities in their community. Community members at one site (regional) suggested changes be made to the approach of the TIS team, such as involving the whole community in the design, development and implementation of activities, and for exercise to be used as a means of engaging people and spreading the word around tobacco cessation. Community members at one site (focus group, regional) voiced some concern about TIS resources being spent on promotion of tobacco control outside their immediate community (which suggests some possible tension between the program goals of increased geographic reach and local expectations). Community members at one site (focus group, urban) mentioned they felt young people are the most important priority group, which suggests that the TIS team's efforts to reach non-youth audiences may be poorly perceived. Community members at another site (focus group, regional) felt too much emphasis was being placed on football related activities, which limits reach to community members who are not interested in this sport.

Taken together, these more negative comments from community members suggest that local support for the TIS Program depends on the extent to which they are involved in co-design of the program and how much it reflects their priorities. This contrasts with the quantitative indicators TIS teams have available to measure local support – they measure the number of events they are asked to co-host and the number of people who participate. While these are valid and appropriate measures of local support, the community member comments above suggest that these measures are missing some nuanced views in the community.

Recommendations

- TIS teams should continue to strengthen and broaden community support for their activities through: community consultation and co-design of activities; partnerships with local organisations and groups; inclusion of local languages, places, people and art in program materials and advertising; engagement of local people as TIS Ambassadors; and being inclusive and interactive in their activities.
- TIS teams should consider an array of indicators of community support including, but not limited to, partnerships and requests to co-host events.

3.2.1.4 To what extent and how have RTCG recipients built strong collaborations and partnerships with external organisations and individuals to achieve the goals of the program?

Summary of our findings:

Almost all RTCG recipients have entered partnerships and collaborations with a range of organisations and individuals. These partnerships have been hugely helpful to TIS teams in reaching new audiences, both general as well as priority populations, delivering activities and learning and sharing information. Among the partnerships formed to reach priority populations, most are formed to reach people who do not attend ACCHOs, which is consistent with the goals of TIS. The quality of TIS partnerships and their activities suggest that they will be long-lasting, so long as they continue to be mutually beneficial, can weather the challenges of COVID-19, and are able to overcome the social and relational challenges of partnership maintenance. There is scope to continue to extend partnerships to other organisations, especially ACCHOs in each TIS region.

Evidence to support our findings:

Since they received the grant, TIS teams have formed nearly 3,500 partnerships (almost a third being partnerships with individuals), having entered into 641 partnerships between July and December 2020 alone to support their general outreach to community members. In addition, RTCG recipients have formed many partnerships with organisations and individuals to reach priority populations, including pregnant women, people living in remote communities, and those who do not access Aboriginal Health Services (817 partnerships in July to December 2020).

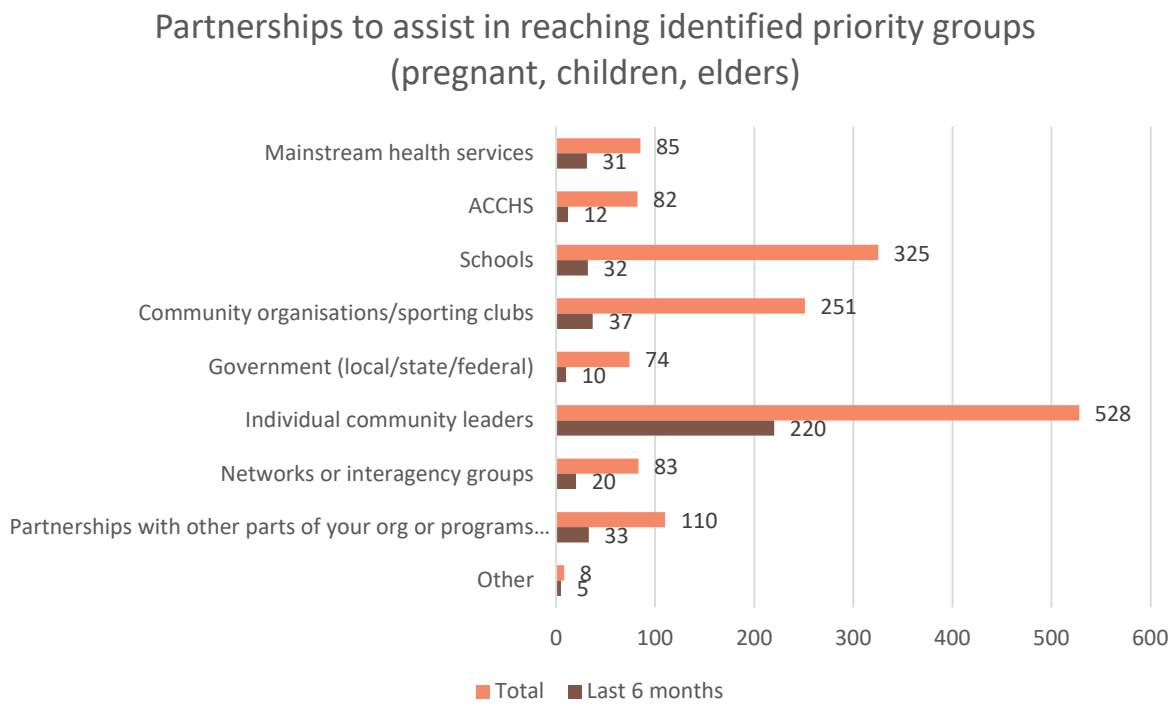
> Any activities that we do within regions are always led and co-designed with the regional organisation that we're working with. It is something that we can't really do without their input and their support (Grant recipient, interview/focus group, urban)

According to Performance Report data, challenges to partnership establishment for reaching pregnant women as a priority population included limited staff capacity and one organisation reported that their ability to form a partnership to target pregnant women was hindered due to a lack of female staff.

All 37 RTCG recipients who submitted Performance Reports in 2019 reported at least one partnership to assist in reaching other identified priority groups in their service delivery region, for a total of 395 partnerships. These other priority groups were predominantly children and youth, but also included people with chronic conditions, those living with disability, those in aged care, and people who are incarcerated. This increased substantially in 2020 to a total of 1,546 partnerships to reach priority groups (including ongoing partnerships from the previous year) for the 33 RTCG recipients for which we had Performance Report data (see Figure 4).

The most common targeted partnership that RTCG recipients have entered into since the beginning of the grant is with individual community leaders (1,091), followed by schools (838). The relatively low number of partnerships with other ACCHOs and mainstream health services suggests that more work could be done with these organisations, as a means of reaching wider audiences beyond their own ACCHO's health workers. In total for July to December 2020, the 33 RTCG recipients reported 155 partnerships within their own organisation, 42 of which were established in the last six months of the year. The vast majority of RTCG recipients are based in an ACCHO but are considered a distinct service, therefore connections within the broader organisation enables them to reach more people.

Figure 4: 2020 partnerships to assist in reaching identified priority groups



RTCG recipients identified partnerships as helping them in three practical ways: 1) to reach people outside their general sphere; 2) to deliver activities and distribute messaging and resources; and 3) to learn and share information. Partnerships open opportunities for TIS teams to provide educational programming to people already receiving a service or participating in activities offered by another organisation. This offers TIS teams a captive audience and the other organisation another way to positively engage their audience. The example below demonstrates the power of a mutually beneficial relationship:

> We worked really closely with the PC, the local PCYC and the Tackling Indigenous Smoking staff member…, she approached the PCYC and said, "hey, you know, like we can talk about smoking with young people, but I want them involved." So we actually, she used to go up there on a Wednesday afternoon, and she did it over … about four weeks, and talked to the young people about smoking and she had the stall there with the Smokerlyzer and the smoky eyes and the cigarette with all of the poisons in and, et cetera, and at the end of the four weeks they actually developed a big banner together. And, you know, all of the young people who attended that in the afternoons, they had some education about smoking and tobacco, et cetera, and then got to be a part of doing this big banner together, which when it was finished, because PCYC and council obviously work really closely together, it was hung on the fence out the front of the PCYC and it had all the messaging and their names on it. So that was a bit of a real success in terms of developing a good relationship with PCYC where, you know, now

> the door is always open for us to come and deliver whenever they want it or whenever we are looking to engage, and knowing that the council also are happy for us to do that sort of work was really good. (Grant recipient, interview/focus group, regional)

Successes have been achieved when mutually beneficial partnerships and collaborations have been formed, but challenges related to navigating the social and relational aspects of partnerships have also emerged. One organisation noted that partnering with other organisations can lead to a higher number of event cancellations, which can strain partnerships:

> When partnering with other local organisations, we have unfortunately had a rise in cancellation of events. This is most often out of our control due to a variety of adverse situations. This continues to be an issue within our service area, often making it difficult to successfully collaborate with other organisations (Grant recipient, interview/focus group, remote)

Teams have also faced challenges to building partnerships. Sometimes challenges are experienced during the initiation phase, if the grant recipient and other organisation have different KPIs, or in trying to find common objectives, particularly if tobacco use is not a priority for the other organisation. Worryingly, one TIS staff member spoke about being dismissed by workers in other organisations because of their racial background, "*So obviously, the first thing that sticks out like a sore thumb, is the racial part of it. Sometimes going in by myself and talking, and then they're not really accepting of what I'm saying. And then when it comes from my white manager or coordinator*…" (Grant recipient, interview/focus group, regional). A few TIS staff members spoke about partners sometimes not keeping to the partnership agreement, "*just the following up, it just seems like sometimes you have to chase them all the time*". One respondent suggested more professional development training could help build staff confidence in their negotiations with other organisations.

Other issues raised related to shifts in personnel in either organisation, and limited institutionalisation of partnerships between the two organisations. Partnerships need consistency of relationships and actors in the partnership to work:

> We haven't been able to get, I guess, access as regularly as we'd like to. We're looking to get it once every two months or so, but yeah, again, COVID-19, change of staffing, that's kind of prevented us to continue our regular visit up at the … juvenile detention centre. (Grant recipient, interview/focus group, regional)
>
> So the weakness, I guess, would be that there is not the relationship for our service to feel that we can refer clients to the state health department, for them to provide them with NRT, because the state health department just thinks, well they're only coming to

> us for free NRT. So, I think, that's probably our biggest challenge. (Grant recipient, interview/focus group, regional).
>
> Also due to the high turnover of staff, both within [our TIS team] and organisations with which we collaborate, there is often a breakdown in communication between organisations leading to disruption of events and activities. We are putting strategies in place to mitigate this by ensuring comprehensive documentation of activities and events to allow for the continuation of planned activities in the event of change in staff. (Grant recipient, Performance Report, remote)

Grant recipients mostly spoke about forming long-term partnerships but also discussed more short-term collaborations, typically formed for the purpose of events. Long-term partnerships were sometimes so close that organisations established a memoranda of understanding (MOU), shared data and held regular meetings over time. It is not clear how many partnerships across all TIS teams are short-term compared to how many are longer-term, deeper partnerships.

Recommendations:

- TIS teams should continue their partnership efforts, particularly with all the ACCOs in their area. TIS teams should continue to navigate the challenges associated with staff turnover and keeping partners to their agreements, to promote partnership formation and sustainability. We suggest TIS teams also aim to maintain clear expectations and understandings within the partnership, as well as good communication.

3.2.1.5 To what extent and in what ways is there an increased focus on priority groups, particularly pregnant women?

Summary of our findings:

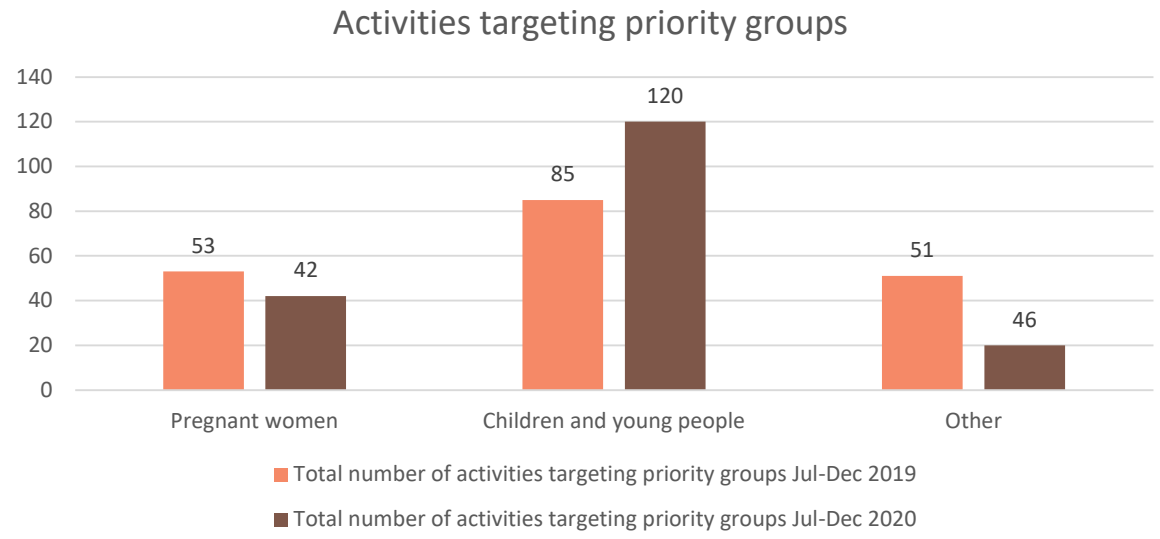
RTCG recipients are directing activities and reaching various priority groups. These vary and include pregnant women, children and young people, people with chronic conditions, men and women. A continued focus on priority groups, especially pregnant women who smoke, will help TIS teams build on their successes to date.

Evidence to support our findings:

RTCG recipients are clearly reaching various priority groups. For the second half of 2020, grant recipients reported implementing 208 activities targeted at priority groups and 207 activities in the second half of 2019. From July to December 2020, RTCG recipients implemented 120 priority group activities targeting children and young people, which was more than the 85 they had for the same period in 2019 (see Figure 5). Most activities targeting children and young people were information sessions run through primary and secondary schools about the harms

of tobacco and benefits of quitting. Aside from these, common activities included healthy lifestyle and exercise sessions with this target group (e.g. boxing, football, basketball and skate boarding), that incorporated health promotion and education about tobacco use. Activities also included a virtual disco and circulation of merchandise like bags, socks and headphones with TIS messaging. While TIS staff and community members spoke about children and young people going home to talk with family members about the harms of smoking (see section 3.2.2.8), they did not mention young people speaking about the harms smoking with their pregnant relatives, which could be an area for further development.

Figure 5: Total number of activities targeting priority groups, July to December 2019 and 2020



For July to December 2020, RTCG recipients conducted 42 activities with pregnant women, slightly fewer than the 53 activities targeting this group for the same period in 2019. Six organisations in 2019 and seven organisations in 2020 did not report any activities targeting pregnant women. Most of the activities targeted pregnant women directly, but some were delivered to intermediaries, such as midwives. Activities targeting pregnant women mostly related to raising their awareness of the risks of smoking during pregnancy and around infants. These activities typically took the form of information sessions run through Mums and Bub's groups, playgroups, women's groups, and via Aboriginal maternal health workers/programs. Information was sometimes conveyed by TIS staff in yarning circles and camps for pregnant women, though storytelling, art, weaving and other cultural practices. TIS messages were included by some grant recipients in the milestone Blue Book for mothers and in pregnancy gift bags from AMS services, as well as via brochures, posters, videos, billboards, in signage outside hospitals, on websites and through radio and television advertisements. In the responses to open-ended questions in the Performance Reports, RTCG recipients reported investigating other mechanisms, for example, trialling iSISTAQUIT and developing resources and partnerships specifically targeting pregnant women:

> We have partnerships with mums and bub's groups throughout the region, women's groups, community centres. We use social media, we're developing new resources that we always pass on. And the evidence of the reach is attendance, Facebook posts reach, the use of SurveyMonkey for participants. (Grant recipient, interview/focus group, regional)

Grant recipients noted, however, that despite their efforts, there are challenges in addressing the issue of smoking by young women and pregnant women, particularly in remote areas. This includes challenges for teams with staffing gaps, lacking female staff and being able to easily identify and access pregnant women in the community (particularly early in their pregnancy):

> It's still a tough market to get into only because a lot of pregnant women, if their partners smoke, or the family members, it's still a bit of a barrier for them, and the majority of the time when we are on location, they are with those people so it's really hard for them to be able to come and have a yarn on their own (Grant recipient, interview/focus group, urban)

> When people are pregnant, it's not talked about and it's not discussed, and it certainly, it's kept very private until people are very pregnant and it's quite noticeable. But even then people don't really talk about it. So that's why in our program here, we do one-to-one with the pregnant women. So we see them individually… But we do have a local pregnant woman on a poster, that's actually in the women's room, so we do have that. We have a lot of stuff about pregnancy but it's all in the women's room. (Grant recipient, interview/focus group, remote)

In addition to children and young people, and pregnant women, RTCG recipients identified other priority groups they are targeting. These included: remote communities; smokers; ex-smokers; fathers; mothers; women; people with a health heath issue or disability; prisoners; men; Elders; elderly people; Aboriginal carers; early childhood; people with chronic conditions;; employees and parents.

Figure 6 shows the types of activities that were delivered to these priority groups in the period from July to December 2019. Young people were the most common target - receiving 84 activities across 27 organisations, meaning they were more commonly targeted than pregnant women (53) for activities. Men were the target of nine activities across six organisations; and people with chronic conditions were the target of nine activities by two organisations. Across the remaining 15 groups, 32 activities were conducted.

Figure 6: Priority group activities by activity type and priority group, Jul-Dec 2019

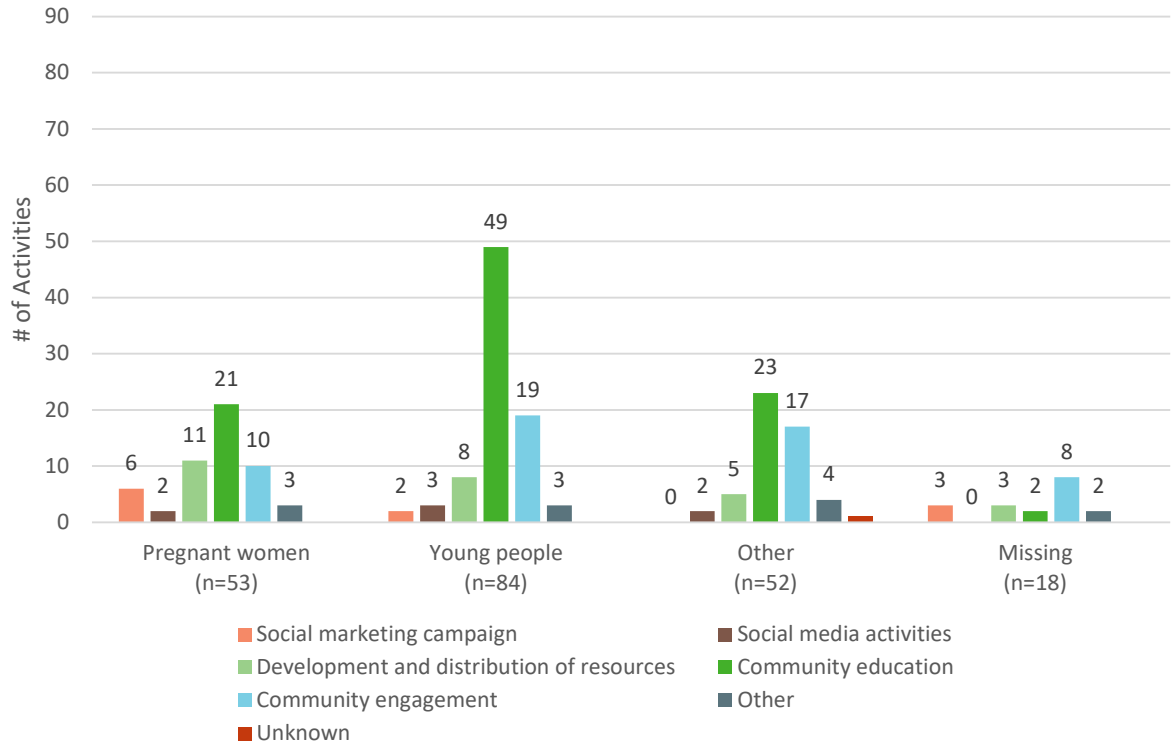
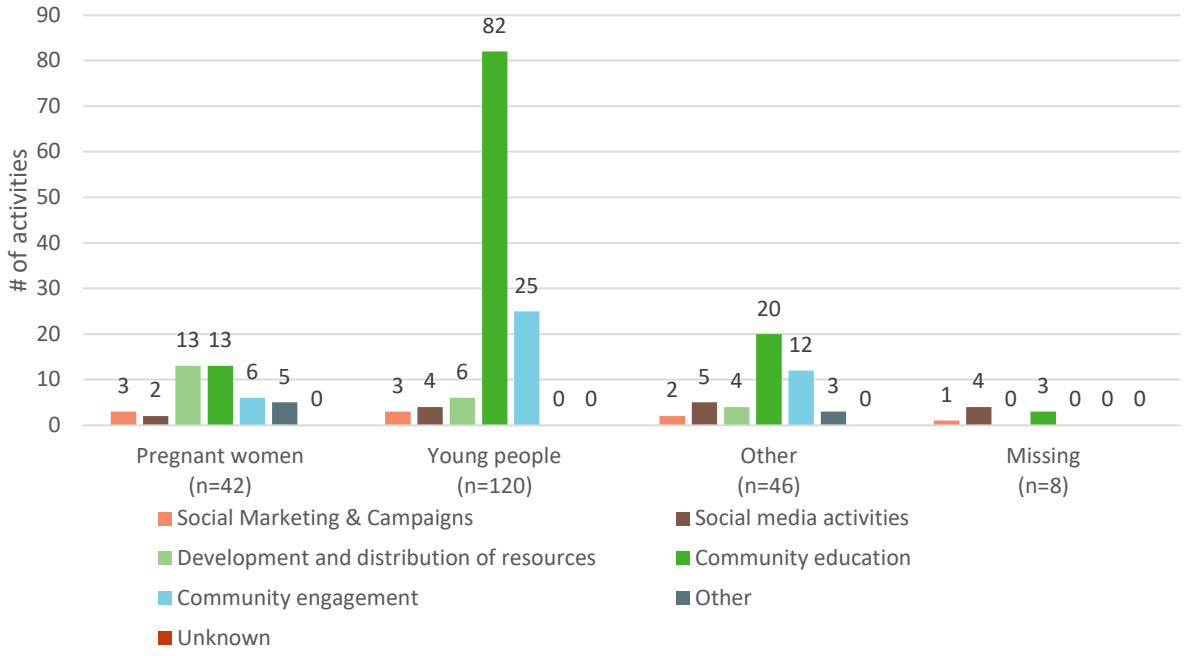


Figure 7: Priority group activities by activity type and priority group, Jul-Dec 2020



As Figure 7 shows, in the second half of 2020 TIS teams doubled down on their targeting of children and young people, targeting this group almost three times as many activities as were targeted at pregnant women. Community education was the most common type of activity delivered to all priority groups and by far the most of this type of activity were delivered to children and young people. This is likely to be due to the fact that children and young people are commonly convened together in age-based groups at community or school events, while pregnant women are more likely to convene in community settings among mixed groups of other community members. Interestingly, RTCG recipients targeted pregnant women via social marketing more than they did for young people.

National health data indicates that smoking rates among pregnant Aboriginal and Torres Strait Islander women continue to be higher than for other Australian women, indicating a need to improve tobacco use reduction outcomes for this cohort. Previously, a roundtable was held with TIS teams to discuss and review strategies used to reach pregnant women in remote communities and elsewhere. It may be worth holding a second roundtable to update and assess ideas for working with this group going forward. This could be informed by maternal health and midwife teams, iSISTAQUIT and facilitated by the NBPU and National Coordinator.

Among the 34 respondents to the 2020 online survey, 79% either slightly or strongly agreed with the statement that "in the last six months, TIS activities have led to a greater focus on pregnant women". There were six who neither agreed nor disagreed (18%) and one person who strongly disagreed (3%). This question only asked about a focus on pregnant women, however, and some teams have prioritised other groups, so this result should be considered in that context. In addition, some grant recipients expressly mentioned their work targeting priority groups as brand new – for their organisation and even in their communities.

Recommendations:

- Grant recipients should continue their efforts to reach priority groups, as many of these strategies appear to be working well.
- Grant recipients should continue considering ways to overcome the challenges of reaching young women and pregnant women, as this is a cohort with continued high smoking rates. It may be worth holding a second roundtable of experts to update and assess ideas for working with this cohort going forward. This could be informed by maternal health and midwife teams, iSISTAQUIT and facilitated by the NBPU and National Coordinator.
- Grant recipients could expand their information delivery to children and young people to talk about the harms of smoking during pregnancy or around pregnant women – to encourage them to discuss these issues with family members.

3.2.1.6 What have been the key successes and barriers to RTCG recipients achieving their short-term outcomes? How have these differed for remote communities?

Summary of our findings:

The five short-term outcomes identified in the TIS Program Logic are:

1. There is evidence that community members are being reached by evidence-based population health promotion approaches for tobacco control
2. Population health promotion activities are locally relevant and have community support
3. Increase in activities aimed at minimising exposure to second-hand smoke
4. Grant recipients have increased their focus on priority groups
5. There are strong collaborations and partnerships between TIS operations and external support for tobacco control

RTCG responses to open-ended questions in their Performance Reports recipients identified key enablers and barriers to achieving these outcomes. These are summarised in Table 10 and explored in detail below.

Table 10: Barriers and enablers to short term outcomes

Barriers	Enablers
Evidence that community members are being reached by evidence-based population health promotion approaches	
COVID-19 and restrictions on travel and face to face engagement	Greater development and distribution of resources Savvy utilisation of wide-reaching media outlets and social marketing
Staff recruitment and retention challenges	Ongoing recruitment and training
Logistical challenges to reach people in communities	Formation of partnerships and collaborations with other organisations and community leaders to facilitate reach
Limited staff and organisational capabilities to capture data	Development of simplified and streamlined data collection and analysis tools and approaches
Population health promotion activities are locally relevant and have community support	
TIS campaign materials and program activities need to be seen as locally and culturally relevant to gain community traction Language and literacy levels in remote communities	Consulting with community members in planning and co-design of activities Incorporating local languages, images of local places, people and art in program materials and advertising TIS teams being regularly present and seen at community events
Community disinterest/smoking not a priority	Having TIS merchandise as an ice breaker Working with local women and men as TIS Ambassadors Appealing to local interests and use of culturally resonant approaches, like community events

Barriers	Enablers
Community perceptions of TIS staff as the "smoking police" and lecturing them	Having activities that are inclusive, interactive and fun, rather than lecturing or shaming people
Tensions between the population-level and one-on-one personal approaches	Building up the capacity of clinical staff to deliver interventions one-on-one
Increase in activities aimed at minimising exposure to second-hand smoke	
Difficulty finding organisations to establish or review smoke-free policies	Looking at enforcement and signage, not wearing health uniforms while smoking Work with smaller community groups to go smoke-free, e.g. families and households
Organisers not wanting events to be smoke-free, fearing community resistance and having to enforce policies	Liaising with other organisations to create smoke-free events
Lack of community knowledge or concern around second-hand smoke	Using props and hands on tools like Smokerlyzer® to demonstrate the extent and harms of second-hand smoke
Grant recipients have increased their focus on priority groups	
Lack of staff, including gender and age diversity among teams as appropriate to working with children or pregnant women	Partners as a means to reach priority groups
There are strong collaborations and partnerships between TIS operations and external support for tobacco control	
Partnerships as challenged by staffing changes and availability within TIS teams or their partners, differing expectations and objectives between organisations	Partnerships are supported through good communication, clear expectations and shared objectives

Evidence to support our findings:

Barriers and enablers to accumulating evidence that community members are reached by evidence-based population health promotion approaches for tobacco control

There is evidence that grant recipients are connecting with communities, delivering community education, engaging in social marketing and social media, forging partnerships, promoting smoke-free events and spaces, and promoting Quitline and other quit support services – all of which are supported by different types of evidence articulated in their AWPs. Two major barriers identified by grant recipients in reaching community members have been the impact of COVID-19 and resulting restrictions on travel and face-to-face engagement, and difficulties in staff recruitment and staff retention for some TIS teams. TIS teams could not do much about staffing other than to continue to recruit and train new staff. However, in response to COVID-19, teams shifted their focus of activities to concentrate on the development and distribution of resources, social media and social marketing activities, online community education, and working with smaller groups like households and families, rather than large community events when restrictions were in effect. While there were a similar number of partnerships in the same

six-month period in 2019 and 2020, there were fewer than half the number of referrals to quit support services in 2020.

An issue raised by some TIS staff is their host organisation imposing restrictions that impinge on their capacity to reach community members. Issues raised in interviews and focus groups included restrictions on funds for travel to communities, despite the RTCG grant making travel funding available, and a lack of understanding by host organisation management of the TIS goal to conduct population health activities outside of the ACCHO clientele. Other issues raised with the National Coordinator by TIS teams were restrictions placed on their working on weekends and outside of standard business hours, and on establishing social media pages (e.g. Facebook). These latter issues were not raised by staff in the focus groups we held for the evaluation, which may have been a feature of the way in which these were conducted (i.e. with TIS managers present), but were also not raised in the one-on-one interviews with TIS staff possibly because this was not an explicit question for the interviews. These issues should be discussed and resolved with RTCG recipient CEOs.

The evaluation identified other barriers in simply reaching people. RTCG recipients talked about these as largely logistical (e.g. poor weather, community events or Sorry Business limiting access to communities or activity partners being unavailable) but they also relate to gaining community trust and interest (particularly where smoking is not seen as a priority issue). RTCG recipients spoke about having to use multiple strategies to get sufficient numbers of community members to attend activities or events, including working with community leaders, partnering with other organisations, and marketing activities through multiple channels. However, community engagement in activities appears to be improving across regions as the program and TIS workers become more well known.

> [One of] the challenges is … you have to promote it really heavily for people to attend when you want a bigger number. No good putting all your hard work [if] you've only got a handful of community members, so promoting is one of our key [things]. And then you have to go not just sticking to one stuff, like, one, sending newsletter to community peoples' home, you have to go use about several different ways of getting to get that number, like, last World No Tobacco Day, not last, in February, we had 400 community members attend it and that wouldn't be just sending the newsletter home to them. So media, Facebook page, … radio station, so you have to really work on that to have a successful event, yeah. (Grant recipient, interview/focus group, urban)

In terms of data collection and gathering evidence that community members are being reached, this has also presented challenges for some grant recipients. One organisation noted that data capture was a *"new focus for the program"* (grant recipient, urban), meaning they did not have the infrastructure in place to easily do so. Some teams have had to develop simple evaluation

tools and streamlined processes, and train up their staff in the required skills for data collection and analysis:

> Key challenges have been ensuring that staff record all interactions and the outcomes achieved, and knowing the importance capturing this data. We have tried to address this by recording key data required for outcomes on a template during events and following up during team meetings to ensure we were capturing our KPIs effectively, we continue to look for ways to improve in this area and like talking to other TIS teams to look for options that are working in other locations effectively (Grant recipient, Performance Report, urban)

Data capture is sometimes new and cumbersome for program participants as well, which has translated into low participation in data collection:

> Challenging to get the pre-event surveys completed and returned. In future, may be better to liaise in person with the Principals or Vice's and complete evaluation survey on site (Grant recipient, interview/focus group, Performance Report, regional)
>
> Difficult to get solid evidence or collect data in a formal way. For example, people don't want to fill out [post activity] surveys or it does not contain really important information. (Grant recipient, interview/focus group, remote)

TIS teams have looked at simplifying processes to gather participant feedback, as well as making greater use of photos to provide information about attendance and participation. One TIS staff member spoke about their organisation's ongoing commitment to continuous quality improvement and gathering community feedback (Grant recipient, interview/focus group, urban).

Barriers and enablers to population health promotion activities being locally relevant and having community support

Grant recipients have identified that TIS campaign materials and program activities need to be seen as locally and culturally relevant to gain traction in the community. Teams are employing several strategies to do this. They are consulting with community members in planning and designing program activities and forging partnerships with local organisations and community leaders. They are also designing or modifying campaign materials and resources to include local languages, places, people and artwork. They are engaging with local women and men to be Ambassadors who will continue advocating TIS messages when staff are not in communities. It is important to note that for remote communities, English language and literacy levels in the community were identified as a challenge to creating relevant resources:

> There are also issues around numeracy and literacy in English and in written [local Aboriginal language]… (as many can't read or write their language as it was an oral language, and school predominately teach writing in English). The TIS worker…is a local [Aboriginal language] speaker so we were able to deliver it in [that language] as well as in English, with [TIS staff member] interpreting when needed (Grant recipient, Performance Report, remote)

RTCG recipients noted that for some communities, smoking is not a priority issue alongside other difficult social issues. In these communities, TIS teams have had to use multiple strategies to get communities to engage and, for some, this is an ongoing process. In these situations, RTCG recipients have spoken about TIS merchandise (e.g. bags, caps, tee-shirts, hoodies, jumpers), as being great ice-breakers with community members.

A key enabler for reaching large proportions of the population about the harms of smoking has been to use mechanisms that automatically reach and resonate with a lot of people. RTCG recipients talked about their successes resulting from hosting and participating in community events, and disseminating messages via television, radio, newspapers, billboards, their website and social media.

Working with local women and men as TIS Ambassadors, and using culturally resonant approaches, like community events, incorporating music, art and food have also helped build community relationships: *"So we're able to sort of do events and activities that Aboriginal community can come to celebrate strength and culture. And whilst sort of sharing the importance of the tobacco messaging throughout that as well and changing behaviours and building that trust"* (Grant recipient, interview/focus group, urban). Engaging in cultural activities and fun events, community-building, and regularly attending and being seen at community events have helped RTCG recipients gain a presence in communities. For example:

> The hip hop was a week-long kind of education, but it was so fun. The kids were so engaged. It was just such a fun way for them to learn. And they came up with all the messaging themselves. So it was just really effective. (Grant recipient, interview/focus group, regional)

RTCG recipients have noted they sometimes need to combat community perceptions that they are the "smoking police" coming to lecture community members about their smoking habits. To counter these perceptions, they have needed to present TIS activities as welcoming and inclusive regardless of whether a person smokes or not, to be interactive and to invite questions.

Another identified barrier is the tension between RTCG recipients mandate to deliver a population-level approach and community expectations regarding a one-on-one personal approach to supporting tobacco cessation. In one community focus group, participants talked about not understanding why or how TIS teams can expect them to quit smoking without that one-on-one approach.:

> I know they started the…program, but they didn't go to the…smokers, do you know what I mean? I think that was an individual thing, whether I wanted to or not. I was set in my ways and I'm not going to change, but there are programs out there for people, if they want to, but the TIS workers, they don't go door to door. They expect us to read pamphlets and go, do you know what I mean? It's our own individual decision, but if they're so adamant in getting it done, come and see the people. Yes. I still smoke. (Community member, interview/focus group, regional)

Grant recipients have had to overcome this tension by building up the capacity of clinical staff to deliver interventions one-on-one, and establishing local support for individuals to quit, where resources and capacity allow. Though this tension is real and makes it challenging to get community support, it underscores the importance of TIS being seen as part of a holistic effort to reduce smoking across the population.

Barriers and enablers to increasing activities aimed at minimising exposure to second-hand smoke

There is evidence that grant recipients are effectively working with organisations to establish or review their smoke-free policies, and to review their signage and enforcement of these policies. However, this proved more difficult for some grant recipients in 2020, which is likely to be as a result of COVID-19 restrictions. It may also reflect the effectiveness of their previous work, where organisations already have policies in place, which they do not feel need updating or review. As one grant recipient focus group revealed, even though some organisations could stand to update their smoke-free policies, the TIS teams are shut off from helping them:

> But a lot of the organisations that we've visited and went to have already got their smoking policy in place. But again, they're not really acceptable to us because, in a lot of them, they've got where their smoking areas are, where their staff is smoking, kids have got access to where their butts are, and stuff like that. So, we want to try and make that known, that it's not right for them to leave their butts out where kids can access them or don't smoke where you can be seen. If you go on a break, change your shirt, like don't use your actual shirt and put another shirt on, stuff like that. We've actually been through all the AMSs in our region and offered support with that. But again, they're like, "No, we've got one." All right. So yeah. (Grant recipient, interview/focus group, regional)

To compensate, in 2020 grant recipients conducted more work with families and households to go smoke-free and have also focussed on developing and strengthening their own organisational, as well as others' organisational policies around smoking in and around the buildings they use:

> We think we've had a good impact on reducing exposure to second-hand smoke. For example, with our no-smoking policies, we deliver every six months to different organisations and we're also separate to that we can go back and review existing policies. So that ensures that our community organisations have no smoking 10 to 15 metres from the entrances, their staff are being provided with the training package, they're educated about why it's important to reduce second-hand smoke. (Grant recipient, interview/focus group, regional)

In addition, enablers come from increasing momentum in communities to reduce exposure to second-hand smoke. If TIS can capitalise on that momentum of other organisations and leaders promoting the same thing, they can continue to do more activities to reduce exposure to second-hand smoke.

> So I think through our voices and there's more people doing that yarning, they've got voices too as well as the campaigns and everything, and I think that all helps get the word out, and I think more people are becoming aware. And they'll spread the word too. (Community member, interview/focus group, urban)

Both community members and TIS staff spoke about there being general community awareness of the harms of second-hand smoke but not necessarily the high levels of nicotine for those in the immediate vicinity or the associated health impacts (especially for children, pregnant women or those with compromised health). Many TIS teams spoke about the value of using props (like models of the community) and hands on tools (like the Smokerlyzer®) to engage community interest and provide visual demonstration of the movement and impact of second-hand smoke.

Barriers and enablers to grant recipients having increased focus on priority groups

Lack of staff and lack of gender and age diversity in TIS teams were noted as challenges to reaching priority groups. For some locations, staff recruitment and retention are challenging in any case. For example, some teams have lacked female staff, making it difficult to work with pregnant women. Some TIS teams have sought to address this through working with representatives from the priority population to co-design activities and educate the team itself, but finding people who can do that is a challenge:

> A challenge working with priority groups is connecting with those members who have the time to facilitate the co-development of relevant campaigns, events and messaging, assist in the coordination of content production with correct and respectful terminology, focus groups, research and feedback and educate our TIS team in the needs and culture of that priority group in a sensitive manner. (Grant recipient, Performance Report, urban)

Partnerships and collaborations have proved an important enabler for facilitating reach to and engagement of priority groups. This includes partnerships with midwives, maternal health workers, schools and youth groups.

Barriers and enablers to strong collaborations and partnerships between TIS operations and external support for tobacco control

Collaborations and partnerships have proved to be key enablers for many RTCGs in delivery of the TIS Program, especially in remote communities. Partnerships can help to facilitate access to communities, save on logistical costs, limit the burden on communities' time, allow organisations to share ideas and reinforce complementary health messages. However, partnerships can sometimes struggle to get off the ground or erode over time. This may be due to staffing changes and availability, differences in primary objectives of the partnering organisations (i.e. not directly related to addressing smoking), different expectations by partners, poor communications and/or time constraints. Partnerships with community leaders or members may also be affected by local community politics and tensions:

> We have been trying to link up with other health organisations within the [local area] but have been unsuccessful due to other organisations not wanting to be involved due to lack of support and/or interest by these other organisations that interferes with the ability to build on these connections. There is also a lot of apprehension with external organisations in our outer region that may have a small number in the area that will often tell us that the there isn't enough Indigenous clients in the area using their service (Grant recipient, Performance Report, regional)

Seeking out partnerships and collaborations with a diverse range of internal and external stakeholders was seen by grant recipients as an enabler to building collaborations, instead of focusing narrowly on some organisations. In addition, in communities where the TIS message is that making the community smoke-free is a shared responsibility for all, partnerships and collaborations were easier to form.

Moving forward, we suggest the barriers and enablers listed above be discussed in the jurisdictional workshops, CEOs' workshops and elsewhere where TIS teams have opportunities to share strategies and resolve challenges.

3.2.2 Localised population health promotion approaches – medium-term outcomes

3.2.2.1 To what extent and how have RTCG recipients prioritised evidence-based population health promotion approaches with maximum reach within their identified TIS region?

Summary of our findings:

According to RTCG recipients' AWPs, most activities and approaches are evidence-based for population health promotion, suggesting grant recipients have prioritised these activities. RTCG recipients are undertaking a mix of approaches – some that maximise reach and others that maximise depth of engagement. This mix looks to have changed as a result of COVID-19 that forced teams to shift activities from predominantly community engagement and education in 2019, to focus more on resource development and distribution, and media-based approaches in 2020. The latter are more likely to maximise reach. TIS teams and implementation stakeholders are in a good position to assess the optimum mix of approaches to offer both maximum reach to communities and depth of engagement.

What is of concern, however, is that a large percentage of activities listed in plans have no or unclear sources of evidence. Given that the TIS Program is supposed to be evidence-based, the AWPs demonstrate a significant deficit in grant recipients' capacity at the time of writing the plans to identify reliable information to inform activities. It is likely that grant recipients' capacity has improved over time, with NBPU and peer support, but this should be an ongoing area of development for teams and their supports.

Evidence to support our findings:

RTCG recipients listed 745 planned activities across all submitted AWPs. Across these:

- 417 activities listed clear sources of evidence (56%)
- 312 activities presented unclear sources of evidence (42%)
- 16 activities had no sources of evidence (2%).

This data shows that at the time plans were written, only the slight majority of activities and approaches were evidence-based for population health promotion (56%). Concerningly, 42% of activities listed had unclear sources of evidence to justify their selection and an additional 2% presented no evidence at all. This indicates that at the first iteration of AWPs, there were deficits in grant recipients' capacity to identify reliable information for their planned activities – which is a problem for an evidenced-based program. It is likely that grant recipients' capacity to find

quality evidence for their planned activities has improved over time, with NBPU and peer support, but this should be an ongoing area of training and development for teams, and monitoring through updates to AWPs.

Between July and December 2019, 32 RTCG recipients from whom we had data reported implementing 425 general population activities. Of those general population activities, 22% reached people 100 times or more,[17] suggesting that RTCG recipients are not focusing solely on activities with maximum reach. Table 11 shows that just over half of all social media campaigns undertaken by grant recipients had broad reach (reaching people 100 or more times), but this activity was not the most common among grant recipients. Instead, community engagement and community education, the most popular activities undertaken by grant recipients in 2019, tend to be the least effective at achieving reach – only 14% and 16% of these activities, respectively, reached people more than 100 times. This means that understandably in 2019, TIS teams were focussing their effort on connecting with communities and promoting the program through community engagement and education activities, although these activities had less reach. In 2020, due primarily to COVID-19 restrictions, TIS teams shifted their emphasis to doing more development and distribution of resources and fewer community engagement activities – but the reach of these activities also changed, with 25% of the former and 20% of the latter reaching people more than 100 times.

Table 11: Number and percentage of General Population activities that reached people more than 100 times, by activity type

Activity type	Number of activities that reached people more than 100 times Jul – Dec 2019	% of activities that reached people more than 100 times Jul – Dec 2019	Number of activities that reached people more than 100 times Jul – Dec 2020	% of activities that reached people more than 100 times Jul – Dec 2020
Social marketing	13	48%	13	48%
Social media	13	54%	14	35%
Development & distribution of Resources	13	38%	18	25%
Community education	20	16%	20	17%
Community engagement	29	14%	19	20%
Other	6	43%	0	-
Unknown	1	100%	0	-

[17] 100 was selected as it is close to the median number of times people were reached by RTCG recipients' general population activities (calculated to be 116).

Activity type	Number of activities that reached people more than 100 times Jul – Dec 2019	% of activities that reached people more than 100 times Jul – Dec 2019	Number of activities that reached people more than 100 times Jul – Dec 2020	% of activities that reached people more than 100 times Jul – Dec 2020
Total	**95**	**22%**	**84**	**24%**

Grant recipients spoke about how partnerships and collaborations helped maximise their reach, by enabling them to host or participate in community events and deliver community education. They spoke about reaching many community members by holding promotional stalls at community events, assisting external organisations with holding smoke-free events, doing promotional activities with local schools, and hosting World No Tobacco Day and Spirit Colour Fun runs. We acknowledge that methods that reach a lot of people (e.g. via TV, radio, or social media) do not necessarily have a major influence in changing community attitudes or behaviour and that face-to-face interaction and in-person visibility may be more effective. However, used in concert, these different strategies can be complementary and reinforcing.

Almost all RTCG recipients are working to encourage households, workplaces and events to be smoke-free. This has the effect of extending the reach and influence of the TIS Program to all people who come into contact with those homes, workplaces and events, even when TIS teams are not around. In the second half of 2019, grant recipients reported supporting 6,483 homes to become smoke-free, and were even more successful in the second half of 2020, assisting a further 14,843 homes to become smoke-free. According to the 2016 census, there were 263,037 households with Aboriginal or Torres Strait Islander residents or occupants. This suggests that around 8% of households were reached by TIS teams in the two six-month periods in 2019 and 2020. TIS teams assisted 77 organisations to establish a smoke-free policy in the second half of 2019 and a further 24 in the second half of 2020 (i.e. a total of 101 organisations). They also supported 86 organisations to review an existing policy in the second half of 2019 and a further 43 in the second half of 2020 (i.e. 129 organisations). We suspect that COVID-19 restrictions played some part in this drop in numbers in 2020 (with a corresponding increased focus on households) but this may also reflect TIS teams' success with organisations in the previous year. Finally, teams were able to assist 532 events to be smoke-free in the second half of 2019 and 364 events in the second half of 2020 (i.e. a total of 896 events).

Interviews with grant recipients after the onset of COVID-19 and associated restrictions reveal that some TIS teams used this time productively to do more research into their communities and potential strategies, and to conduct assessments of their activities and update their AWPs.

During this time, TIS teams also had to adapt their strategies and did so by shifting from in-person activities like community education and community engagement to online and other media outlets. Grant recipients we interviewed spoke of shifting events from in-person to

online, via social media (e.g., Facebook) and spending more time and resources developing television, radio newspaper and billboard advertisements. They also used this time to review their activities and to informally update AWPs, as well as research their communities to better target their strategies. These actions suggest that in this period (roughly March to October 2020), TIS teams increased the extent to which they prioritised maximum reach activities. TIS teams may now be in an optimum position to assess the balance of activities that best offers them an opportunity for maximum reach and depth of engagement for greatest impact.

Recommendations:

- TIS teams and implementation stakeholders should continue their current approaches and consider the best balance of activities to maximise both reach to communities and depth of engagement for greatest impact, with assistance from NBPU.

3.2.2.2 To what extent and how have RTCG recipients been successful in reaching priority groups, particularly pregnant women?

Summary of our findings:

RTCG recipients have delivered many varied activities to reach priority groups, including pregnant women, and have reached people a significant number of times in the latter halves of 2019 and 2020. Estimates for reach of activities to children and young people, and pregnant women suggest TIS teams have made in-roads with these priority groups, but there is clear room for improvement.

Strategies for reaching pregnant women have included through maternal health workers and midwives, through health promotion at Mums and Bubs and other pregnancy women's groups, through health promotion and quit support via dedicated yarning groups for pregnant women, at health or women's information forums (e.g. Women's Health Expo), through health promotion via home visits as part of maternal health teams, and through the design of resources and social marketing (e.g. television and radio advertisements, posters, billboards and brochures). We suggest it may be useful to TIS teams to assess strategies targeting pregnant women and new mothers to determine the most efficacious for reach and influence.

Evidence to support our findings:

Activities targeting priority groups reached people just over 240,000 times in the second half of 2019 and 147,219 times in the second half of 2020. In 2019, this was primarily achieved through (in order of extent of reach): (i) development and distribution of resources, (ii) social marketing; (iii) community engagement; and (iv) community education. In 2020, TIS teams necessarily had to accommodate COVID-19 restrictions. For the six-month reporting period of 2020, development and distribution of resources, and social marketing were the most successful strategies for reaching priority groups.

For the July to December 2020 period, teams were asked for the first time to report the number of people in the priority group population, so that we could calculate the proportion of people reached. For that period in 2020, 31 TIS teams reported reaching, on average, 27% of young people, 8% of pregnant women, and 3% of Elders in their region. These represent good in-roads to these priority populations, particularly to young people, but these figures also clearly show more should be done to reach greater proportions of these populations.

Responses of RTCG recipients to the Performance Report open-ended questions make clear that TIS messages are being targeted to pregnant women, as well as to others like midwives or maternal health workers. Case study data in the Performance Reports indicates that targeting intermediaries is an acceptable avenue to this priority group:

> A young woman, who was supported by her non-smoking partner, quit whilst pregnant and although her relationship has been stressful and they have faced some challenges as young parents since she remains quit and still in contact with [our] TIS team (Grant recipient, Performance Report, regional)
>
> Of the existing pregnancies that we were still seeing, six had quit during pregnancy, one had quit prior to getting pregnant, three had reduced their CO levels below seven (two of which had come down from 17 ppm and 20ppm). We also have an increase in referrals from the midwives for smoking education for young women who smoke and who want to get pregnant and are being advised to quit before they get pregnant. In the last six months, I have found that when I see the women for the first time, a number of them have already quit on finding out they were pregnant and another number had reduced the amount they were smoking drastically (Grant recipient, Performance Report, remote)

RTCG recipients rely on various means to reach pregnant women, as documented in their Performance Reports:

- Delivering education sessions and resources to maternal and child health workers as part of their training, and building partnerships with maternity workers and clinics
- Holding or developing yarning circles and quit support programs for pregnant women who smoke or live with people who smoke (e.g. weekly sessions to deliver TIS health promotion and cultural activities, conducting regular Smokerlyzer® testing and providing incentives for women to remain smoke-free)
- Joining pre-existing mothers' programs (e.g. mums and bubs groups and women's groups) to deliver health promotion

- Making home visits in partnership with maternal health workers to deliver TIS health promotion and quit support (including provision of nicotine replacement therapy)
- Identifying pregnant women to become Ambassadors and champions for TIS health promotion, creating campaign materials (social media posts, billboards, posters and brochures) for display at local maternal health services, kindergartens, childcare centres and Aboriginal Medical Services
- Having a presence at a Women's Health Expo and giving away TIS resources in Women's Health Check bags
- Social marketing through the creation of radio and television advertisements, billboards, posters and pamphlets targeting pregnant women, smoking and second-hand smoke; drawing on Quitline's 'Quit for You, Quit for Baby' program for Aboriginal pregnant women, as well as specific promotional materials about the dangers of smoking during pregnancy distributed at community events.

Grant recipients cite evidence of the reach of these activities via attendance in program activities, Survey Monkey responses and social media reach (i.e. LIKES and follows).

In terms of return on investment, social marketing, development and distribution of resources, and social media activities achieved the greatest reach to priority groups for the number of activities conducted (see Table 12). Community engagement and community education had far less reach per activity in both years.

Table 12: Estimated number of times people were reached by priority group activities

Activity type	Number of activities, July-Dec 2019	Estimated number of times people were reached, July-Dec	Number of activities, July-Dec 2020	Estimated number of times people were reached, July-Dec
Social Marketing	11	72,020	8	76,417
Social Media	7	4,249	11	17,014
Development & Distribution of Resources	27	125,801	23	35,537
Community Education	95	12,755	115	14,005
Community Engagement	54	24,338	43	3,908
Other	12	855	8	338
Unknown	1	12	-	-

Activity type	Number of activities, July-Dec 2019	Estimated number of times people were reached, July-Dec	Number of activities, July-Dec 2020	Estimated number of times people were reached, July-Dec
Total	**207**	**240,030**	**208**	**147,219**

Recommendations:

- TIS teams and implementation stakeholders should continue and strengthen their current approaches to target priority groups. Previously, a roundtable was held with TIS teams to discuss and review strategies used to reach pregnant women in remote communities and elsewhere. It may be worth holding a second roundtable to update and assess ideas for working with this group going forward. This could be informed by maternal health and midwife teams, iSISTAQUIT and facilitated by the NBPU and National Coordinator.

3.2.2.3 To what extent and how have RTCG recipients been successful in increasing their geographical reach within their service area?

Summary of our findings:

The data indicate that grant recipients are implementing many activities to reach community members across a broad geographic area, as well as people who do not attend ACCHOs. Grant recipients are using a variety of means to achieve this reach – the most frequent type of activities in 2019 were community engagement and community education activities, and in 2020 were social marketing and community engagement. However, in 2019 increased reach was achieved most successfully, in terms of numbers of people reached, through social marketing activities; in 2020, this was through social media activities. Success, however, must be gauged carefully because it is not entirely clear which mode of message delivery is more impactful for community members, as this was not in the scope of this evaluation to assess.

Evidence to support our findings:

In the last six months of 2019, the 37 grant recipients which provided Performance Reports had conducted 130 activities to increase their reach, and in 2020, the 32 grant recipients which provided Performance Reports had conducted 132 activities to meet this objective. This included activities to extend the geographical reach of TIS programs, as well as activities to reach people who do not attend ACCHOs.

Table 13 indicates that "increased reach" activities reached people close to 1.8 million times in 2019 and 918,863 times in 2020. As explained previously, it is important to note when reading Table 13 that the Performance Report template changed in 2020 to record increased reach more accurately. That is, the 2020 template recorded *the number of people reached* for each activity (for multiple activities to the same group, as in a multi week school program, the

number of people were recorded only once). The 2019 template, in contrast, recorded the *number of times people are reached* for each activity (in which case a multi week school program would count the same class each time a session was delivered) – which overcounted reach.

Table 13: Estimated number of times people were reached by increased reach activities

Activity type	Number of activities, Jul-Dec 2019	Estimated number of times people were reached, Jul-Dec 2019	Number of activities, Jul-Dec 2020	Estimated number of times people were reached, Jul-Dec 2020
Social marketing	14	1,696,000	30	168,023
Social media	16	8,284	26	668,992
Development & distribution of resources	11	39,486	17	57,900
Community education	40	6,141	27	9,211
Community engagement	43	41,779	28	12,687
Other	3	260	4	2,050
Unknown	3	536	0	0
Total	**130**	**1,792,486**	**132**	**918,863**

As shown in Table 13, for July to December 2019, RTCG recipients predominantly conducted community engagement followed closely by community education activities – although both of these types of activities had much less reach than their social marketing efforts. For July to December 2020, RTCG recipients predominantly focussed on social media and social marketing, both of which had the greatest reach per activity.

In addition to activities with a particular focus on increasing reach into communities, many RTCG recipients also used radio and television forms of electronic media to extend their reach:

> [The local radio station], remains one of our most valued partners to reaching out to [Aboriginal peoples] living in remote regions who may have limited or no access [to our ACCHO] clinics. For this reason, [radio station] plays a critical role to enhancing health literacy across our region, as health messages are delivered in both English and local languages. It is estimated that [radio station] has a reach of approximately 10,000 people in local communities and that at any given time around 10-15% of these are tuned into the radio station. For this reporting period, we were able to create three distinctive radio broadcasts with [radio station], and also one additional live broadcast

> with [another radio station] when attending the [local] festival 2019. (Grant recipient, Performance Report, remote)

In the six months covered by the 2019 Performance Reports, 19 of the 35 RTCG recipients (54%) reported organising a broadcast of tobacco control advertisement on radio or television (see Figure 8). Similarly, 34 of the 35 RTCG recipients had shared tobacco control information on social media over that period. Radio and television broadcasts of messages reach far and wide, suggesting they are a critical means for reaching a wide number of people including those in remote areas and older adults, who may use social media less frequently or not at all:

> I've gone home… which is about 900ks from [TIS site], and they're all talking about these TV ads [we did]… they even get – we get coverage in [state capitol city]. We've had people – I've had clinic people comment – because I'm actually in the TV ads myself, some of them – I've had people comment, and they say they saw the ad, and so that was probably the biggest thing for us. (Grant recipient, interview/focus group, remote)

Although radio and television broadcasts can reach many people across a wide geographic area it does not guarantee people will see the messages, retain them, or know where they came from, and it is difficult to measure level of influence over attitudes or behaviour, as the following discussion illustrates:

> Q: Are you aware of any local campaigns or any campaigns around smoking? I guess either TV, radio, social media, billboards?
> A: No.
> Q: No, that's all right.
> A: I am pretty ignorant to some things if I don't sort of see them…I don't really pay much attention. (Community member, interview/focus group, urban)

While the community member in the prior quote did not recall any social marketing campaigns, these next quotes illustrate examples of community members who recall the messages, but it is not clear if the messages came from the TIS teams or from other tobacco control organisations.

> Q: Have you seen or heard any information recently, in the past six months or so that has been around quitting smoking or promoting people to stop smoking?
> A1: Yeah, I have seen a blackfella quit smoking sort of thing… [where] a girl is talking to her father in a cemetery and all that sort of stuff. Sort of scare tactic.
> A: And that ad that was going around: "Butt out your butt", or whatever it's called. (Community members, regional)

Q: Do you see any other messages like TV, radio, billboards? I guess at sporting events and things?
A: I have only seen the nicotine ads and - - -
Q: Just the general ones on TV?
A: Yeah.
A: Just I remember the smoking advertisement back in the days that, I don't know if it was these fellows that brought it up, but it was like, "Smoking? No, it's not our way," or something, and it had an awesome symbol and there was lots of mob getting around in the advertisement, all the t-shirts and all that stuff. Because the design was appealing to mob, they were getting around in the shirts and a bit like the Deadly Choices t-shirts kind of thing. So that was the only one I saw.
Q: It's not our culture, not our way.
A: Yeah. Something like that. And I did, like I obviously can remember that.
Q: Yeah, so that talks to what you're saying then around that, no don't, makes you feel strong in that - - -
A: Yeah.
Q: - - - and a sense of pride, is that - - -
A: Yeah.
Q: - - - a good way to describe it perhaps? (Community members, interview/focus group, urban)

TIS teams also used websites and social media forms of electronic media to increase their reach. (see Figure 8 and Figure 9). Most grant recipients reported that their organisation had tobacco control information on its website and that the TIS Program has its own dedicated website or social media pages, like Facebook or Instagram.

Figure 8: Use of electronic media in 2019

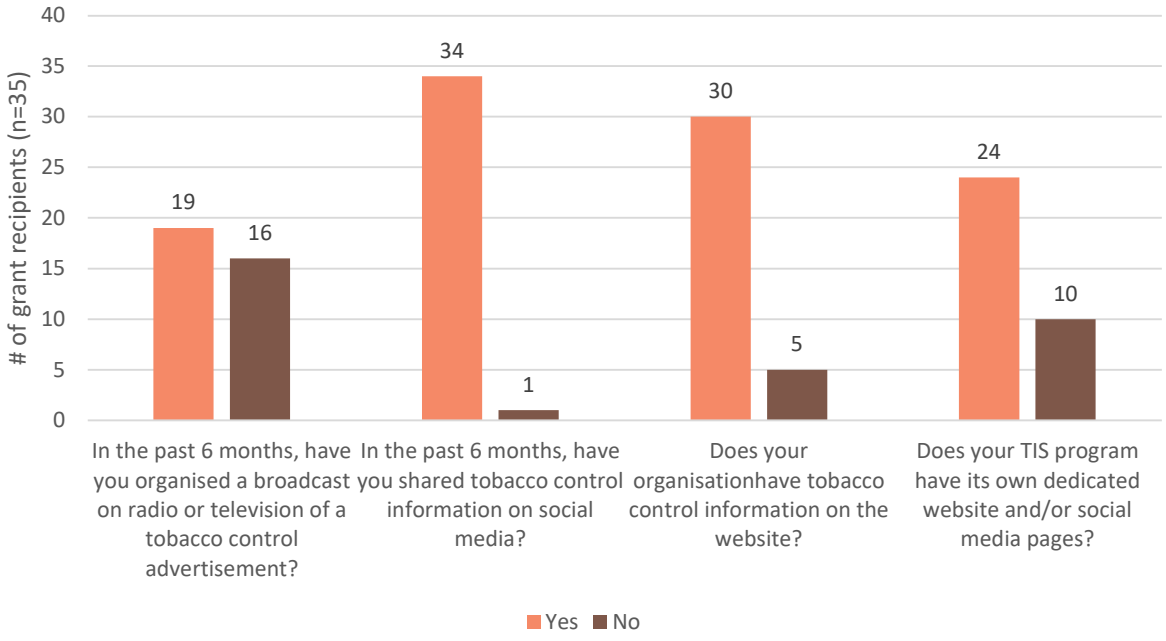
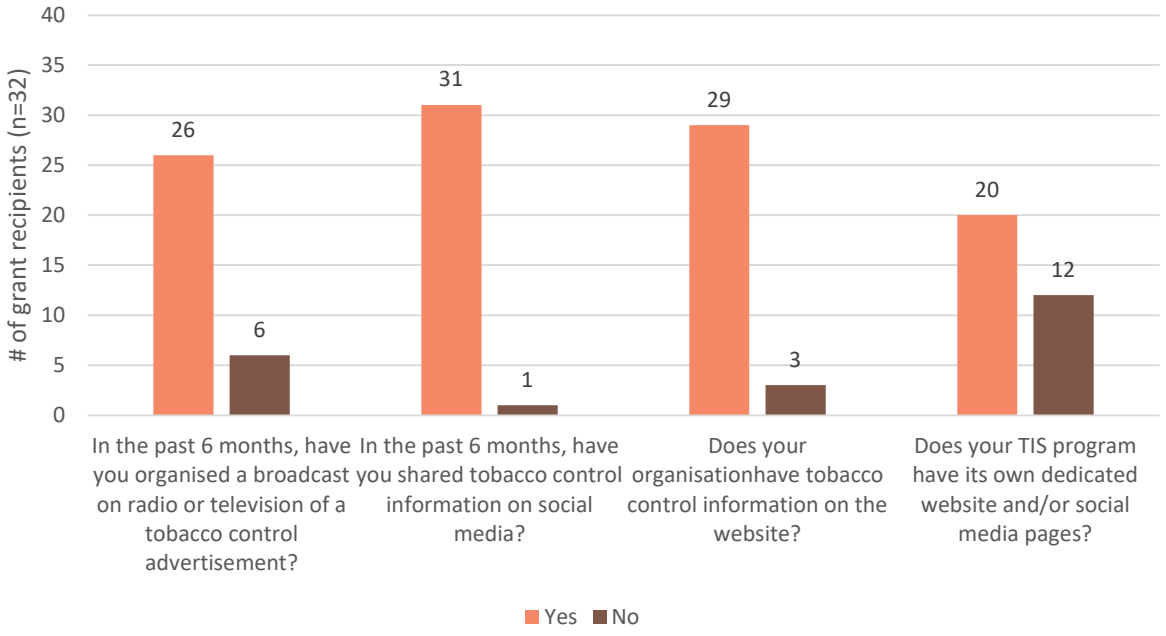


Figure 9: Use of electronic media in 2020



As a result of the restrictions on movement and in-person gatherings in response to the COVID-19 pandemic, grant recipients reported increasing their use of electronic media to communicate with community members – particularly through radio, television and billboard advertisements, and via social media. The benefits of social media include allowing teams to reach a large audience and keeping people engaged in activities, even during lockdowns. Indeed, some

community members we spoke with noted that they did not access regular television or radio (being hooked up to streaming services) and source most of their news and information online, which suggests this is a valuable means of reaching those people.

> So, yeah, you come up with ways of doing it and that reach is really quite wide and we have so much sharing within our social media as well and particularly if you are doing a community-specific activity and you have got lots of photos of people involved in the activity and then you are just seeing it take off basically, for family just sharing and sharing [posts and pictures]. (Grant recipient, interview/focus group)

However, TIS staff also acknowledged that certain cohorts like Elders and those facing internet and telecommunications barriers are unlikely to access this medium. TIS staff by and large saw social media and electronic communications as complementary strategies to communicate with and receive feedback from communities, rather than stand-alone activities.

With regards to reach generally, 80% of the 2021 online staff survey respondents agreed with the statement that "In the last six months, TIS activities have led to increased geographic reach" (up significantly from 68% in 2020), where 42.5% slightly agreed and 37.5% strongly agreed. The remainder were either unsure or did not feel strongly one way or another. This suggests that more respondents in 2021 felt they had achieved this outcome than had in 2020.

The data indicate that grant recipients are conducting many activities to reach community members across a broad geographic area, as well as people who do not attend ACCHOs. While the COVID-19 pandemic has curtailed some of these activities, grant recipients have innovated by shifting their emphasis of activities to greater use of social media and marketing, as well as development and distribution of resources. This has had the effect of increasing reach both geographically and beyond ACCHO clientele. Less clear is the level of impact of these strategies. Measurement of impact may be an area around which the NBPU could provide some guidance.

Recommendations:

- Grant recipients should continue their use of social media and marketing, and development and distribution of resources to increase reach. The NBPU may consider providing guidance as to how to measure the impact of electronic media activities.

3.2.2.4 To what extent and how have RTCG recipients ensured that Aboriginal and Torres Strait Islander peoples who do not attend Aboriginal Community Controlled Health Organisations (ACCHOs) or Aboriginal Medical Services (AMS) are prioritised and reached?

Summary of our findings:

The data indicate that grant recipients are implementing many activities to reach people who do not attend ACCHOs. They are using a variety of strategies to do so, primarily through community engagement and community education activities but most successfully, in numeric terms, through social marketing campaign activities. Success, however, must be gauged carefully because it is not entirely clear which mode of message delivery is more impactful for community members, and this was not in the scope of this evaluation to assess. TIS teams and implementation stakeholders should continue their approaches (i.e. social marketing, social media and partnerships) to maximise their reach to people outside of the ACCHO clientele.

Evidence to support our findings:

Changes to the 2020 Performance Report template mean we can differentiate between activities designed to extend geographical reach, reach beyond the ACCHO clientele and other people not typically reached (see Table 14).

Table 14: Extension of reach by geography, beyond ACCHOs and other people not typically reached, Jul-Dec 2020

	EXTENDED REACH – GEOGRAPHICAL		EXTENDED REACH – BEYOND ACCHs		EXTENDED REACH – OTHER PEOPLE NOT TYPICALLY REACHED	
Activity type	**Number of activities**	**Estimated number of times people were reached**	**Number of activities**	**Estimated number of times people were reached**	**Number of activities**	**Estimated number of times people were reached**
Social marketing campaigns	25	166,571	25	166,851	28	167,451
Social media activities	20	655,434	21	663,734	21	663,084
Development & distribution of resources	15	56,900	14	57,835	15	57,900
Community education	21	4,265	22	7,281	20	4,192
Community engagement	21	12,035	16	12,376	24	12,567
Other	4	2,050	2	1,960	3	2,010
Unknown	0	0	0	0	0	0
Total	**106**	**897,225**	**100**	**910,037**	**111**	**907,204**

The table above does not include information for 2019 because, due to a lack of information from RTCG recipients on the Performance Reports, it was not possible to differentiate activities reported in Indicator 6 between those that targeted people who do not attend ACCHOs and those that focussed on increasing geographical reach.

There is evidence from qualitative data gathered from RTCG recipients suggesting that they are reaching people who do not attend ACCHOs. Strategies cited in Performance Reports include: development and distribution of resources (e.g. a men's magazine, brochures and posters); local and commercial radio and television media buys; social media and websites; signage put up across the community; events attended by a wide cross-section of the community (e.g. Colour Fun Runs, NAIDOC events, sports events); and via community Ambassadors. For example:

> Okay, so obviously we have our partnerships with the AMSs, but we also have a partnership with AES down in [a neighbouring community]; what they do is they allow us to use their area for our marketing and putting our signage up. We've also teamed up with pretty much everyone on that strip. So we have a – what do you call it – a business strip I guess, and we've partnered up with everyone along one side of the street who now displays our non-smoking signage. (Grant recipient, interview/focus group, regional)
>
> We know that our community events that we have are engaging people who aren't coming into our clinic. I guess we don't really have any data as such on that, but I think it's just knowing the population on a recognition basis that we know that message is getting out to members who aren't in our clinics. (Grant recipient, interview/focus group, regional)
>
> Q: Do you believe that's beyond just community members who attend Aboriginal community controlled organisations? That it's reaching people who might not necessarily go to services like [your ACCHO], or other community organisation services.
> A: A lot. Because even with my follow-up phone calls, I've had 28 people to phone up, and I'd say half of them don't attend [our ACCHO] as patients. So it's definitely getting out to other places. We've also just started to do animation videos. We're on our second one. And that's going out through Aboriginal TV. But the problem is with that, it's community-based, but find out last week that they can only play that in [our ACCHO] services – [ACCHO] TV – so it has to be a bigger – which [the TIS Coordinator] is having discussions with because if it's a free community TV station then it needs to go wider than just [our ACCHO]... So that's another way of getting information through community TV. But of course commercial TV in the city costs so much money you can't really – your money's gone in 30 seconds if you spend it all on doing ads for - - - (Grant recipient, interview/focus group, urban)

As this last quote illustrates, connecting with audiences beyond the ACCHO clientele can be expensive, but negotiations are possible to achieve broader reach without breaking the bank.

In 2019, 28 of 37 RTCG recipients reported a total of 441 partnerships with other organisations (e.g. schools, PCYCs and sporting organisations) and/or community leaders aimed at reaching people who do not attend ACCHOs. Twenty RTCG recipients reported that 130 partnerships of these were established for this purpose in just the last six months of that year. We do not have corresponding data for 2020.

Additional evidence that the TIS Program is reaching Aboriginal and Torres Strait Islander community members beyond those who attend ACCHOs comes from information provided by RTCG recipients in the online survey. In the 2021 survey, 80% of respondents agreed with the statement that, "In the last six months [January to July 2020], TIS activities have led to a greater reach to Aboriginal and Torres Strait Islander peoples who do not attend ACCHSs" (up slightly from 76% in 2020), where 39% slightly agreed and 41% strongly agreed. The remaining 20% either did not know or neither disagreed nor agreed; no respondents disagreed.

Recommendations:

- TIS teams and implementation stakeholders should continue their approaches to maximise their reach to people outside of the ACCHO clientele, retaining a focus on social media, social marketing and partnerships.

3.2.2.5 To what extent and how has the program increased community involvement and support of tobacco control initiatives?

Summary of our findings:

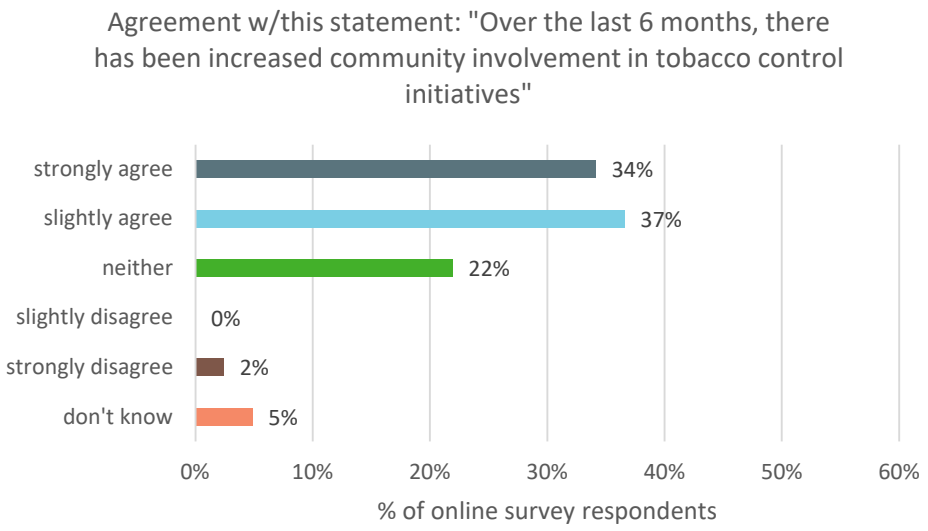
Data from the staff surveys, Performance Reports and interviews and focus groups indicate that the program has increased community involvement and support of tobacco control initiatives. This is being measured through involvement of community members in co-design of TIS activities, community attendance at activities, community feedback on activities via formal and informal data collection processes, regular participation in activities from some community members, and willingness of community members to become Ambassadors and champions for TIS messaging. However, this is not universal and challenges to building and maintaining community involvement and support include COVID-19 restrictions on travel, staff turnover, unexpected cancellation of events and internal community tensions. Despite these challenges, TIS teams continue to consult and plan activities with communities, tailor activities to be culturally and locally appropriate, conduct community engagement, maintain a regular presence in communities and use strength-based approaches. Overall, smoke-free events appear to have a strong impact in changing local community attitudes towards tobacco use and expectations. More work can be done around identifying TIS Ambassadors and spokespeople (especially women and young people).

Evidence to support our findings:

Data from the staff surveys, Performance Reports and interviews and focus groups indicate that the program has increased community involvement and support of tobacco control initiatives. However, this is not universal and the impact of COVID-19 on TIS activities in communities in 2020 and 2021 may have lessened the level of community involvement and support that the program may have otherwise had.

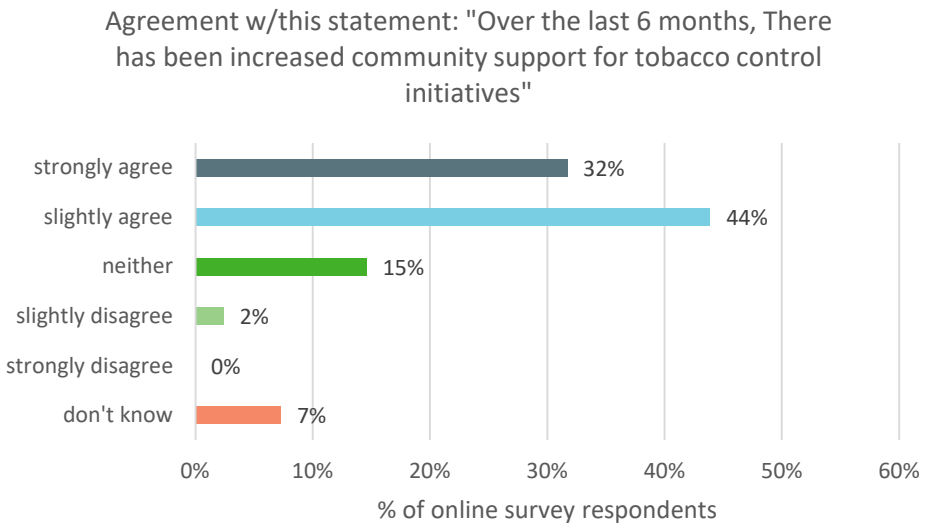
Of the 41 respondents to the 2021 staff survey, 34% strongly agreed and 37% slightly agreed with the statement, "Over the last 6 months, there has been increased community involvement in tobacco control initiatives"; only one respondent strongly disagreed which does signal that their team is struggling to engage communities (see Figure 10).

Figure 10: Increased community involvement in tobacco control initiatives, 2021 RTCG survey



Of the 41 respondents to the 2021 staff survey, 32% strongly agreed and 44% slightly agreed with the statement, "Over the last 6 months, there has been increased community support for tobacco control initiatives"; with only one respondent slightly disagreeing (see Figure 11).

Figure 11: Increased community support for tobacco control initiatives, 2021 RTCG survey



A couple of TIS teams cited increases to the number of community members getting involved with their programs as evidence of increased community involvement and support:

> There has been a significant increase in the number of community Champions from this reporting period to last. The number of champions has grown from 19 to 39, an increase of 95%. A significant increase in the development of new resources for the Champions across our communities was developed (Grant recipient, Performance Report, regional)
>
> We worked closely with our graphic designer to create a graphic and used [a local] event to pilot the billboards and get consumer feedback on the final design from five women. We also put a call out to the staff at [TIS host organisation] to provide feedback and vote on their favourite design. We received 63 responses from staff and community - this is the most engagement we have received from our team and shows the buy in we have… (Grant recipient, Performance Report, regional)

It is important to note that these RTCG recipients were actively cultivating community involvement and support for tobacco control by providing formal avenues for it, such as through a Community Champions program and through a formal feedback process. One TIS team staff member talked about the importance of this feature of the TIS Program, one that is intentionally built-in to their program design:

> So, for us, [TIS is] an exciting program that we're allowed – we can, sort of, use those funds for and it's not so much treatment, clinical service delivery, so it has allowed us to hold more community events, get community engaged more in the conversation and

> also opportunities for Aboriginal people to gather in spaces that are culturally friendly and celebrate that, sort of, space as well as getting some messages through that. (Grant recipient, interview/focus group, urban)

Involving community members as TIS Ambassadors or spokespeople in campaign materials and resources has elevated community interest and support in the program:

> We used our local community to do our last brand campaign so they have been used in our Tackling Indigenous Smoking posters, and they're all faces that are familiar in our community, our community leaders, our community football clubs, our well known community members that use our services, we have local families in our promotional pictures and our videos. We like that, but they like it too and I find it gets a really good reach if you use people that are local that are known to each other and it gets shared around a bit more and people see that the reach of that message might get a little bit further (Grant recipient, interview/focus group, urban)

However, TIS teams acknowledged that they predominantly worked with men as TIS Ambassadors and that they needed to expand their work to include more women. Our consultations also identified many strong advocates for tobacco control among general community members (as opposed to leaders or high-profile people), including young people, who could be encouraged to be TIS Ambassadors and spokespeople.

Community support and involvement can signal to RTCG recipients when certain tobacco control activities or initiatives are appropriate. In one TIS site, a staff member explained that they are seeking to work with partners to make the local CBD smoke-free. The TIS team is actively soliciting community input on that proposal to inform their approach, and that builds community support for their work:

> Okay, so we have an initiative we're working on; it's not fully complete yet, but for a smoke-free CBD. It has had a lot of feedback and following, very little – what do you call it – very little against… we've also got to work in with our council…up here and it doesn't seem like they're going to be too supportive, but I think once we get a little bit more practical on from our health organisations around and keep up with that I think we can make our [community] as a smoke-free CBD. So that's on the edge of being successful so far, and that's just increased our community support because we're doing a bit of surveys throughout the street just to see what people think of upgrading our main area smoke-free. So that's going to be one of our – hopefully, our big successes. (Grant recipient, interview/focus group, regional)

Smoke-free events and zones, when enforced, can be highly influential in conveying messages to communities about the harms of smoking and second-hand smoke. They also assist in standardising community expectations for smoke-free spaces. TIS teams are routinely present at smoke-free events to provide information and one-on-one discussions with community members about smoking prevention and cessation.

TIS teams do consult local community members to identify their needs and perceived best methods for conveying messages, and in some cases community members are involved in co-designing and distributing resources:

> So between July and now, I obviously liaised with my mob and they provide a lot of guidance to what's appropriate, what's not appropriate, how to try something, how to engage with a certain service. (Grant recipient, interview/focus group, regional)

In interviews and focus groups, grant recipients spoke about being regularly present in communities and at events to promote recognition of both TIS staff and the program. Where this has been successful, community members engage actively in TIS activities and sometimes approach TIS staff for assistance:

> The TIS team has been approached by certain Elders or family members requesting them to go to their house and deliver an education session with their family members, and asked for some stickers and resources that they can put across - around the house to promote smoke-free homes and smoke-free cars, the impact of second hand smoking. … So, yeah, quite good engagement from the community, to be honest. (Grant recipient, interview/focus group, remote)
>
> Well, we have, we've had people that used to come to our [gym] program every week. And then out of that, they've talked to us, we've also provided them with flyers and stuff we get around opportunities for jobs and provide them with that. (Grant recipient, interview/focus group, urban)
>
> People know who we are in the communities. When we run a TIS [activity], they know who's running it, I guess, which has already been identified within the community without, I guess, signage and stuff. … I think most of it, it's just repetitive and then being able to, I guess, allow the community to take responsibilities for, or accountability for, delivering the messages after we're not delivering them, I guess. (Grant recipient, interview/focus group, remote)

A number of grant recipients spoke about the importance of using a strength-based approach and connecting to culture as a means of building rapport and trust with communities:

> So we're able to sort of do events and activities that Aboriginal community can come to celebrate strength and culture. And whilst sort of sharing the importance of the tobacco messaging throughout that as well and changing behaviours and building that trust. So I think together that's vital or key for this sort of role, or for this program. To be able to provide something that's able to lift the community and share those things. So I think it builds trust, it builds rapport, it builds connection, and it builds just the listening and the openness to sharing, which other senses we don't really get if you're just going to have a health day or something that doesn't allow for both. (Grant recipient, interview/focus group, urban)

These data indicate that TIS teams are building community involvement and support. Grant recipients also identified some challenges in this area. These included: COVID-19 restrictions on travel and face to face engagement limiting TIS presence in communities; staff turnover or gaps in staffing in TIS teams; TIS staff or program partners cancelling events unexpectedly; navigating competing events in community calendars; internal community tensions resulting in people not attending activities where others will be; and transience of community members.

Recommendations

- TIS teams should continue to build community involvement and support through the range of strategies they are currently using
- TIS teams could expand their pool of TIS Ambassadors and spokespeople (e.g. for greater age and gender diversity), and make greater use of them in communities to convey TIS messaging.

3.2.2.6 To what extent and how did the RTCG recipients enhance leadership and an advocacy role of community leaders in tobacco control?

Summary of our findings:

It appears that to varying levels, RTCG recipients have managed to enhance leadership and advocacy, within communities, around tobacco control. This is evident through the establishment of TIS Ambassadors and spokespeople within communities, and the involvement of community members in TIS advertising campaigns. It is also evident through more anecdotal reports from TIS staff about community members advocating to family members, work colleagues and others about the harms of smoking and benefits of quitting. Although many grant recipients have partnered with individual community leaders, staff are ambivalent about the extent to which they have been able to encourage these leaders to step up in the community. It has been challenging in some instances to convince people to participate in a TIS advertisement or on campaign materials, for example. Where community members have agreed to take on leadership roles, it is more common for them to have been young people and male Elders.

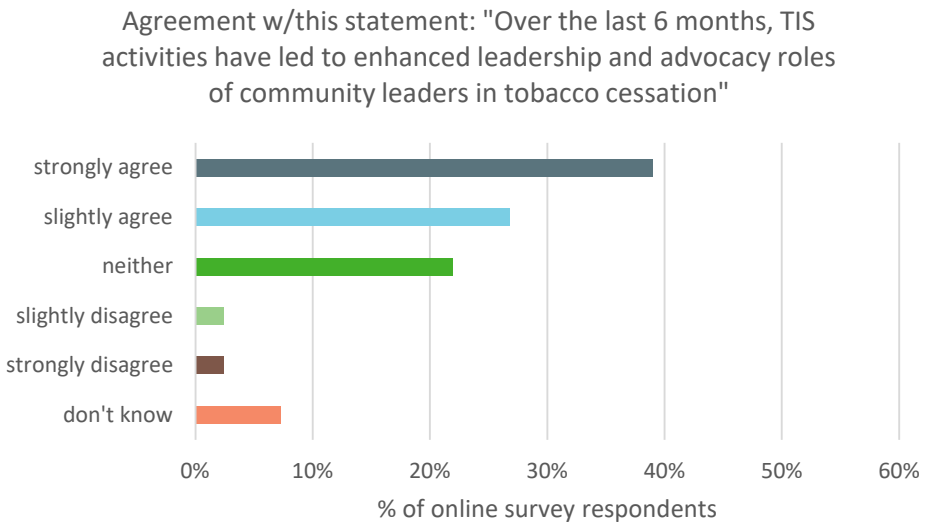
Evidence to support our findings:

It appears that to varying levels, RTCG recipients have managed to enhance leadership and advocacy, within communities, around tobacco control. This is evident through the establishment of tobacco control Ambassadors and spokespeople within communities, and the involvement of community members in TIS advertising campaigns. It is also evident through more anecdotal reports from TIS staff about community members advocating to family members, work colleagues and others about the harms of smoking and benefits of quitting.

In the 2019 Performance Reports, 33 RTCG recipients reported that a total of 1,408 community leaders had participated in planning or implementing population health activities and events since the start of the TIS grant, and 24 grant recipients reported that 226 community leaders had participated for the last six months of 2019. The number of community leaders engaged by individual TIS teams since the start of the grant ranged from 3 to 461, with 21 grant recipients reporting engaging 10 or more community leaders. Only one RTCG recipient reported that no community leaders had ever been involved in planning or implementing activities and events (they did not provide an explanation why). For July to December 2020, 16 RTCG recipients reported 1,091 total partnerships with individual community leaders since the start of the TIS grant, with 242 of these being formed in the last six months of that year.

Despite the engagement of many community members from the start of the program through to December 2019, in the online survey TIS team staff were mixed in their appraisals of the extent to which their activities had recently encouraged community leaders to step-up their roles in tobacco control in the community. That is, of the 41 respondents to the 2021 TIS staff survey, 39% strongly agreed and 27% slightly agreed with the statement that "Over the last 6 months, TIS activities have led to enhanced leadership and advocacy roles of community leaders in tobacco cessation", and two respondents either slightly or strongly disagreed (see Figure 12). Some TIS staff noted challenges in convincing community members to participate in a TIS advertisement or on campaign materials, for example.

Figure 12: Enhanced leadership and advocacy roles of community leaders in tobacco cessation, 2021 RTCG survey



Interviews and focus groups with TIS team staff suggest that RTCG recipients have had the most success in this area with young people as community leaders and utilising Elders as program Ambassadors, for example in online activities, to share messages about smoking cessation and the harms of smoking. Other examples include involvement from Aboriginal Police Liaison Officers during school holidays, and higher profile individuals within local communities. Discussions with community stakeholders suggest that TIS teams would be wise to engage and utilise a diverse array of role models and Ambassadors; while having local or regional athletes as Ambassadors will appeal to many in the community, having other types of local or regional leaders from other professions and from diverse ages and genders as Ambassadors will help broaden the appeal of the smoking cessation message.

Recommendations

- To increase the leadership and advocacy roles of community leaders in tobacco control, successes of other TIS teams should be considered by those who have struggled in this area. These data suggest that creating opportunities for women, young people and Elders to share messages about smoking cessation, as well as targeting regional athletes and regional leaders from a variety of backgrounds, are good steps toward enhancing community leadership.

3.2.2.7 To what extent and how have RTCG recipients contributed to an increase in the number of smoke-free homes, workplaces, and public spaces?

Summary of our findings:

RTCG recipients are contributing to increased prevalence of homes, workplaces, and public spaces that are designated as smoke-free. In 2019, only three of the 32 grant recipients for whom we had data reported supporting no homes or public events to be designated as smoke-free (partially due to missing data and partially due to challenges faced in the community). The grant recipients engaging in these activities have assisted many organisations, events, and households by sharing information about the harms of second-hand smoke and providing them the resources and support to transition to be smoke-free. Although we do not have data about the adherence to smoke-free policies among all of the recipients of TIS team support, evidence from the organisations that house TIS teams suggest that adherence can be quite high in some policy aspects and a bit lower in other realms. However, taken in conjunction with other broad efforts to curb smoking, TIS teams' efforts are contributing to a cultural shift away from smoking that many communities are experiencing. Going forward, it will be valuable for TIS teams to track adherence to smoke-free policies, homes, and zones.

Evidence to support our findings:

In the last six months of 2019, 20 RTCG recipients reported assisting a total of 77 organisations to establish a smoke-free policy and 24 RTCG recipients assisted 86 organisations to review their existing smoke-free policy. In 2020, 11 RTCG recipients reported assisting a total of 24 organisations to establish a smoke-free policy and 20 RTCG recipients assisted 43 organisations to review their existing smoke-free policy.

Some of the challenges grant recipients face in working toward this goal include organisations already having smoke-free policies in place and organisations being uninterested in establishing smoke-free policies:

> …With smoke-free policies…most places already [have] an existing smoke-free policy and [feel] no need to change anything in their policies. There are only three Indigenous specific organisations / services in [our region] and so other organisations do not see that there is any need for our input into their smoke-free policy when they do not see only Indigenous families. (Grant recipient, Performance Report, regional)

While grant recipients can try to encourage workplaces to revisit their existing smoke-free policies, this quote demonstrates the resistance they can and do receive from organisational leadership.

In the Performance Reports, 33 RTCG recipients reported having assisted at least one event to be smoke-free in the last half of 2019; although five organisations did not assist any events. In total, 33 RTCG recipients assisted 532 events to be smoke-free by in the last half of 2019. In the last half of 2020, 27 RTCG recipients assisted at least one event to be smoke-free and five assisted no events. In total for this period, 364 events were assisted to be smoke-free.

One TIS team which reported assisting no events to be smoke-free explained that they have:

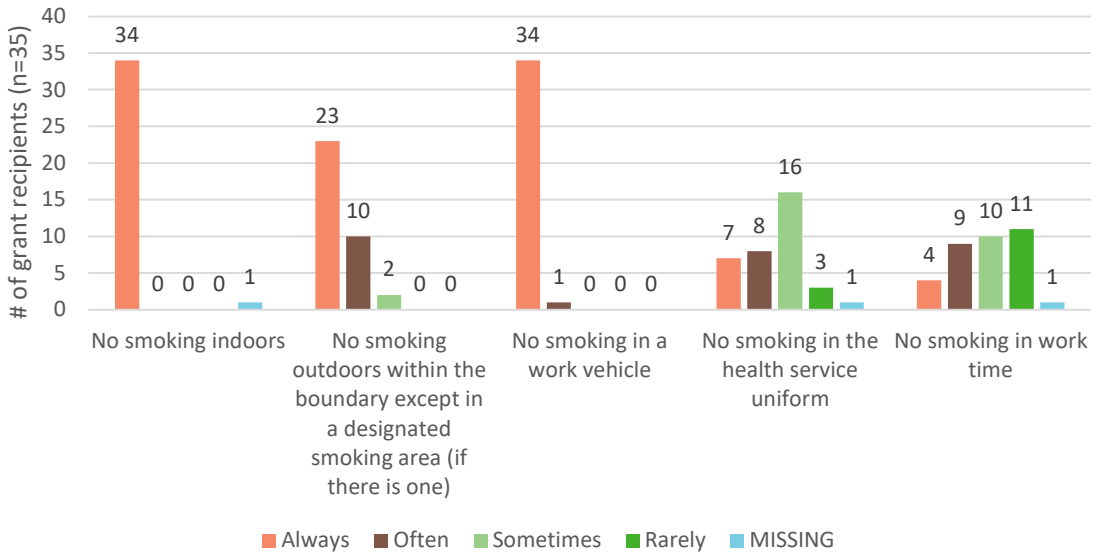
> Approached multiple events to assist them to go smoke-free. Unfortunately, each time this has been rejected. There is a belief by these event coordinators that there is too much work involved in making the event smoke-free, the danger of those attending becoming hostile if staff were to approach them about complying with a smoke-free event or that attendance would be affected if the event were to be smoke-free (Grant recipient, Performance Report, regional).

Another TIS team whose data on this indicator was missing reported in their Success Story that "*community events planned in collaboration with [our ACCHO] are promoted as smoke-free events. Appropriate signage is taken to all events to increase public awareness*", suggesting that this team has helped some events be smoke-free, they just did not report the number (Grant recipient, Performance Report, regional).

In the Performance Reports, 25 RTCG recipients reported assisting 6,483 homes to become smoke-free in the last half of 2019. One organisation in an urban setting, however, accounted for over 70% of this number. In the last half of 2020, 22 RTCG recipients reported assisting 14,843 homes to become smoke-free.

Many RTCG recipients also reported that their own organisation's smoke-free policies were generally being respected. Results for the Performance Report questions that ask about adherence to smoke-free policies are displayed in Figure 13.

Figure 13: Frequency that aspects of smoke-free policies are followed at organisation, by staff and Board members



As Figure 13 shows, all but one RTCG recipient reported that their staff and Board members always refrain from smoking indoors or in work vehicles. The majority also reported that staff and Board members always refrain from smoking outdoors within the boundary, except in a designated smoking area, if there is one. Smoking in the health service uniform and smoking during work time were less successfully implemented. Over half of RTCG recipients reported that the "no smoking in the health uniform" policy was only sometimes or rarely followed by their staff and Board members; this was the same for smoking during work time.

Respondents to the 2020 online survey were also consistent in their self-appraisal of their progress toward this outcome. Of the 34 RTCG recipient staff respondents, 78% agreed with the statement that "In the last six months, TIS activities have led to an increase in smoke-free homes, events, workplaces and workspaces in the region" (39% strongly agreed and 39% slightly agreed). Interestingly, overall staff agreement with this statement was slightly lower in 2021 than in 2020 (85% of staff agreed), despite the lower risks and restrictions of COVID-19 in the first half of 2021 compared to the first half of 2020.

To promote smoke-free homes, workplaces, and events, RTCG recipients have promoted the importance and positives of smoke-free spaces to program participants. Grant recipients have also promoted the harms of second- and third-hand smoke at events attended, produced smoke-free signage, and created and distributed promotional materials and stickers for households (including smoke-free signage for households to put up). At one remote site, agreements with community councils and the grocery stores to install smoke-free signage in the immediate vicinity where people usually sit and smoke were entered into. And at this site local young people will assist in developing the messages and artwork for the smoke-free signage:

> Most of the community stores, people will go in and buy a packet of cigarettes and then they'll sit outside the store and have a smoke or share smokes or whatever. We've now got agreements with community council and the stores, if they're community run or privately run, to have people, have a smoke-free area and have smoke-free signage up, and there's one store in particular in [the community] where we'll be heading to this year -- now that COVID-19 [restrictions have eased and] we're allowed into communities -- where outside the store, the council and the store group have agreed that there they've got big cement boulders, and on those cement boulders where people usually sit, we will have all of our smoke-free signage and we're working with the local youth to develop that signage and we've got a graffiti artist who will work with us to develop what those messages are that the young people want to put onto that, and that's all approved through council and community stores. (Grant recipient, interview/focus group, remote)

Comments from community members indicate that people in the community are increasingly choosing to smoke outside of the house and adhering to legislation relating to smoke-free public

and other spaces (e.g. cars). They spoke to broad shifts in community behaviours and attitudes, resulting from a combination of factors including legislation, tobacco costs, and changes to the built environment (which RTCG recipients also influence). For example:

> I certainly think…sense…that attitudes are changing, especially around smoking and spaces. Indoor smoking has really changed quite rapidly, I think, and are changing rapidly. They're the changing of public perception and public modelling. The increase of signage around smoke-free spaces, that kind of thing as well, are quite influential. (Community member, interview/focus group, regional)

Recommendations:

- TIS teams and implementation stakeholders should continue their current approaches in this area and consider the best balance of focus in terms of encouraging workplaces, homes and events to be smoke-free.
- AMSs and TIS teams should also look to opportunities to promote those organisations, events and homes which have gone smoke-free.
- TIS teams, with assistance of NBPU, should develop mechanisms to track adherence to smoke-free policies, homes, and other spaces.

3.2.2.8 What evidence exists from the evaluation about if and how the RTCG recipients have prevented uptake among community members?

Summary of our findings:

Our data around prevention of uptake of tobacco is relatively scant. We have some anecdotal, promising signs that prevention is being encouraged by TIS activities. The anecdotal reports from grant recipients suggest that prevention is most likely occurring via their work with children and young people, although challenges remain among this cohort. Measurement of this metric is important, particularly in some of the remote areas where we received reports of uptake among children and young people at very early ages.

Evidence for our findings:

Measurement of the effectiveness of prevention is notoriously difficult and so it is too for TIS teams without access to local population data on smoking rates. However, there is anecdotal data from some of the TIS teams about the impact of their activities on prevention of uptake of tobacco:

> Well even the thing, just the stigma around it, when I go there, the other day they were all kicking the footy on the park, and I pulled up there, went over and two of them run

> up to tell me that one of the other boys was over there smoking bumpers the other day. And then they all started teasing him about it, about smoking. Whereas it's not like before where you'd get teens who were smoking, whereas before you were the cool guys that smoked cigarettes and stuff. But now a young person, they'll gang up on the people that smoke cigarettes and they'll go, "smokers, he can't run", they know that. And I feel like that's had the most effect, is with the younger ones. (Grant recipient, interview/focus group, remote)
>
> Well, because when we were talking to the kids, the last year, was it last week? The week before? They themselves saying, "Well, my six-year-old brother is smoking." So we said, "Are you going to smoke?" They said, "No, we're not, after what you've shown us," and whatever. So that fear is there in those 19 kids. (Grant recipient, interview/focus group, remote)

In the last six months of 2019, 32 RTCG recipients reported having held at least one event to support prevention of uptake of smoking and/or smoking cessation. Only 2 RTCG recipients reported no events. In the last six months of 2020, 26 RTCG recipients held at least one event to support the prevention of uptake of smoking and/or smoking cessation. Five RTCG recipients reported no events and data is missing for one. It is unclear how successful these events were at preventing uptake among community members.

Evidence suggests that RTCG recipients have prevented uptake among some community members, although we do not have data on how many. Grant recipients report they have had the greatest impact on the attitudes of school children and youth about not taking up smoking:

> So, featuring youth in our ads and posters is a great prompter for discussion with youth. Because there's definitely an attitude of smoking not being good and smoking – and young people seeing that people around them are really struggling with quitting. (Grant recipient, interview/focus group, urban)

Another grant recipient relayed the impact they hope to have on prevention, as well as quitting, via their work with young people. This TIS team provides school children with an 'I want to Quit' Card. After hearing the presentation at school, children take the card home and give it to family members who are smokers. As this TIS team staff member put it:

> It prompts young people to not take up smoking, and it also involves them in the prevention activity and early intervention or even management of their parents. Then it also encourages the smoke-free home environment as well. (Grant recipient, interview/focus group, regional).

For some remote areas, work has been done around sporting activities and school children, but they, "*find it quite challenging with how normal smoking has become here within the community*" (Grant recipient, interview/focus group, remote).

Measurement of this metric is important, particularly in some of the remote areas where we received reports of uptake among children and young people at very early ages. For example, in one remote community consultation, participants said they knew of children as young as 10 years old smoking. When asked why they thought children were doing this, they either attributed it to stress or that children thought it was "cool", as they were copying role models in the community.

Recommendations:

- NBPU could assist RTCG recipients to develop data collection tools that can assist them to track and understand the extent to which they are preventing smoking uptake among community members they work with.

3.2.2.9 What have been the key successes and barriers to achieving medium term and longer-term outcomes? How have these differed for remote communities?

The six medium-term outcomes identified in the Tackling Indigenous Smoking Program Logic are:

1. Grant recipients have increased their geographical reach and reach to community members who do not attend ACCHOs
2. There is evidence that priority groups are being reached through evidence-based approaches
3. There is an increase in smoke-free homes, workplaces and public spaces
4. Increased leadership and advocacy role of community leaders in tobacco control
5. Increased community involvement in and support for tobacco control activities
6. Increased understanding by the community of the health impacts of smoking.

Our evaluation identified the following factors that help and hinder TIS teams achieving impact, which are explored further in the report.

Enablers	Barriers
Collaboration and partnerships	TIS-funded organisations (outside of the TIS team) restriction of TIS teams' ability to travel, their travel budgets, and their ability to work overtime
Staffing of TIS teams by Aboriginal and Torres Strait Islander individuals	Distance
Taking an educational approach with community members	Bad weather conditions and poor infrastructure (road, accommodation)

Enablers	Barriers
TIS teams funding smoke-free events for community organisations	Difficulties navigating community politics and reaching people who are not interested in the tobacco control messages
Legislation that has come into effect that outlaws smoking around people in certain circumstances, like in cars where there are children present	Measurement and reporting challenges
Creating opportunities for community members to step up into leadership and advocacy roles and be visible	Avoidance of antenatal checks by pregnant women
Actively seeking out community input and creating space for that involvement	Existence of other similar programs in the community
Engaging the right local leaders as Ambassadors – those who are well respected and can help bring more people into the TIS fold	Difficulties in enforcing smoke-free policies and spaces
Education sessions that cover new or novel information about harms of smoking	Sentiments from community members that they do not want to be told what to do and that they do not respect the message because they do not have a positive view of the messenger

Important to note is that across all of the outcome areas, COVID-19 has caused some challenges. Of the 30 respondents to the online survey who provided a response to the open-ended question about what their greatest challenge had been as a TIS team in the last six months, 23 cited COVID-19 as that challenge. They talked about the challenge of COVID-19 in a few ways, namely the stress it created among community members, which challenged their desires to quit and affected their priorities, and the movement and gathering restrictions meant that all planned in-person activities had to be called off, which affected teams' abilities to reach their intended audiences.

Barriers and enablers to grant recipients increasing their geographical reach and reach to community members who do not attend ACCHOs

Collaborations and partnerships were most often reported as enabling RTCG recipients to increase their geographical reach. The type of partnerships reported to increase geographical reach included working with community Elders and organisations to gain access to communities, and working with other organisations on the delivery and/or promotion of activities and distribution of resources. The use of media and branded resources were also identified as enabling RTCG recipients to have a greater geographical reach:

> These partnerships help us to get foot in the door for other things that may go on in that community. We're invited to other events. It helps us become more recognised in other communities also and it just enables us to deliver more programs and people are more willing to have us in. (Grant recipient, interview/focus group, regional)

Another enabler identified is the staffing of TIS teams by Aboriginal and Torres Strait Islander individuals. At one site, community members we spoke to talked about preferring to meet and have a yarn with their own mob in TIS roles, because they feel more comfortable and can build up trust when providing what they perceive to be sensitive information without judgement. This helps the TIS team forge new relationships with people who have not been part of the ACCHO before.

On the other hand, limited access to resources, such as limited funding and staff was identified as affecting the ability of RTCG recipients to increase their geographical reach. Costs of travel and staff turnover were particularly noted as affecting RTCG recipients' ability to reach remote communities. This may be due to various factors. According to the national implementation stakeholders, one of the reasons the teams may cite resource limitations is that TIS-funded organisations (outside of the TIS team) have been known to restrict TIS teams' ability to travel, their travel budgets, and their ability to work overtime, without the TIS teams' knowledge that these restrictions run counter to the agreement of the grant. Unfortunately, due to the nature of the grant, it is not possible for the Department to force TIS-funded organisations to comply and remove restrictions on travel, budgets, and overtime of TIS teams; this is where the influence of the National Coordinator and NBPU come into play.

Related to access to resources, distance was identified as a barrier to greater geographical reach, especially for remote communities. In addition, bad weather conditions and poor infrastructure (road, accommodation) also made accessing remote communities difficult. Cultural ceremonies and sorry business were however the biggest challenge to reaching remote communities faced by RTCG recipients, who also face pressures to deliver on activities within timeframes associated with their grant funding:

> Cultural Ceremonies, Sorry Business, family disputes: Ceremonies start in December and travelling to remote communities is restricted from December till February. Sorry Business is another hindrance as planned activities get cancelled in respect of loss in the community. Family disputes sometimes force TIS team to cancel their activities. One example would be Health Promotion Day event... Family dispute erupted which forced TIS team to pack up and leave. Barriers like these can cause substantial delays in the TIS activities planned for the year. Servicing all [of our] remote communities twice a year in limited time can be very challenging (Grant recipient, Performance Report, remote)

This example illustrates a challenge resulting from RTCG recipients sitting squarely between two cultures, both of which they need to comply with – the culture of the Commonwealth which provides the funding and has priorities related to budget, time, and achieving goals and the

culture of the Aboriginal communities where services are to be delivered which have priorities related to culture, family, and relationships. As this example shows, grant recipients struggle to navigate this space if they do not feel they have the flexibility from either side of the cultures they straddle or if they struggle to articulate realistic budgets, timeframes, and goals.

Additional factors grant recipients cited as challenging their ability to increase their geographic reach and reach community members who do not attend ACCHOs included difficulties connecting with people who are not permanent residents of the community, as well as difficulties navigating community politics and reaching people who are not interested in the tobacco control messages that they are trying to convey. Grant recipients would likely benefit from some guidance from the Department, NBPU, or other grant recipients on how to navigate these challenges or how they may need to adjust their expectations.

Barriers and enablers to accumulating evidence that priority groups are being reached through evidence-based approaches

Barriers and enablers to achieving this medium-term outcome echo those articulated earlier as barriers and enablers to achieving the short-term outcome of accumulating evidence that community members are being reached by evidence-based population health promotion approaches for tobacco control. Shared barriers include measurement and reporting challenges, and shared enablers include partnerships and collaborations. Barriers unique to this medium-term outcome include not having the right staff on board to reach a particular priority group and trying to do outreach to the priority group where many other organisations are doing the same or similar work.

Barriers particularly related to reaching pregnant women included cultural factors such as avoidance of antenatal checks, finding the topic "*confronting to discuss*" (Grant recipient, Performance Report, regional) and a lack of female staff.

> An ongoing challenge remains to engage with pregnant women directly as a priority group due to limited numbers of female workers in some communities despite having open positions. Within [the local Aboriginal] culture, pregnancy is considered a highly culturally sensitive topic and it would be inappropriate for our male workers to conduct these sessions with women (Grant recipient, Performance Report, remote)

One organisation also noted that the existence of multiple similar programs appeared to hinder their ability to reach priority groups.

> A key challenge of drawing in participation from people within priority groups has been the fact that certain regions may have pre-existing mainstream programs that are similar to [our] programs, but without the cultural connection. To address this, [we]

> have made steps, where possible, to initiate partnerships with other community-based groups (Grant recipient, Performance Report, urban)

Barriers and enablers to increasing smoke-free homes, workplaces, and public spaces

A factor identified by some grant recipients as enabling them to increase the number of smoke-free homes and workplaces was taking an educational approach with community members. Grant recipients have found that after educating community members about updated regulatory information, information about the harms of smoking and second-hand smoke, or information about the support available from RTCG recipients to assist keep homes and events smoke-free, it is easier to encourage them to make their homes, public spaces, and workplaces smoke-free. Partnering on other projects was also identified as facilitating the introduction of an organisational smoke-free policy.

> The biggest challenge last report was letting people know that [our TIS team] is available and willing to assist in spreading non-smoking messages and assisting in keeping events and homes smoke-free. Being aware of this challenge in particular we put in place strategies to advertise the fact to organisations, services, community groups, sporting clubs etc that we were available to attend their events, bring some TIS paraphernalia, put up signs advertising that it was a smoke-free event - this was taken up by 12 groups in the past 6 months, 4 sporting events, 6 community days and 2 health organisations. (Grant recipient, Performance Report, regional)

One RTCG recipient identified an additional enabler, namely funding smoke-free events, and this practice has been promoted among all TIS teams and undertaken by many.

> We are certainly known as an organisation that will fund your smoke-free event. So I think one of the perceptions is that we are a funding body, but we certainly get a lot of requests for funding for smoke-free events. (Grant recipient, interview/focus group, urban)

Another enabler is legislation that has come into effect that outlaws smoking around people in certain circumstances, like in cars where there are children present. Where community members know about the legislation (or even do not know about it), grant recipients are able to use these as opportunities to educate and to support the implementation of the legislation.

> We see, that a lot of the adults with kids at home, they are choosing to smoke outside of the house. It's legislated now that you can't smoke in the cars with any kids under the

> age of 16, and by all reports people are adhering to those recommendations. We continue to promote that as well. (Grant recipient, interview/focus group, regional)

Difficulties in enforcing smoke-free policies and spaces is a challenge identified by TIS teams. TIS staff noted that residents complained of their difficulties in enforcing smoke-free homes when visitors come over who do not heed the requests of their hosts. Lack of buy-in by organisations and particularly by management, was an often-reported factor for organisations not adopting a smoke-free policy. Shared offices were mentioned as making it difficult to enforce existing policies. Some TIS teams also spoke to the challenges of enforcing smoke-free policies at community events or in their own workplaces, which they are sometimes able to overcome:

> At the moment [our organisation] rents office space in [a building] which is occupied by several other businesses and organisations. Whilst [our organisation] does have a smoking policy and this is enforced to all [our] staff and clients, it is difficult to enforce our policy on other businesses that share the offices at [the building]. [Our] clinic in [a different location] is in the process of being built and is scheduled to be opened mid 2020 (Grant recipient, Performance Report, remote)
>
> Challenge would be getting people to comply with it. People, if they want a cigarette, they'll have one. I've been to concerts and there's someone sitting four seats away and having a cigarette when they're not supposed to be in there doing that. People will just stop and have a cigarette wherever they want. If they're on a community hall or community area, and they've hired it out for the day, people will just stay on the premises and walk over in a corner and have a cigarette instead of doing the right thing and getting off that (Community member, interview/focus group, urban)

We note that it is not the responsibility of TIS staff to enforce smoke-free policies, although they may take on that role in certain circumstances to encourage compliance and or community discussions.

Barriers and enablers to increasing leadership and advocacy of community leaders in tobacco control

Grant recipients identified the key enabler for increasing leadership and advocacy of community leaders was creating opportunity for them to step up into these roles and be visible. Many programs have developed and instituted formal Ambassador or advocate roles for community members, typically those who have quit smoking, to fill. TIS teams then use these Ambassadors and advocates in their media campaigns (social and traditional).

> We utilise program Ambassadors, so trying to share messages directly from our clients to our clients on how the program has supported them or the importance of not smoking and all the harms. (Grant recipient, interview/focus group, urban)

Beyond just creating these roles and recruiting for them, grant recipients did not provide further concrete insight into enablers for getting community leaders to step up, but it does seem that having locally respected individual community members who have quit smoking successfully is important.

> So we did use [an individual advocate]. We used him throughout – so those ads were developed last year around August, so we used those up until 30 June this year. So we sort of used him in our social media as well, being a community leader and advocate to a healthy body, and a past quitter. We also have one of our local Elders who quit smoking three years ago. So we often get her to give us – we often record her and put her on our Facebook and Instagram, our social media. You know, just to feed back to the community how she almost died and how that – going to hospital prompted her to quit smoking, so that was just an example, yeah, of a community Elder sort of taking on that role in the community around some of our activities. (Grant recipient, interview/focus group, urban)

It is also important for there to be avenues for Ambassadors and advocates to tell their stories and encourage behaviour change in the community. As a result of COVID-19 some grant recipients struggled to provide these opportunities, indicating a challenge for them has resulted from the pandemic:

> So what we try to do is try look for young leaders within our community, someone that can relate to each age group. So we like to have our young-uns, maybe late teens, and they'll work on being leaders within their little community and promoting – just promoting the messaging around smoke-free and what sort of lifestyle you can make and how good it will be for your [health]. So we try to aim at those things with advocacy. Ambassador role and market – so we haven't really had any more Ambassadors though, just due to the COVID-19 and our shut down of all of our events, but yeah, we try to aim for our younger generation to lead the way in the smoking cessation (Grant recipient, interview/focus group, regional)

Some TIS teams, however, found that the pandemic and the use of podcasts and social media enabled the participation of Ambassadors more frequently than before COVID-19. Also, some found their young workforce was a way to role model to young people in the community and may have experienced this as an indirect mode of advocacy and a more sustainable approach.

Other barriers to increasing the leadership and advocacy of community leaders identified by grant recipients include needing or seeking out permanent advocates or Ambassadors and gender. One grant recipient spoke about their team's struggle to find people who are willing and able to commit to a long-term role as a role model or advocate.

> Yes, we have used role models in the past and that certainly was a success, and that was through a bus back campaign where they had their images on [local] Metro buses and also on video clips, but we've also had local people do voice overs for our radio campaign, especially through – in the lead up to World No Tobacco Day event, so they've certainly had role models across all dimensions. But in terms of actually securing someone on a permanent basis, no, we haven't unfortunately had, that, but it's still on our box of tasks that we certainly want to still have someone identified as being an ongoing Ambassador. (Grant recipient, interview/focus group, urban)

Other grant recipients spoke of challenges they have experienced connecting to and identifying people in the community who will be influential, and their struggles to some extent are gendered.

> And unfortunately for me a lot of the community Elders that have a voice are male, so it's culturally inappropriate for me to engage with them, unless I'm asked to speak, I guess. (Grant recipient, interview/focus group, remote)
>
> But most of our Elder men are smokers. Several of them are trying to quit their smoking habit so, it's been a little bit of a conflict in having the – but the ones who have quit we have used, in that poster production and they've often been good to use in all communities. (Grant recipient, interview/focus group, remote)

As these examples illustrate, the challenge is that in these communities Elder men have the sway and influence but the TIS teams struggle to connect with them due to cultural protocols and gendered dimensions of smoking behaviour.

From the perspective of community members, we have insight that stepping up into an advocacy role or as a role model can be personally challenging for them. People sometimes feel hypocritical if they are ex-smokers and they may feel they do not know enough to effectively talk to people about smoking or quitting. Indeed, some focus group participants discussed they were reluctant to offer quit smoking advice if they are ex-smokers or if they feel it can cause conflict with the other person:

> Not really because you can be seen as a hypocrite because you used to smoke as, when I have tried in the past with family like you know, say things like you should give up

> smoking if you can't afford it or what do you smoke for when you got sickness or whatever but people through it back at you, you know, what are you talking about, you smoked for how long…. (Community member, interview/focus group, urban)

Recommendation:

- TIS teams should continue to try to normalise leadership in tobacco control and try to fight the stereotypes that ex-smokers do not have the right to be role models.

Barriers and enablers to increasing community involvement in and support for tobacco control activities

A key enabler to increasing community involvement and support is actively seeking out community input and creating space for that involvement. Many grant recipients spoke to community engagement as a key attribute of their program and the flow-on effects it seems to have for them. TIS teams used different mechanisms for engaging the community, such as focus groups, formal committees, project-based community input groups, and surveys.

> I think it's very important still to have that community engagement, especially when you want to focus test a new publication or any sort of resource I guess, that everyone's sort of involved, or who should play a part in providing advice and support as well to us. (Grant recipient, interview/focus group, urban)
>
> We actually have a separate group within [our ACCHO] that is actually made up of community leaders and Elders. One of our Board members…heads that up. He [is] very well-known... So he has got great reach into community, and oftentimes as part of those meetings we will talk about different programs, of which TIS is one. In those meetings there might be some idea or observation around how to approach non-smoking. It might not be articulated in, "Oh, we've got an idea for Tackling Indigenous Smoking program," because our community leaders and Elders don't tend to speak like that. What they're talking about are the grassroots requirements of their community, and therefore we as [a TIS team] see the opportunity for TIS. So they might talk about a particular problem within a particular section of community in a particular area, and we might go, oh, we should really visit X, Y, Z school and provide them with some TIS resources and maybe give a little chat, or get [an individual] to go in and talk about mental health, social and emotional wellbeing and whilst we're there also look at smoking. So they're more like the voice of community coming back and the observations because of their role in that community. (Grant recipient, interview/focus group, regional)

Another enabler that grant recipients said was important for helping them increase community support and involvement included engaging the right local leaders as Ambassadors – those who are well respected and can help bring more people into the TIS fold.

> It is challenging to, I guess, beat the cultural norms of smoking within the [local] region, given that it's such a part of their history and part of song lines and dance and…So, that's something that we've identified that the Ambassador program is where we need to start and that includes having people on [our] health board being Ambassadors as well. (Grant recipient, interview/focus group, remote)
>
> A: We just work with the Elders that come along and with Public Health. They support us and encourage…and how we're supposed to do it and they come up with ideas and support us and encourage. That's how we get more participants…involved with the activities that we do.
> *Q: They encourage their families to come along?*
> A: Yeah… For the last month we have been doing a wellness program. We had Elders coming in. We've got Elders…used to do stuff and showing…towards the future. We have heaps of participant schools and some kids, early school leavers, who even are involved with activities as well.
> *Q: …How have the Elders help to take on that advocacy role?*
> A: I think the Elders are the most successful client that we have.
> A: It's good to have them working aside with us.
> *Q: Because everyone listens to the Elders, eh?*
> A: Yeah.
> *Q: So if they're there taking the lead...*
> A: Sometimes it's a bit hard to engage with the community itself. In the community alcohol and other drugs are the main issue that causes stuff like violence and all that in the community. It's better to work with the Elders because they're the ones who some of the people look up to as well.
> A: I think sometimes the Elders can work across all the organisations. Whereas sometimes you're working with the organisation and they only do this, and they just do that, and they just do that. Whereas Elders just can work with everybody. (Grant recipient, interview/focus group, remote)

Finally, grant recipients spoke to negative community sentiments and perceptions of TIS staff being a real barrier to getting community support and involvement. In particular, sentiments from community members that they do not want to be told what to do and that they do not respect the message because they do not have a positive view of the messenger.

> My main challenge has been abuse from different people, like them saying, "It's got nothing to do with you what my alcohol level is or how many cigarettes I smoke. It's got nothing to do with you. Why do you keep coming here?" So that has been a challenge. It's not only me… That is our biggest challenge. If we go to them and talk to them while they're smoking and drinking they go, "Don't talk to us about drinking. You smoke, you drink." But it's part of our job… Sometimes they can just sit there and avoid us. (Grant recipient, interview/focus group, remote)
>
> I mean that in the sense that if [the TIS workers are] not practising what they're preaching out in the community… that undoes all the good work that you're trying to achieve. Because [community members] be like, "Well, you smoke. Why would we listen to you? You're going to be drunk on the weekend," type stuff. So it's that vicious cycle. But if you have Aboriginal people who are traumatised and we've all got some kind of trauma. Trauma doesn't discriminate either. But as Aboriginal people trying to help Aboriginal people, we have to unpack our stuff, otherwise we're just reacting to trauma and we're passing that trauma back and forth to each other…back and forth. So it carries trauma. So for me, the health workers need to be health workers and they need to be practising what they're preaching. (Community member, regional)

Barriers and enablers to increasing the community's understanding of the health impacts of smoking

In relation to increasing the community's understanding of the health impacts of smoking, novel education sessions were identified as helping RTCG recipients achieve this outcome.

> And particularly for people that have lived a life, people that have smoked and given up, and smoked and given up many times, they've heard it all before. So unless you can link some new information and some new awareness around the dangers of the smoking. And now I think the most important thing and the best thing about TIS bringing the second and third-hand smoking to the picture. (Grant recipient, interview/focus group, urban)

3.2.2.10 Were RTCG recipients given sufficient assistance and time to understand and make any changes required as a result of the key areas of focus of the forward TIS program?

There was no feedback in the Performance Reports, online survey, interviews, or focus groups that spoke to this as an issue, so it would appear that grant recipients did feel they had enough time to adjust to the new focus of TIS in this grant period.

3.2.3 Access to Quit support

3.2.3.1 To what extent and how have RTCG recipients continued to form effective collaborations and partnerships to improve access to culturally appropriate quit support and have new partnerships been built?

Summary of our findings:

There is some evidence that RTCG recipients are continuing to form effective partnerships and collaborations to improve access to culturally appropriate quit support. They are partnering with Quitskills to some degree and are partnering with other external organisations and internal stakeholders (e.g. with GPs, chemists and other health workers) to help them provide culturally appropriate quit support. There have been new partnerships built and the development of partnerships appears to be ongoing.

Evidence to support our findings:

A critical aspect of the TIS Program is to encourage people who smoke to quit and to direct them to quit supports. Quit supports include the Quitline, use of nicotine replacement therapies and local quit support groups and counselling. TIS teams are encouraged to form partnerships and collaborations to provide community members with access to culturally appropriate quit support.

In 2020, RTCG perceptions about the achievement of this outcome were very strong. Among the 33 online survey respondents in 2020, 61% strongly agreed and 33% slightly agreed with the statement that "Over the last six months, we have built strong collaborations and partnerships with internal and external stakeholders to increase community members access to quit support" (i.e. a total of 94% of RTCGs). In 2021, RTCG perceptions about achievement had tempered a bit. Among the 41 respondents to the 2021 survey, 51% strongly agreed and 34% slightly agreed with the statement (total of 85% of respondents).

Most RTCG recipients indicate that they have formed strong collaborations and partnerships with diverse external organisations and internal stakeholders for quit support. External partnerships include attending large community events and hosting stalls with promotional material, establishing partnerships with Aboriginal Medical Services, community clinics, GPs, chemists, maternal health workers, TAFE, sports, and youth programs. Internal collaborations included those with other program staff that enable connections with individuals from Elder's groups, men's groups, and Mums and Bubs groups, where TIS teams work with any established Quit Smoking Programs to reinforce quit messages with participants:

> The TIS team are developing a smoking cessation information pack to be given to the Indigenous mothers/families at the antenatal clinics. The TIS team is currently working with the Mums and Bubs midwife to develop culturally appropriate resources. The

outcome for this activity is provide Indigenous mothers, families and mothers of Indigenous children the information to make the informed decision for babies to have the best start in life.

The TIS team is currently sourcing culturally appropriate brief intervention training for health professions in the antenatal field (Grant recipient, Performance Report, urban)

Analysis of online survey responses indicates that RTCG recipients made the greatest resource investments in the prior six months towards implementation and partnerships. They went on to report they felt they had made the most progress in the prior six months toward outcomes related to increased reach into communities (followed by implementation, partnerships, and focus on priority groups). Looking to the next 12 months, they plan to make the greatest resource investments into increasing reach into communities (followed by implementation and focus on priority groups).

Recommendations:

- TIS teams and implementation stakeholders should continue to form and maintain their partnerships and collaborations to improve access to culturally appropriate quit support.

3.2.3.2 To what extent and how has Quitline been promoted throughout the TIS Program and what evidence exists from the evaluation about the extent to which there are increased referrals and uptake of the service by Aboriginal and Torres Strait Islander peoples?

Summary of our findings:

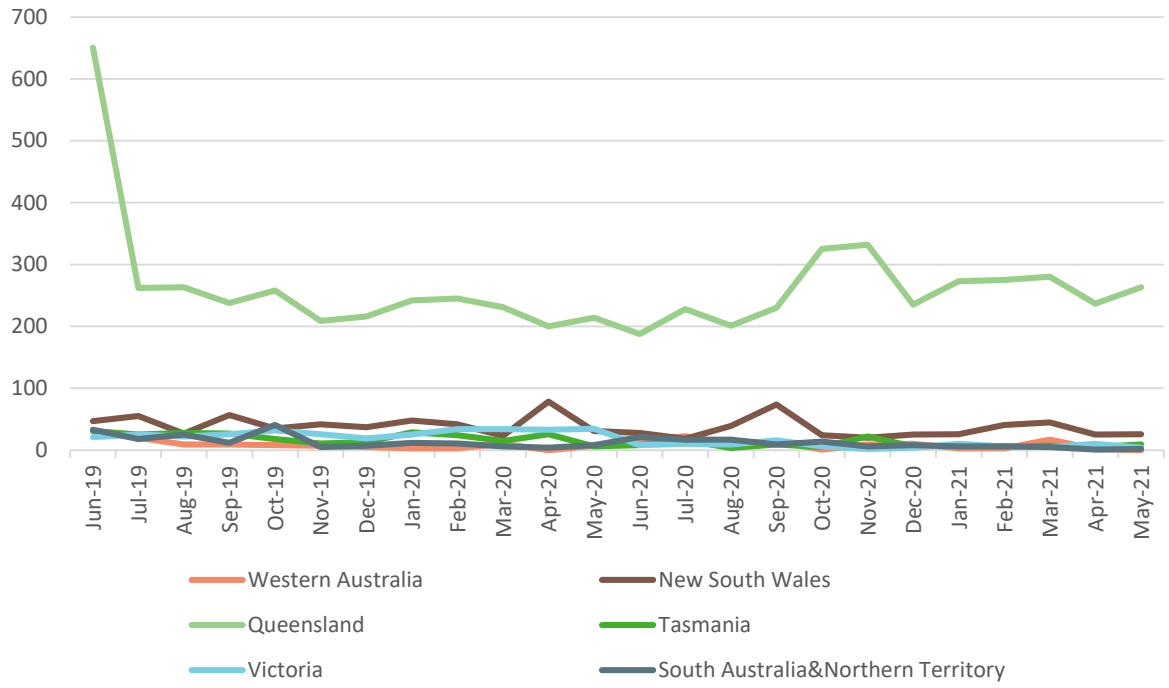
Referrals to Quitline around the country from the TIS Program are relatively low and have shown an overall decline over the two-year period from June 2019 to May 2021. This decline may be due to the impact of COVID-19 and restrictions on community engagement. All jurisdictions saw a decline in referrals during that period, except for Western Australia which had an increase, although started from a low base. Of most note is that Queensland referrals to Quitline in both years far exceeded those for every other state and territory. The high figures for Queensland are predominantly attributable to the work of a single RTCG recipient organisation, which takes a very positive approach to Quitline referrals. There may be scope for all other RTCG recipients to emulate this service by better promoting Quitline and increasing referrals to it, or there could be factors enabling this outcome in Queensland that are not present or replicable across all TIS teams.

Evidence to support our findings:

Quitline data records referrals from TIS teams, as well as referrals from other services and self-referrals (which may or may not result from encouragement by TIS staff). Therefore, this data is not representative of only TIS team referrals.

Quitline data indicate an overall decline in the number of referrals between the two time periods of June 2019 to May 2020 (4600 referrals) and June 2020 to May 2021 (3872 referrals) (see Figure 14). Over this period, Western Australia was the only jurisdiction to see an increase in total referrals (of 24%), although this is coming off a low base. Every other jurisdiction saw a decline, the most substantial being in Victoria, followed by Tasmania, South Australia, and Northern Territory (combined), New South Wales, and Queensland.

Figure 14: Monthly Quitline referrals by state and territory, June 2019 - May 2021



What is clearly apparent from these figures is the great discrepancy between Queensland and other jurisdictions. Queensland referrals over both 12-month periods far exceeded those of the rest of the country combined (see Figure 15).

Figure 15: Total Quitline referral data by state and territory, two-year comparison

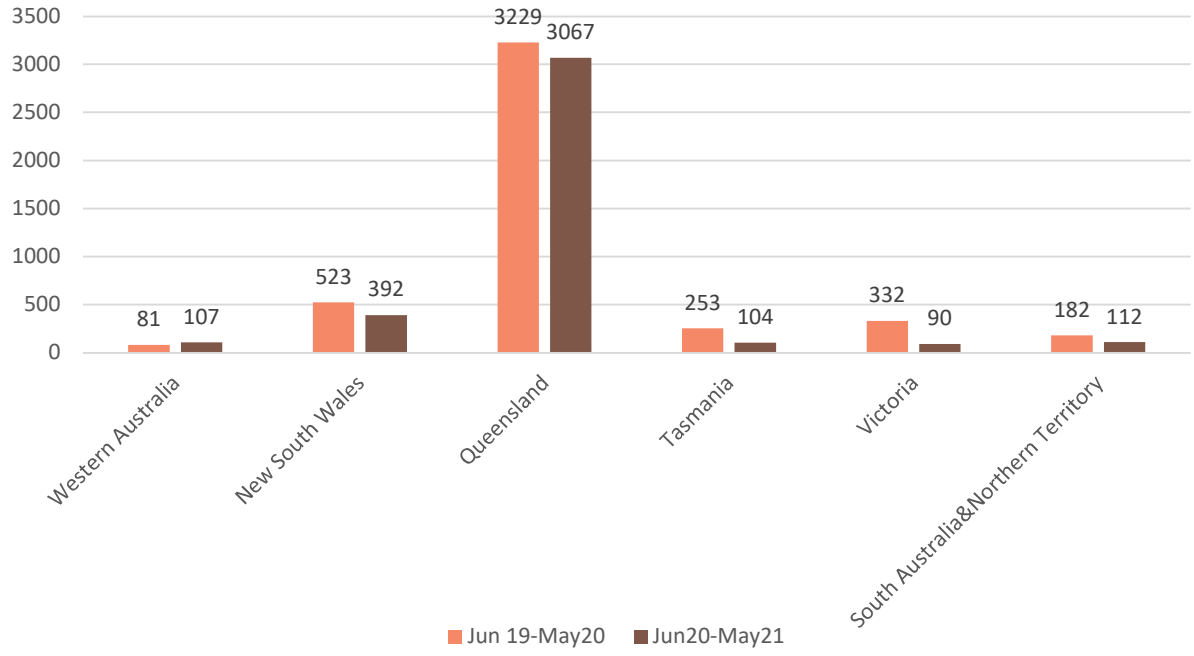


Figure 15 shows that after Queensland, the strongest referral numbers are for New South Wales, but a distant second.

When interviewed, one Queensland Quitline staff member attributed the discrepancy to the availability of free nicotine replacement therapy in Queensland. However, these therapies are available for low or no cost for Aboriginal and Torres Strait Islander individuals nationwide. The national Closing The Gap prescription measure (CTG) allows many Aboriginal and Torres Strait Islander individuals to access PBS medicines at a co-payment cost, that is further reduced from the standard Australian PBS-subsidised co-payment rates. This means that concession card holders with a CTG script can receive some nicotine replacement therapies at no cost. The s100 Remote Area Aboriginal Health Service measure also allows Aboriginal and Torres Strait Islander individuals in remote communities to access most PBS medicines at no cost.[18]

A deeper examination of the state Quitline referral data reveals the Queensland state average is being elevated by a single health organisation making an exceptionally high number of referrals in comparison with its counterparts. This organisation takes a positive approach to Quitline referrals, has a well-integrated service model in partnership with the Queensland Government, and is well connected with the AMSs in that state.

[18] See NACCHO 2020, Submission: Post-market review of medicines for smoking cessation, Australian Government Department of Health. p.4. Viewed 28/01/2022 <https://www.pbs.gov.au/reviews/post-market-smoking-cessation-files/folder_2/Submission-4.PDF>

Taking a cue from this Queensland service then, there may be scope for other TIS teams to better promote and refer more community members to Quitline. We do acknowledge that some TIS teams and community members have expressed barriers to using Quitline, especially in more remote regions, which are discussed in section *3.2.3.4 To what extent do Aboriginal and Torres Strait Islander peoples have improved access to culturally appropriate quit support?* Nonetheless, Quitline is a service available to all Australians and should be promoted as an option for those looking for support on their quit journey.

Recommendations

- The Department of Health and NBPU should continue to strongly encourage TIS teams to promote Quitline and to refer community members to Quitline.

3.2.3.3 How well are referrals made to supports such as Quitline, social media tools and local community support groups?

Summary of our findings:

RTCG Performance Report data indicate that TIS teams are making referrals to a range of quit supports. The number of RTCG referrals to the Quitline and other quit support services vary, depending on the service and the state or territory. RTCG referrals to Quitline can take two forms – either as a written referral from the TIS team on behalf of an individual to Quitline or an informal referral to an individual that they call Quitline. Written referrals by TIS teams are generally received by Quitline, although there are some discrepancies between TIS team and Quitline data on number of referrals. Aside from a high number of referrals to Quitline from one Queensland RTCG recipient, overall referrals received by Quitline for Aboriginal and Torres Strait Islander peoples suggest they are likely to come from sources other than the TIS teams and informal referrals. RTCG Performance Report data similarly indicate that TIS teams make more referrals to local quit support services than to Quitline. It is worth noting that social media-based quit supports appear to be getting good traction among Aboriginal and Torres Strait Islander peoples.

Evidence to support our findings:

RTCG Performance Report data for July to December 2019, show that 22 grant recipients made 425 written referrals to Quitline (see Table 15). The same period in 2020 saw far fewer, only 167 written referrals from 17 grant recipients. This is likely to reflect COVID-19 restrictions on staff travel and movements in communities but may also reflect changing TIS staff practices. It is important to note that the referral data is skewed by high numbers from a few RTCG recipients. In 2019, two organisations accounted for close to 60% of written referrals and in 2020, again two organisations accounted for over 50% of written referrals (with one organisation providing the majority of referrals in both years). In both 2019 and 2020, ten RTCG recipients reported no

written referrals at all to Quitline and in 2020 there were a further five RTCGs with missing data.

Notably, RTCG referrals to other quit support services were far more common than referrals to Quitline (see Table 15). From July to December in 2019, 26 grant recipients made 1,780 referrals to other quit support services and, in the same period for 2020, 18 grant recipients reported making 692 referrals. Five grant recipients reported no referrals to other quit support, and two reported making no referrals at all to either Quitline or other quit support services.

Table 15: Referrals to Quitline and other quit support

	Number of RTCG recipients who made referrals to Quitline	Number of referrals to Quitline	Number of RTCG recipients who made referrals to other quit services	Number of referrals to other quit services
Jul-Dec 2019	22	425	26	1,780
Jul-Dec 2020	17	167	18	692

In addition to written referrals to Quitline and other quit support, TIS teams can simply recommend to people that they call Quitline or other support services directly and if a person does call the quit support service, this would be called a "self-referral". Self-referrals can be encouraged by TIS teams but also by anyone else or can occur if people who smoke see Quitline marketing and are inspired to call. It is not clear how often self-referrals were recommended by RTCG recipients, but Quitline services generally keep track of the total number of self-referrals.

To explore how well referrals are made, we can compare the number of written referrals to Quitline that TIS teams made, by state and territory, to the number of referrals received by Quitline services in that state or territory from ACCHOs or TIS teams. This is a crude metric, however, because not all Quitline services reported how many referrals came from TIS teams and there are often more ACCHOs in a state or territory than TIS teams based in an ACCHO. Between May 2019 and May 2020, Quitline NSW reported receiving 122 referrals from ACCHOs. TIS teams (which are mostly ACCHOs) reported making 91 referrals to Quitline between July and December 2019. This suggests a good relationship between TIS team making referrals and Quitline receiving them, as it appears that all 91 referrals were received, although there is an unknown margin of error around this figure.

Between June 2019 and June 2020, Quitline WA reported receiving 59 referrals from TIS teams, and five TIS teams in Western Australia reported making 65 total referrals to Quitline between July and December 2019. As the TIS team reporting period for referrals is shorter than that from Quitline WA and the number of referrals they made in the shorter period is more than the number Quitline reported receiving, there is an interesting discrepancy here. There appear to be

a significant number of TIS team referrals to Quitline WA that are not being picked up in the Quitline WA metrics. This discrepancy could be due to referrals falling through the cracks in the referral system, calculation errors by either sets of organisations, or due to differences in definition of "referral" between TIS teams and Quitline services (where a referral for Quitline services may mean a case – which is when Quitline is able to successfully contact a person who was referred, but a referral to TIS teams means a written referral passed on to the Quitline service that may not successfully convert to a 'case').

Between July 2019 and June 2020 (12 months), Quitline Vic reported receiving 24 referrals from TIS teams in Victoria. Between July 2019 and December 2019 (six months), the four Victorian TIS teams reported making 24 referrals to Quitline. Although these numbers match up, as the reporting period for the TIS teams is half that of Quitline, we would expect a higher number of referrals received by Quitline than the 24 for the year. We cannot be certain, of course, that there would have been more referrals made by Victorian TIS teams between January and June 2020, particularly given the bushfires over January and February 2020 and the impact of COVID-19 from March 2020 to the end of that year. These data suggest a good relationship between the TIS team making referrals and Quitline receiving them, but the strength may be overestimated in our figures.

One RTCG recipient noted issues between their own organisation and Quitline around referrals, which may explain the type of discrepancies described above:

> The team faced delays in receiving Quitline data from the Department of Health due to time constraints. The Department of Health require four weeks to provide the data. Further, the data is always under-represented, means the number of referrals is less than what [our TIS team] emailed to Quitline. The team rarely received client feedback/progress from the Quitline counsellors. We hope that this will be resolved in near future (Grant recipient, Performance Report, regional)

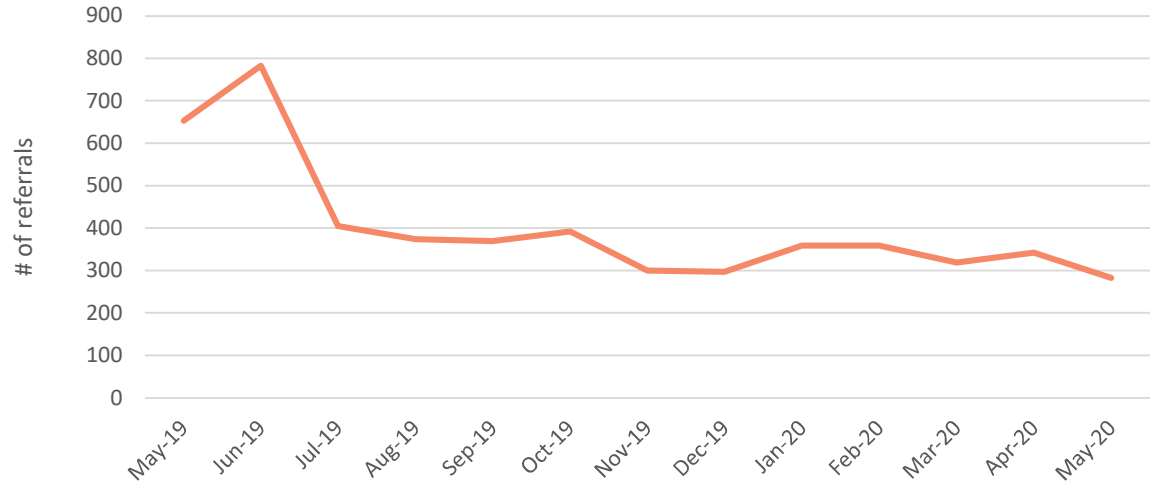
Some grant recipients spoke of confusion surrounding what defines a referral to Quitline when completing their Performance Report. They noted that they are unsure whether to count individuals who say, "*Yes, I'll call the Quitline*", or only individuals who are directly referred via written referral. The Performance Report does request the number of people who have been given a written referral to Quitline, but there may be ambiguity about this among grant recipient staff who complete the reports.

Another cause of discrepancy between Quitline and RTCG referral figures may stem from the referral process itself. The referral process involves the TIS team meeting someone who is interested in talking to Quitline, filling out a form with their contact details and passing that on to the Quitline team (via fax, email or online form). The Quitline team then attempts to call that individual to provide them coaching support to quit, perhaps on multiple calls – although there

is no guarantee that the individual will answer the call from the Quitline team member. Through this process, there is room to lose the interest of people who wanted to quit, as well as room for data errors.

Another way to gauge how well referrals were made to Quitline is to examine the total number of Aboriginal and Torres Strait Islander peoples referred to Quitline services, regardless of the referral source. This allows capture of the self-referrals that may have been encouraged by TIS teams, as well as many other referral sources. Figure 16 shows that between May 2019 and May 2020, there were 283 to 783 referrals made each month to Quitline services across seven states and territories (ACT data are not reported). The figure also shows significant spikes in May and June of 2019. Following these spikes, the number of referrals received by Quitline declined slightly from July 2019, the monthly number of referrals was down to around 400 and by May 2020 it fell further to below 300.

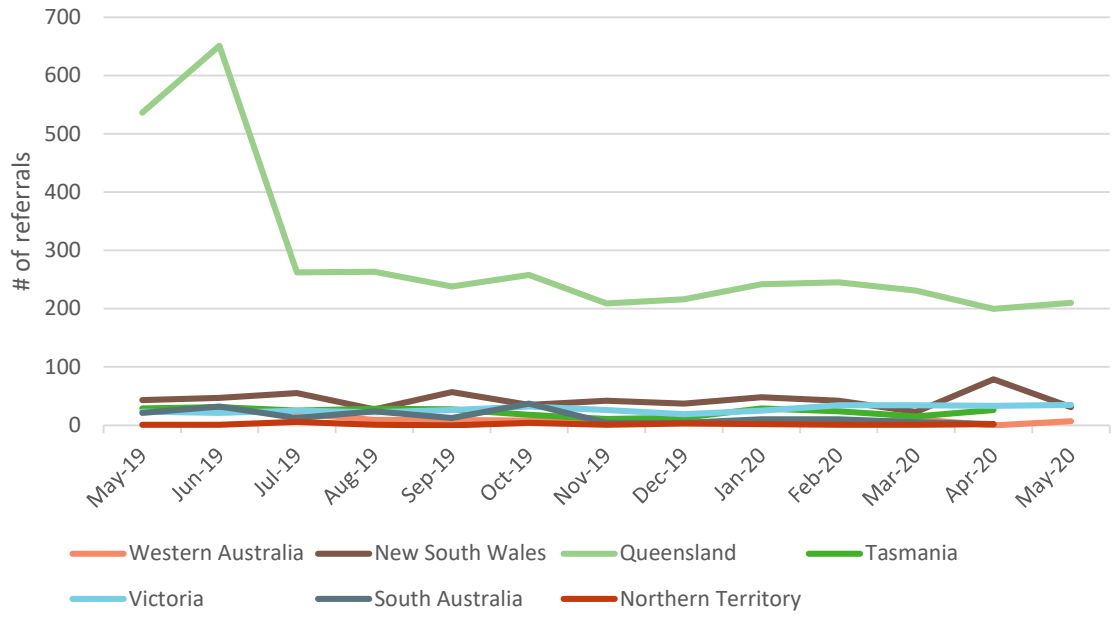
Figure 16: Total National Monthly Quitline referrals for Aboriginal and Torres Strait Islander peoples - May 2019 to May 2020 (excludes ACT)



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Series1	653	783	405	374	369	392	300	297	359	359	319	342	283

Disaggregating by state and territory in Figure 17, we can see how referrals vary by jurisdiction. The spikes observed in the overall data are the result of spikes that occurred in Queensland - unfortunately, we do not have information about why these spikes occurred. As previously indicated, Queensland clearly dominates the data in the number of referrals received.

Figure 17: Month to month Quitline referrals for Aboriginal and Torres Strait Islander peoples - May 2019 to May 2020, by state and territory (excludes ACT)



In Figure 18, to get a better picture on Quitline referrals by state and territory month-on-month, we truncated the period to July 2019 to May 2020, cutting out the Queensland spike in May and June 2019. This truncation gives us better visibility on the month-to-month data for the states and territories that have lower referral numbers.

Figure 18: Month to month Quitline referrals for Aboriginal and Torres Strait Islander peoples - July 2019 to May 2020, by state and territory (excludes ACT)

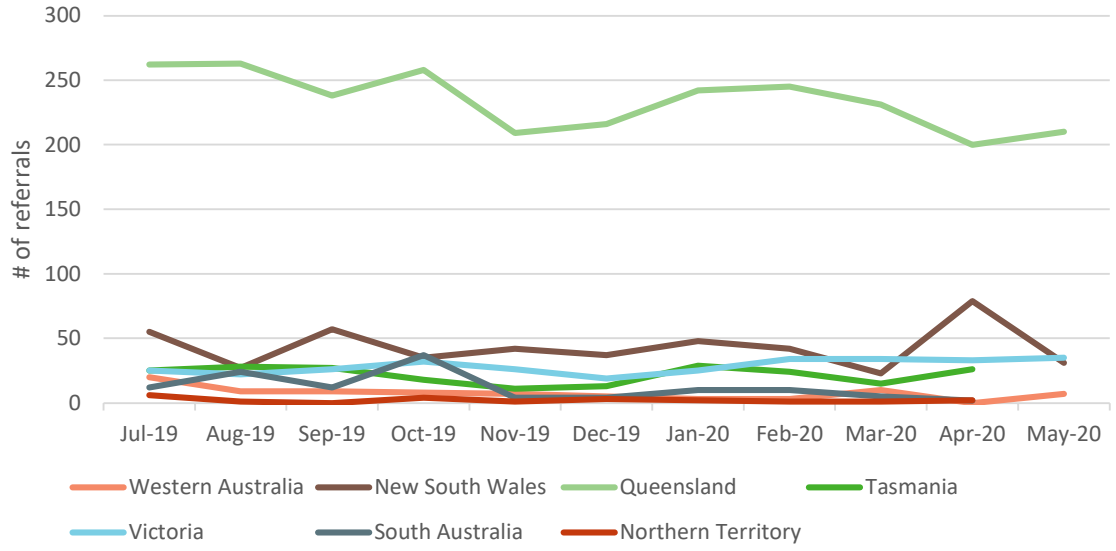


Figure 18 shows that while Queensland, Western Australia, and South Australia experienced declines in the number of referrals between July 2019 and April/May 2020, New South Wales, Northern Territory, and Tasmania did not experience a decline and were, in fact, steady through the period. These data suggest that month to month, referrals went well in New South Wales, Northern Territory, and Tasmania but declined a little in Queensland, Western Australia, and South Australia.

Quitline staff and RTCG recipients report noticing that a spike in referrals of Aboriginal and Torres Strait Islander peoples to Quitline is sometimes seen following a community event, such as NAIDOC events and World No Tobacco Day, as opposed to consistent referrals from general TIS program activities (it is unclear if this applies to the Queensland spikes). These events would be an opportune time for TIS teams to make a push for referrals to Quitline.

With respect to how well referrals are made to quit support via online tools, Quitline stakeholders reported that Quitline's Quit Stories have been strongly received by the Aboriginal community – even during COVID-19 – and have provided an online connection through podcasts for the Aboriginal community, featuring stories, yarns, and narratives from various individuals. Furthermore, Quitline reported that social media and television advertisements have increased the Aboriginal statistics for Quitline, especially requests for Quit packs.

Recommendations:

- Going forward, future evaluations should request that Quitline services provide their data broken down by TIS team referral source, and in any cases where Quitline services do not track this, they should be encouraged to monitor these referral sources
- TIS teams should review their process of making and tracking referrals (including in their Performance Reports) to ensure that data are not lost along the pathway.

3.2.3.4 To what extent do Aboriginal and Torres Strait Islander peoples have improved access to culturally appropriate quit support?

Summary of our findings:

Through a combination of RTCG recipients, local quit support services, and Quitline services, Aboriginal and Torres Strait Islander peoples appear to have improved access to culturally appropriate quit support, but there are areas for improvement. Quitline services are largely doing all the right things internally to ensure that staff and phone counsellors are culturally appropriate in the types of conversations they have with callers and that the teams are staffed appropriately. But what appears to be missing is the culturally appropriate delivery of the Quitline service. The Quitline service relies on phones, there are limited numbers of phone counsellors who speak Aboriginal languages, and there is a physical, social and temporal distance between Quitline phone counsellors and local community members. Despite these

challenges, successful Quitline services are able to get out into community more, allowing community members to connect their faces and voices with the services. Moreover, they adjust the branding of their service to make it clear that they are there for Aboriginal and Torres Strait Islander audiences. This approach could be emulated more widely by other state Quitline services.

Evidence to support our findings:

One measure of access to culturally appropriate quit support is the number of Aboriginal and Torres Strait Islander peoples in the TIS Program who community members can turn to. For the 31 RTCG recipients who provided Performance Report data in 2019, between 60% and 100% of the then filled TIS funded positions were held by Aboriginal and Torres Strait Islander peoples. For the 32 RTCG recipients who provided Performance Reports in 2020, the variance had widened to 0% to 100% of positions being filled by Aboriginal and Torres Strait Islander peoples. However, digging deeper into the data, we find that of those 32 RTCGs in 2020, 27 had 50% or more of their TIS funded positions filled by Aboriginal and Torres Strait Islander peoples; and on average, across all the RTCGs in 2020 76% of TIS funded positions were filled by Aboriginal and Torres Strait Islander peoples.

The online surveys in 2020 and 2021 show a slight evolution in staff perceptions that TIS activities have improved people's access to culturally appropriate quit support. Among the respondents in 2021, 49% strongly agreed that "in the last six months, TIS activities have improved community members' access to culturally appropriate support to quit" (down slightly from 52% in 2020), and 32% slightly agreed (a greater decline from 40% in 2020). In 2021, 12% of respondents reported neither agreeing nor disagreeing with the statement, 2% (one person) reported strongly disagreeing with the statement, and 5% reported they did not know.

Despite this downward shift in staff perceptions over time, the data still suggest that Aboriginal and Torres Strait Islander peoples generally do have access to culturally appropriate quit support through the TIS Program. Some remote TIS teams are providing quit support to community members because alternative culturally appropriate support is not accessible and community members ask them for it. That quit support might take the form of direct counselling or it may take the form of accompanying the person on their Quitline call. In these ways, as well as by referring people to other local quit support services, RTCG recipients are contributing to the accessibility of culturally appropriate quit services:

> Quitline is quite difficult here. We tried to promote Quitline but because they're all from somewhere else, and it's not in language, people don't [use it]… and also we try very hard, even people that have really good English, we go out and get them and when we give them the number they're given permission, but when Quitline rings them, they don't answer it, because they don't know that number. And then we tried doing it then and there, and we've rung the Quitline and they've made me stay with them. So, all the

> time they were talking. Because they said, "[TIS staff member's name], we just want to speak to you. We don't know those people. And they're just saying the same messages as you." So we found Quitline really problematic. We certainly use it for Quitskills training, so they've come up with the Quitskills training and we've talked to them about if they want us to use it more, we suggested they had somebody who can speak language, that there's enough [language speakers in the metro area] now, that they could actually train up somebody who speaks language…And we've also tried, we talked to them about coming up here and starting some yarning circles and so that we can get some training in doing it. (Grant recipient, interview/focus group, remote)

Within the Quitline services themselves, all of them are working to improve access to culturally appropriate quit support by having male and female Aboriginal and Torres Strait Islander phone counsellors at each of the services who can speak to community members, if they request it. In addition, most Quitline services implement cultural competency training for all Quitline staff. These features build the internal capacity of Quitline services around providing a culturally safe service. For Aboriginal and Torres Strait Islander peoples to access the service, however, they need to be willing and able to speak over the phone to a Quitline phone counsellor. This can present a barrier, particularly for individuals from remote communities, due to complexities around language and cultural differences, limited access to internet, phones or phone credit, and a lack of relationships with Quitline staff. These factors challenge the extent to which Quitline services can be viewed by community members as culturally appropriate:

> … there is huge barriers in accessing Quitline for the service users we work with for a couple of reasons: services users feeling shame, the impersonal nature of phone support, phone aren't consistently accessible for a lot of people here. (Grant recipient, Performance Report, remote)
>
> We can help them access Quit support through the clinic, but we've struggled with being able to develop a relationship with Quitline. I guess, we've suggested things like trying to get our staff at [the ACCHO] trained up in Quitline, so that they could be your Quitline support counsellors, but we haven't had a lot of feedback from Quitline, which is okay. So, that's been a bit of a challenge is just the link between helping people to quit. We are very good telling people why it's bad, but just supporting them to quit is the biggest thing about stepping into the individual based support counselling roles. (Grant recipient, interview/focus group, remote)

Some Quitline services do make it a priority to do community outreach to help people connect the service with a face and voice. This community engagement positively affects their use:

> So, the other thing is that we take the Aboriginal Quitline counsellor out to major events and do that on a regular basis and get him out to the organisation so the community are aware that he's there, and that is building a lot more on their comfortable – getting the community comfortable enough to actually ring Quitline. The evidence is basically when [Quitline staff member] goes out to those events that we have a higher stats after them. And he attends all the Quitline, I mean the Quit cafes, as well as myself going out and promoting the Quitline and the Quitline counsellor. So it's yeah, maintaining that relationship. (Quitline, key informant interview)

In addition to the features mentioned earlier, other successful Quitline services have internal processes in place to navigate engagement with Aboriginal communities and with individual Aboriginal callers appropriately and have culturally relevant promotional material:

> What the service we provide is about is giving people support to be able to purge the addiction, as the addictions to nicotine causes a person to lose their freedom of choice in that part of their life, as to whether or not they want to continue smoking if they really want to stop and is dictating their choices and decisions and behaviour. And when you add the traumatisation from colonisation on top of that as a layer yourself, quite a hard job. It is a terrible place to start in my view, to start that job out with scaring people as you introduce them to your service. So, what we've changed is embedding that concept of words we use such as empowerment, empower people, to inform people, to say this is the knowledge we want you to have, this is the information we want you to have, without judgment, without expectation. And if you choose that you want to stop smoking and come and talk to us, acknowledging that people will probably be expecting to be freaked out by Quitline. They will be expecting to be told what to do by a mainstream service and they actually get cultural autonomy and personal autonomy and freedom of choice. (Quitline, key informant interview)
>
> We also have a number of working instructions that relate to engagement with Aboriginal and Torres Strait Islander clients and the utilisation of the Aboriginal and Torres Strait Islander team to support culturally appropriate support for clients. We have a community engagement procedure, which steps through the engagement steps and processes that we do, not just for Aboriginal and Torres Strait Islander communities, but for all engagement, but there's a component in that, that's specifically about having the most appropriate representatives at certain meetings or events and making sure that we are providing culturally appropriate representation by bringing Aboriginal and Torres Strait Islander staff and not representing ourselves in the absence of an identified person. (Quitline, key informant interview)

The work of these Quitline services to make themselves available, in culturally mindful ways, is important. However, it was not possible to assess the exact impact of these actions on the number of referrals received, particularly from remote Aboriginal and Torres Strait Islander community members. In the future, there may be more changes to the way that community members can access Quitline support, which will positively affect the numbers.

Recommendations:

- TIS teams should continue to refer community members to appropriate quit support services – be they Quitline or other local quit support.
- Quitline services should share amongst each other and explore new ways to become better connected to and better known within remote communities.
- In areas that lack sufficient and culturally appropriate local quit support and where trust in Quitline or access to phones continues to be limited, local TIS team staff should continue to play a mediating role with helping community members access quit support.

3.2.3.5 To what extent has there been an increase in TIS staff and relevant health professionals receiving Quitskills training and to what extent are they better equipped to provide culturally appropriate quit support as a result?

Summary of our findings:

All the TIS staff we spoke with had heard of Quitskills and most have already undertaken or have plans to undertake the training. Many other people outside TIS teams appear to have or are planning to undertake the training, sometimes promoted or organised by TIS staff. The principal logistical challenges to attending the training raised by TIS staff was the amount of time (three days) staff are required to be out of the office; limited availability of training to certain times and locations, worsened by COVID-19 restrictions; and the turnover of TIS staff which means a loss of expertise and requiring new staff to undertake the training. The 2021 Cancer Council South Australia review of the Quitskills training[19] identified the COVID-19 pandemic to be the greatest challenge to program delivery in the past two years. Training was able to be continued through online delivery or a hybrid of online and face-to-face. While both educators in the Quitline review report and some TIS staff in our consultations expressed their preference for face-to-face learning, other TIS staff spoke about the online option as facilitating accessibility, particularly for staff in remote regions.

Many TIS staff found Quitskills useful in giving staff the language and confidence to speak with community members about quitting, particularly for staff new to the program. However, a number of staff were critical that the training centres on one-on-one support to clients

[19] Cancer Council SA 2021, Quitskills. Future Program Recommendations, October 2021

conducted over a series of visits, rather than a population health approach as adopted by TIS. A few staff also suggested that the material was somewhat outdated. This suggests there is scope for reviewing and updating quit training for TIS staff.

Evidence to support our findings:

Quitskills training is available for free to TIS staff and other health professionals. All Quitskills educators are assigned a state or territory jurisdiction that they are responsible for in building relationships with TIS teams and other workers, and marketing the training. This appears to have been effective. All the TIS staff we spoke with had heard of Quitskills and most have already undertaken or have plans to undertake the training. Several TIS staff also reported that other people outside TIS teams had or were planning to undertake the training (e.g. health clinic, rehabilitation and mental health staff, GPs, chemists and community members).

Performance report data for six-month periods in 2019 and 2020 indicate that both grant recipients and non-TIS funded staff at TIS funded organisations are undertaking Quitskills training (see Table 16). Although these figures are modest, they suggest partnerships with Quitskills are being forged. Grant recipients also reported assisting or helping many other organisations to establish, maintain, or improve on their provision of support for smoking cessation. Several RTCG recipients indicated that their organisations coordinate groups of TIS and non-TIS staff for training, to make it more economical for Quitskills trainers to deliver training on site.

Comparing the training data for the two six-month periods in 2019 and 2020, it does appear that there is a decline in attendance by individual staff and TIS sites in 2020. This could be a consequence of staff having already undertaken the training, impact of COVID-19 on travel or staff priorities, or for other reasons.

Table 16: Undertaken Quitskills training

	Jul-Dec 2019	Jul-Dec 2020
TIS staff attended training	55	33
Number of TIS sites where TIS staff attended training	16	14
Non-TIS funded staff attended training	41	61
Number of TIS funded organisations where non TIS staff attended training	9	9

TIS staff feedback on the Quitskills training itself was more positive in the second wave of data collection than in the first wave, as reported in the mid-term report. This may be a function of who participated in data collection this time round or possibly changes to Quitskills training. Examples of positive comments received include:

> … very detailed and comprehensive training. (Grant recipient, interview/focus group, remote)
>
> Yeah. It's very informative. I think you walk away knowing how to speak to clients in the right manner. Make sure you're not saying anything triggering or inappropriate or just having more access to knowing the right ways in which to approach it, really. (Grant recipient, interview/focus group, urban)

A number of TIS staff spoke about the Quitskills training giving them confidence to approach community members about quitting:

> Yes. My two staff did it quite recently in [community] and they felt it's really good in helping them to more better, maybe, understand some counselling aspects around it. And yeah, and more confident building up plans around Quitskills for people, for individuals. (Grant recipient, interview/focus group, remote)
>
> I think increased confidence and knowledge has an impact in how people then communicate to other health professionals and for the community more widely. (Grant recipient, interview/focus group, regional)
>
> Now you get a lot of information on smoking; it gives you a lot more confidence to talk to people. (Grant recipient, interview/focus group, regional)

Despite this positive feedback, an issue creating confusion for some TIS staff is the focus of Quitskills training on provision of one-on-one support to people attempting to quit, conducted over a series of visits, when TIS staff are instead funded to deliver population health initiatives:

> I think the only downfall for us with the Quitskills training is that it's purely based off one-on-one and in reoccurring visits, which doesn't help us because everything's just opportunistic and done once-off in community. We don't organise appointments, follow-up visits and stuff like that with community members. (Grant recipient, interview/focus group, urban)
>
> It's very outdated … that's something that needs a big overhaul, I think. It's motivational interviewing, that sort of thing, but it doesn't - where teams aren't really when it's not one on one, it's not, we're population health based… (Grant recipient, interview/focus group, urban)

Aside from the content of the training, an issue raised by many TIS staff was to do with the amount of time (three days plus travel time) staff are required to be out of the office:

> Given that the Quitskills training does take three full days to do, we can't really take nurses and Aboriginal health workers or people like that out of their role for three days; that's quite hard. (Grant recipient, interview/focus group, regional)

Other challenges included the limited availability of training to certain times and locations, worsened by COVID-19 restrictions; and the turnover of TIS staff, requiring new staff to undertake the training. The 2021 Cancer Council South Australia review of the Quitskills training identified the COVID-19 pandemic to be the greatest challenge to program delivery in the past two years. Training was able to be continued through online delivery or a hybrid of online and face-to-face. Both educators in the Quitskills review report and some TIS staff in interviews expressed their preference for face-to-face learning. The review report found higher course completion rates with face-to-face learning and that educators report challenges in supporting students remotely. However, some TIS staff we interviewed spoke about the online option as facilitating access for staff, particularly those in remote regions.

Some TIS and Quitskills staff noted that with the high staff turnover in the TIS program, a continual stream of new staff need to be trained. A respondent from the Quitskills team did comment that, "*we hope that anybody that's undertaken the training can take learnings from that into whatever their next role might be. So ideally, we're getting broader reach…*".

A final point to be made is that during the jurisdictional workshops and some interviews, it became clear that a couple of grant recipients are not using the accredited and free Quitskills but instead using their funding to bring in other trainers around quit support. When this situation came to light, grant recipients indicated that they had not known that this was inappropriate use of funds – suggesting a lack of clear guidelines and information for TIS grant recipients about the types of activities that are either in or out of scope for TIS program funding.

Recommendations

- NBPU should consult with grant recipients to identify the ongoing training needs for TIS teams around provision of quit support to community members.
- Any quit support training should be offered with options around flexible delivery to maximise staff access, particularly for those in remote regions (e.g. in person or online, breaking down training into modules that can be taken at different times, option for recognition of prior training).

3.2.3.6 To what extent and how has the program increased community understanding of the health impacts of quitting and pathways to quitting?

Summary of our findings:

Qualitative data from focus groups with community members show they are generally aware of the health impacts of quitting, and that RTCG recipients have increased this understanding as well as pathways to quitting. Despite this, there continue to be pervasive myths that need dispelling. Recognising that Aboriginal and Torres Strait Islander communities still have higher smoking rates, including among young people and pregnant mothers, than other Australians, there is clearly still work to be done on this metric.

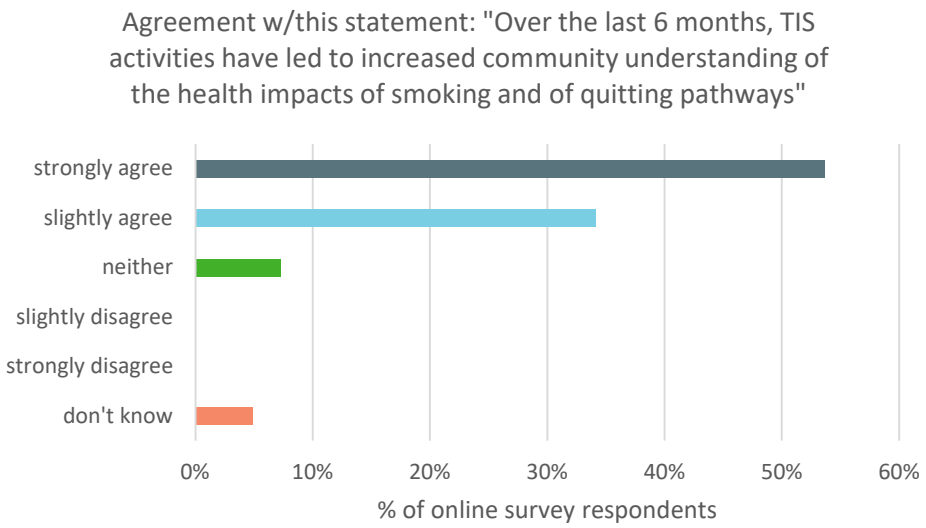
Evidence to support our findings:

In the July and December 2019 Performance Reports, 32 RTCG recipients reported implementing 257 community education activities. These mostly involved education around smoking cessation, passive smoking, smoking during pregnancy and the effects of and health risks associated with smoking. These activities reached people an estimated 47,444 times, suggesting that the program is likely to be influencing community understanding. This is supported by evidence from the responses of RTCG recipients to the open-ended questions in the Performance Reports, that activities are raising awareness of the impacts of smoking, including passive smoking:

> The team regularly conduct school education sessions outlining the impacts of smoking and how it effects the body. They have found an effective messaging to engage the children and youth is to discuss how smoking affects their ability to play sports. For example. Whilst on a trip to [local remote community], the team delivered a smoking physical activity to a group of 42 children, using breathing masks the team showed the children how hard it is to play sport when your breathing is restricted, which is an effect of smoking. Formal feedback with this group was not conducted due to their literacy level. However, informal feedback from the children showed that they enjoyed the session, and by the end had an understanding of how smoking can affect their body. For schools in [another local community], post evaluations have shown that at the end of the session, students can correctly identify where they or family members can go to access quit smoking support. 100% know that passive smoking increases the risk of lung cancer, respiratory disease and heart disease and 98.36% state that third hand smoke can harm them and their family (Grant recipient, Performance Report, remote)
>
> 82% said engaging with the TIS team increased their knowledge about the benefits of quitting smoking (Grant recipient, Performance Report, regional)

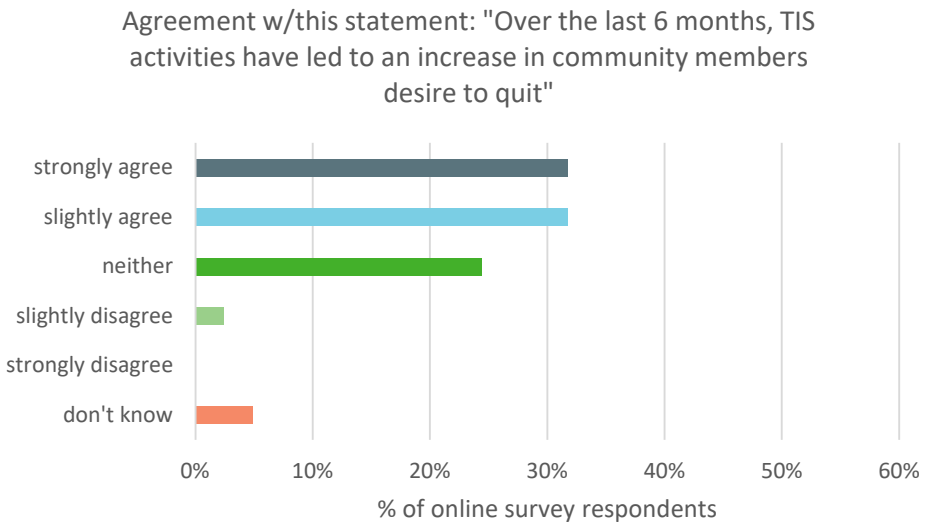
TIS staff respondents to the online surveys in 2021 and 2020 overwhelmingly agreed with the statement that “In the past six months, TIS activities have led to increased community understanding of the health impacts of smoking and of quitting pathways”. In 2021, of the 41 TIS staff, 54% strongly agreed and 34% slightly agreed with the statement (see Figure 19). The response was even higher in the previous year, as 62% TIS staff strongly agreed and 32% slightly agreed, and only two people neither disagreed nor agreed. We can conclude that TIS staff believe their work is improving the capacity of community to reduce smoking prevalence.

Figure 19: TIS activities increasing community understanding of health impacts and quitting pathways, 2021 RTCG survey



Of the 39 respondents to the 2021 staff survey who responded to the statement that, "Over the last 6 months, TIS activities have led to an increase in community members desire to quit", 32% strongly agreed and 32% slightly agreed, while only one respondent (2%) slightly disagreed (see Figure 20).

Figure 20: TIS activities leading to increase in community members desire to quit, 2021 RTCG survey



Some community members provide further evidence to this claim:

> Tackling Tobacco's helped me a lot. I go back home and then when I was a smoker, I'd think – then I'd think of [TIS spokesperson/advocate], he would say, do you know that's going to kill you? (Community member, urban)

And other community members suggest a more limited impact on community knowledge and attitudes:

> *Q: Yeah. Okay, so what about in terms of local campaigns, so have you seen anything on the TV or radio, posters, billboards, social media that have sent out messages about quitting smoking or dangers of smoking?*
> A: Yeah, heaps on TV, radio. They actually still show the sponge and when they rinse out the sponge all that grey gunk comes out of it. They still advertise that on TV; that grosses me out too and then you can see a person breathing in a cigarette and it going down the lungs…
> *Q: Yeah, yeah. So I guess you feel like that it does have like have a big impact, well it had a big impact on you, didn't it?*
> A: Yeah, seeing it.
> *Q: But would you say that, what's the general reaction from kind of like your family and community?*
> A: Roll their eyes. Some people say, "Oh gee, now I feel like a cigarette after watching an ad like that". (Community member, interview/focus group, urban)

Qualitative data from interviews and focus groups with community members highlighted a widespread understanding in the community that smoking is harmful to health and that quitting has health benefits. However, there are some pervasive myths that require dispelling. These include: that for older adults (e.g. older than 50 years) it was too late to quit; that you can get sick after quitting; that you will always put on weight after quitting; that smoking relieves stress from difficult or traumatic situations; and that quitting cigarettes will lead to the take up of other addictive substances. It was also clear from interviews and focus groups with RTCG recipients and community members that there is perhaps a lack of appreciation about the level of potential harm to unborn children if pregnant women smoke and around the dangers of second-hand smoke, especially around children and pregnant women.

Additionally, while most community members we spoke to were aware of nicotine replacement therapy options (e.g. Champix, patches, gum, spray) and some had tried these themselves successfully or unsuccessfully, not all were familiar with all the options, how they work or other quit supports available (such as support groups, counselling, etc). Thus, there are still areas that TIS teams need to address in community understanding about quitting and pathways.

Some of the comments from community members suggest that there is a need for TIS teams to provide nuanced messaging around quitting. For example, that if one form of nicotine replacement therapy does not work for you, that another might; or that it can take time and several attempts to quit successfully and that is okay:

> If you're saying that success is someone access the service and then quit and never went back, well, that's probably not a realistic view of what a service can do. Because it may take many times for people to access a service, and it could be a combination of services, so it could be that they access this one particular service, have some degree of success, have a relapse and find for the second attempt, it may be more beneficial for them to perhaps try their GP. So that doesn't mean the first service was unsuccessful, it means that it opened that road to allow that person to explore more supports, and perhaps find the support that's even more suitable for them. (Community member, regional)

Interestingly, the three most cited reasons given by community members for quitting were the cost of cigarettes, health concerns (particularly if they or someone they knew had developed a chronic or fatal health condition) and concerns for the health of children or grandchildren in the family – and not wanting them to take up smoking. TIS teams may find it useful to centre these factors in their community education about quitting.

Some community members emphasised the persuasive power of having the whole community involved in the design, development, and implementation of TIS initiatives, as well as by having a range of small and large engagements with community and relying on media:

> I think their smaller events that have a lot of community ownership are really the ones that I've seen a lot of impact from [in terms of referrals to the health service for quit support]. (Community member, regional)

Recommendations

- TIS teams and implementation stakeholders should continue their current approaches to promote quitting and quitting pathways.
- TIS teams may wish to consider narrowing their messaging to focus on dispelling myths about quitting, promoting quitting pathways and finding the right pathway for each person. TIS teams should draw on or refer community members to TISRIC, which dispels some of these myths.

3.2.4 Barriers and enablers for TIS services in remote areas

3.2.4.1 How does the implementation of the TIS Program differ between remote and non-remote settings (inclusive of all TIS sites)?

Looking across the whole of TIS, which includes RTCG and Remote Priority Group Grant (RPGG) recipients, implementation of the TIS Program does not appear to differ greatly between remote and non-remote settings. All teams want to and need to create localised resources. They all can struggle to reach certain priority groups. They all develop and implement social and traditional media campaigns. Both non-remote and remote teams have struggled with staff recruitment and COVID-19 restrictions, and benefited from partnerships and collaborations. Remote teams do experience additional challenges around logistics of reaching dispersed communities, and some challenges with dynamics of small and remote communities. To address these, remote teams emphasise the importance of partnerships and collaborations with other organisations and with community leaders and need to be flexible around changing circumstances in communities when planning events or travel. Remote teams noted the value of localising resources and supports (e.g. in local languages, spokespeople, artwork and messages) and using local media channels and avenues.

3.2.4.2 How do the challenges of implementation differ between remote and non-remote settings (inclusive of all TIS sites)?

Summary of findings:

RPGG and remote RTCG recipients, community partners and community members raised certain challenges associated with implementing the TIS Program in remote communities that differ to some degree from non-remote settings. Some of these challenges are more logistical in nature:

- difficulties in staff recruitment and retention, including in other organisations
- high costs in money and time for staff to attend training and jurisdictional workshops
- limited local data to inform the development of activities
- community closures and time and cost barriers to staff travel to individual or multiple communities
- difficulty accessing a variety of nicotine replacement therapies quickly
- telecommunications and internet connectivity challenges, limiting RPGG staff contact with communities, NBPU or Quitskills, and limiting community access to RPGG teams or Quitline.

Other challenges spoke to specific interpersonal or community dynamics in remote areas:

- lack of enforcement of smoke-free policies and zones in remote areas
- language and low literacy barriers to communications
- frequent movement of people
- overcrowding in housing impacting on community members trying to quit
- widely dispersed communities who do not access a single media type
- community perceptions about smoking lagging behind those in regional and urban areas.

Evidence to support findings:

RPGG and remote RTCG recipients, community partners and community members raised certain challenges associated with implementing the TIS Program in remote communities that differ to some degree from non-remote settings.

Some of these challenges are more logistical in nature:

- Difficulties in staff recruitment and retention, including in other organisations, which in turn impact on program delivery:

> Staffing is in remote communities a reality - issues with keeping the positions full. (Grant recipient, interview/focus group, remote)

- High costs in money and time for staff to attend training and jurisdictional workshops – for example, Quitskills training runs over three days and may involve two days travel in each direction for remote staff. This can impose a significant drain on small RPGG teams.

- Limited local data to inform the development of activities:

> A: So when we were trying to build our activity plan for the Commonwealth to fund, we had to source evidence and data of existing – and it was very difficult to source for just the [local area]. We could get it for [region], we could get it for [the state/territory] but we couldn't get anything on the [local area]. (Grant recipient, interview/focus group, remote)

- Community closures and time and cost barriers to staff travel to individual or multiple communities

> One of our biggest challenges is always travel over summertime, because of ceremony and men's business. So we've just had that happen, we lose a chunk of our year where it may not be appropriate for staff to travel, or be doing certain activities remote, which is something that wouldn't be happening everywhere. (Grant recipient, interview/focus group, remote)

- Difficulty accessing a variety of nicotine replacement therapies quickly, for instances where one type of therapy does not work for a person looking to quit:

> … because it takes six weeks to even get the nicotine replacement therapies out of [capital city] for someone who wants to quit. … for someone who wants to quit today, you can't wait that long. And the only way you can get anything out of the chemist on the script is to get a CTG script from the doctor. (Grant recipient, interview/focus group, remote)

- Telecommunications and internet connectivity challenges, limiting remote teams' staff contact with communities, NBPU or Quitskills, and limiting community access to remote TIS teams or Quitline:

> One of the things I am concerned about is, in many of our communities, particularly the remote communities, we have significant mobile phone black spots and very poor internet. And I know that the majority of – well, more than 50 per cent of Aboriginal houses in our region don't have access to the internet other than on mobile phones. So it's relying on just that type of messaging would be to our detriment, if that was what we did. So that's why we don't just rely on that form of communicating. (Grant recipient, interview/focus group, regional)

> … we might get a number off someone, and then that phone gets disconnected and we have to get a new SIM card. So until we run into them again, we have got to double-check their phone because they're using the prepaid stuff. And so it's cheaper just to buy a new SIM card because it comes with some credit, so that phone number is constantly changing. (Grant recipient, interview/focus group, remote)

Other challenges are more reflective of specific interpersonal or community dynamics that may be present in remote areas:

- Lack of willingness to enforce smoke-free policies and zones in remote areas, leading to RPGG staff being the 'sole enforcers' of policies and zones:

> I guess one of the only other things is the enforcement of smoke-free spaces and things like that can make things difficult. We can only do so much, but because they are remote areas, there's no one else there pushing that message with the strongest stance. Whereas I guess in more urban areas, you might have people who do stop people from smoking in the wrong spaces and things like that, so it's more supported. (Grant recipient, interview/focus group, remote)

- Language and low literacy in English of some community members as barriers to communications
- Frequent movement of people can make it difficult for TIS teams to provide ongoing education or support:

> So, quitting behaviour, when - one challenge in the remote communities is that the community - the clients don't stay in one place. They keep on moving. They go from one community to another. Sometimes if the community - if the client is sitting with you in one session, after two sessions they - so it's very hard to have that control where you can measure impact straightway where you can - where you can record behaviour change of just one particular client, especially when that one-on-one referral service is not happening anymore. (Grant recipient, interview/focus group, remote)

- Overcrowding in housing impacting on community members trying to quit:

> Like housing - issues with housing is a very big challenge. People are - if they want to change their habit, there is no way they can escape that. If they were smaller families or people had the opportunity to live in their own units and things like that, I think that would have helped us a lot. But housing remains - housing, remoteness of the area,

> mental health, these three things remain to be very big challenges for us. (Grant recipient, interview/focus group, remote)

- Widely dispersed communities who do not access a single media type create challenges for social marketing, social media and education activities:

> The challenge for us hasn't been necessarily that TIS approach, it's been the difficulties of our geographic area. So, we have small communities, widely dispersed that aren't covered by a single media type. So those, which impacts on our ability to do those broad scale marketing activities, really means that you have to go community by community. And we've got two workers, who basically are meant to be covering the best part of 200,000 square kilometres, which is not an easy task. (Grant recipient, interview/focus group, regional)

- Community perceptions about smoking lagging behind those in regional and urban areas:

> I think in city and regional areas, the general understanding of the risks of smoking and the legislation where you can and can't smoke is all a lot more obvious. I think in remote areas, that's not quite the same and the norm can still be – people say, "It's fabulous to live remotely, it's like we used to live in the '60s." And they're right. That applies to the smoking behaviour as well in some cases. (Grant recipient, interview/focus group, remote)

Given the uniqueness of these challenges for remote areas, it may assist remotely located TIS teams to have targeted forums for sharing solutions to these problems (e.g. specific part of the NBPU website, in person or online workshops, or NBPU online yarning circles). These discussions could be facilitated by the NBPU.

Recommendation:

- NBPU should continue providing remotely located TIS teams with targeted forums for sharing solutions to the particular and unique challenges posed in their regions.

3.2.4.3 How do the successes in implementation differ between remote and non-remote settings, and how do the factors that contribute to success differ (inclusive of all TIS sites)?

Data from interviews, focus groups, and Performance Reports were less clear about successes in implementation that differ between remote and non-remote settings. The following points are drawn from inferences in the data gathered for the evaluations of the national and remote

programs. The next round of evaluation data for the RPGG program should be able to shed further light on these points.

A possible success is the formation of partnerships and collaborations in remote settings where support for each other is how services, organisations, and individuals leverage their effort and impact. These include sharing travel costs, resource development costs, education sessions, and other activities. Such partnerships and collaborations may be more difficult to establish in urban centres where competition between organisations and services may be fiercer and time pressures may be greater.

Establishing direct relationships with communities and community leaders for consultation, support for activities and assistance in implementation may be easier in remote settings where social structures are less formal. Related to this point is the capacity for TIS teams to be present at and engage in community events, like football games, colour runs and community walks.

3.2.5 Value of implementing TIS in remote areas

3.2.5.1 How has the TIS Program addressed barriers to health promotion in remote areas?

Summary of findings:

TIS staff reported that they are implementing a range of strategies to address barriers to health promotion in remote areas, principally through collaborations and partnerships with other services and workers, training other workers, working with local groups of community members, and remaining flexible and adaptable to local circumstances.

Evidence to support findings:

TIS (RPGG and remote-based RTCG) staff identified a range of strategies they use in response to the kinds of barriers to health promotion in remote areas discussed above.

To address a lack of local data on tobacco use, one remote TIS team has partnered with local stores to monitor tobacco sales. In a remote context, these types of relationships can be particularly important and easy to foster, in contrast to dense urban settings where retail providers may be less willing to share this type of information with TIS teams or others.

To address some of the travel challenges to accessing remote communities, TIS workers sometimes collaborate with other organisations and services to make use of their existing travel arrangements (e.g. charter flights), which can reduce the substantial travel costs to reach distant regions or islands. They also aim to remain flexible around community restrictions or seasonal hazards, like flooding, that can restrict access to communities. For example, when physical access to communities is not possible, maintaining contact with community members by phone or email, or working on relationship building with other organisations. One TIS team

noted the importance of flexibility of plans and identifying other actions (e.g. policy writing) to do during times when they cannot access communities:

> We just tried to fit in what we can over the remainder of the year and you've just got to be really flexible because you never know when it may start or finish here. … And I've been working with them [TIS colleagues], when they can't travel, thinking about what they can still work on via phone calls and things like that. They won't be doing delivery to the community, but maybe they could be building that relationship with one of the organisations, to work on their smoke-free policies or things like that, so thinking about what has to be done face-to-face versus what they can do by email and phone and stuff. (Grant recipient, interview/focus group, remote)

To facilitate access to community members, remote-based grant recipients spoke about joining pre-existing social or other groups of men, women and families. These connections are opportunities to talk about the harms of smoking and benefits of quitting, or set up smoke-free spaces.

RPGG and remote RTCG recipient staff spoke about the difficulty of communicating with and supporting community members around accessing quit support when those clients have telecommunication issues or insufficient phone credit. In some circumstances, TIS staff have found it easiest to just provide clients with a SIM card so that they can keep in contact:

> So, until we run into them again, we have got to double-check their phone because they're using the prepaid stuff. And so, it's cheaper just to buy a new SIM card because it comes with some credit, so that phone number is constantly changing. So, I don't know, it's something we've got to look at a different way, which is why we said that, when we set up that web page, have that kind of access, they go online and they've got Internet access or something, they can send that message to these two [workers]. (Grant recipient, interview/focus group, remote)

To provide continued anti-tobacco messaging to remote communities and support to individuals trying to quit when TIS staff cannot be in the community, the TIS team at one site is planning to deliver workforce development and Quitskills training to staff at other health clinics (unaffiliated with their ACCHO) around smoking prevention and smoke-free policies. It is intended that these health staff, in turn, will speak to their clients about tobacco harms and quit options. TIS staff also spoke about establishing local quit support groups, rather than providing individualised support, so as to maximise their time when they are in communities.

To address the delays that might be involved in ordering nicotine replacement therapies from Quitline for a community member trying to quit smoking, TIS staff in one remote site are

partnering with a chemist and hospital and health service doctors to trial different therapies with patients before writing a prescription for a particular therapy:

> So, it was, give them a test and find out what they want, before the doctor now writes a three-month script and then the chemist can make sure that they've got the supply in. Otherwise, we have all got to wait for six weeks for something to come from Quitline. So that was the biggest challenge was giving the people the options to choose what to use as a nicotine replacement option. (Grant recipient, interview/focus group, remote)

3.2.5.2 How has the TIS Program activated and leveraged enablers to health promotion in remote areas?

Summary of findings:

TIS staff in remote areas are taking advantage of locally available enablers to health promotion. These include:

- Working alongside and supporting other organisations which are also concerned about tobacco control and reducing tobacco use
- Accessing small businesses which are nimbler and more open to change
- Targeting existing groups in the community to talk about tobacco harms and opportunities for cessation of tobacco use
- Seeking out existing community advocates and leaders for health promotion
- Using local media channels and social media to deliver messaging targeted to their remote communities.

Evidence to support findings:

TIS workers spoke about ways in which they were drawing on organisations and community members as enablers to leverage their own health promotion efforts. For example, TIS workers are identifying and collaborating with other services concerned about tobacco control and reducing tobacco use (e.g. health, family violence and social services) to establish referral pathways for clients requiring support around smoking cessation. TIS workers are accessing small business and other organisations (e.g. sporting organisations) to establish smoke-free policies and promote smoke-free zones. They are also collaborating with other health services based in remote communities to take up Quitskills training, so that those workers can reinforce messages and provide support to community members around quitting, when TIS workers are not in the community.

TIS staff are joining pre-existing groups in the community (e.g. men's, women's, youth and family groups) to talk about tobacco harms and opportunities for cessation of tobacco use, rather than trying to create groups from scratch. They are identifying existing local advocates or leaders in communities who will speak about the harms of tobacco use and benefits of quitting. They are also using local traditional and social media channels to deliver messaging tailored and targeted to the remote community. This includes their use or planned use of radio and television advertisements, and creation of social media or web pages to publicise tobacco use and its harms, and to promote supports for those looking to cease smoking.

3.2.5.3 How has the TIS Program created unique value for the remote communities in which it has been embedded?

Summary of findings:

There is evidence that the TIS Program has created unique value in the remote communities in which it has been embedded. There is evidence that teams are building local data for evidence of impact. In some communities, they are the only workers pushing for creation and enforcement of smoke-free zones, doing population health level work or are the only ones promoting quit options and local supports to quit.

Evidence of findings:

There is evidence that TIS teams have created unique value in the remote communities in which they are implementing the TIS Program.

- Staff of one RPGG recipient spoke about how they lacked local information on smoking rates and so they have partnered with local stores to monitor tobacco sales to generate local data on smoking and monitor evidence of the TIS Program's impact.
- RPGG staff in another site spoke about the lack of enforcement of smoke-free zones in local communities and noted that their team appeared to be the only ones pushing for the development of smoke-free workplace policies and enforcement of smoke-free zones:

> … it took a lot of promotion and stuff and basically getting everyone on board to say if they saw someone smoking just a reminder of, you know, you can't actually smoke here, there's designated areas. There's a lot of announcements. So yeah, it did take a while but it's the public shaming as well. When they know it's a smoke-free event and someone's lighting up a cigarette, they get the look. And if there's a lot of Aboriginal people that don't smoke, so they don't want to be around people that don't smoke. So we're quite happy to tell people you need to move. (Grant recipient, interview/focus group, regional)

- A community member in another remote TIS site observed that TIS staff are the only health staff local people can go to, to seek help around quit support. Certainly, most TIS staff are trained in Quitskills, are promoting this training to other staff, are coordinating services to provide better quit support or more options to people wanting to quit, and are supporting localised quit support as an option to the less popular Quitline:

> If there was no TIS program, then there would be absolutely no one that would help the community to stop smoking or prevent smoking. We would only have TV ads with non-Indigenous people that wouldn't connect to the audience or our population… So I think they [TIS team] play a fairly big part, because other than them, really, you'd only have a GP prescribing patches, and that's not really going to do anything if mental health and support isn't there. [Community member, interview/focus group, remote)

- In some communities, RPGG teams are the only ones delivering a population health approach:

> Where people had tried or have ceased smoking, it was as a direct result of work done by [TIS team] staff in promoting awareness of the harms caused by smoking and second-hand smoke. This included clinicians and TIS workers in the performance of the TIS worker roles. (Community member, interview/focus group, remote)

3.3 Overarching TIS program

This sub-section provides evidence in relation to key evaluation question 7: *Is the TIS Program as implemented worth maintaining?* As per the evaluation strategy[20], the evidence provided in this sub-section is based on Indicators 1, 2, 3, 4, 5 and 6.

3.3.1 Overall, does the evidence collected through this evaluation suggest that the program as implemented is worth maintaining?

Summary of our findings:

As explored in the sections above, there is considerable evidence that the TIS program is having an impact on promoting smoking cessation and providing quit support to its targeted communities. Areas where the program has had greatest achievements are:

- High levels of community reach through social marketing and social media

[20] CIRCA, 'Draft Monitoring and Evaluation Framework for the Tackling Indigenous Smoking Program 2018-19 to 2021-22', May 2019.

- Extensive reach and delivery of education to children and young people, principally through partnerships with schools
- Good start in terms of reach and education to pregnant women and new mothers, facilitated primarily through partnerships with maternal health workers, midwives, mothers and women's groups
- Large number of organisations assisted to establish or update smoke-free policies, and households assisted to become smoke-free
- Large number of events assisted to be smoke-free
- Large number of community engagement activities, particularly in 2019
- Formation of many partnerships to extend reach, implement activities and reinforce messaging
- Referrals to quit supports.

As time goes on, implementation of the TIS Program is being more finely tailored and targeted to local communities through community consultation and co-design, partnerships with other organisations and individuals, collection of local data and community feedback, and through experience gained by the TIS teams.

The COVID-19 pandemic has impacted on teams and their delivery of the program to different extents, depending on their location. The response of grant recipients and other stakeholders (e.g. NBPU, National Coordinator, and Quitskills) to this situation has opened up different ways of working and allowed new capacities to be developed. Some assessment at the individual grant recipient level and across teams of the expanded range of program strategies and ways of working could help to inform the best balance of strategies in the future for maximum reach and effectiveness.

The evidence strongly suggests that the program as implemented is worth maintaining, with some minor adjustments, as discussed below.

Recommendation:

- We recommend that the program as implemented is maintained, with some changes or refinements, as outlined in the following section.

3.3.2 What changes or refinements are required for the program going forward?

Summary of our findings:

Our evaluation has revealed that in many ways the TIS Program is operating as intended and is having the desired initial outcomes. The evaluation did shed light on some aspects of the program that are critical to its continued success and aspects that could use some refinement, which, if addressed, could further enhance its impact.

Evidence for our findings:

Programmatic

Increased focus on pregnant women as a priority group - Assess the most effective strategies used by different TIS teams to reach and influence pregnant women and new mothers who smoke. This could be led or assisted by iSISTAQUIT or NBPU through a second roundtable on reaching pregnant women.

Increase focus on remote and very remote communities – Smoking rates in remote Aboriginal and Torres Strait Islander communities continue to be high and there some specific challenges facing TIS teams in remote communities. Therefore, there is a need for the program to enhanced its focus on remote and very remote communities.

Improve referrals to quit support – TIS teams should continue to be strongly encouraged to make referrals to culturally appropriate quit support. In some communities that may mean referrals to Quitline, if community members trust it and feel connected to it, and in other communities that may mean referrals to local quit support providers. Where possible and appropriate, TIS teams should support the establishment of standardised referral processes to Quitline and quit support (e.g. in collaboration with other health workers, GPs and chemists). TIS teams should also review their process of making and tracking Quitline and other quit support referrals to ensure that data are not lost along the way.

Outside of Queensland, Quitline in other states and territories should be examined to see how and if adjustments could be made to improve the likelihood of Aboriginal and Torres Strait Islander peoples using the service.

TIS teams should continue to focus on dispelling myths about quitting and provide more nuanced messaging about quitting being a journey (smokers may fail initially but can try again) and that if one nicotine replacement therapy method or quit support does not work, another method may be more helpful. TIS staff could also focus on key motivators cited by community members for quitting in their education and support (i.e. cost of tobacco, concerns for one's own health and the health of children in the family).

Enhance community leadership and support - TIS teams should expand opportunities for young people, Elders, and community members who are already strong advocates for non-smoking, to become Ambassadors and spokespeople for TIS messaging. These roles should not only fall to those in formal community leadership roles or high-profile athletes.

State and national stakeholders

Improve TIS team coordination with Quitline and quit support - Quitline should continue to improve its coordination and connections to TIS teams to overcome the challenges and negative perceptions of the service (particularly among remote TIS teams). Some work needs to be done to build Quitline and TIS team capacities and confidence to help remote community members access that type of quit support. This work may involve some collaborative planning sessions between remote TIS teams and Quitline, or planning sessions among the national implementation teams, as well as more community engagement by state Quitline services.

Make a range of nicotine replacement therapies more widely available – Department of Health should liaise with state and territory stakeholders to improve timely access to multiple nicotine replacement therapies, particularly in more remote areas.

Reassess quit support training for TIS staff – Update content of quit support training for TIS teams (e.g. to reflect a population health approach) and offer flexible training options (e.g. in person and online options, separate modules, recognition of prior learning).

Continue to provide opportunities for TIS team information sharing and peer learning - NBPU should continue to create opportunities for sharing TIS data, successes and failures, and encourage TIS teams to participate, e.g. via jurisdictional workshops, training workshops, online yarning circles, TISRIC, Facebook pages, TIS newsletter and other fora.

Increase mentoring support for TIS teams – the National Coordinator could consider ways to provide TIS teams with more mentoring support, e.g. via webinar series on specific topics. National Coordinator could also identify ways to communicate better to TIS teams about available options for mentoring support, as well as his ongoing advocacy for the program.

Encourage TIS teams to continue monitoring what does and does not work – the Department of Health and NBPU should provide additional guidance to TIS teams on sources of reliable evidence for the development of their activities and AWPs. NBPU should continue to assess knowledge gained by TIS team staff members in evidence-based population health promotion approaches. NBPU could look to ways to improve its consistency and timeliness of advice to TIS team requests for information or guidance. NBPU should assess and advise TIS teams as to an effective balance of activities to maximise reach and level of impact on community attitudes and behaviour towards smoking.

Planning and monitoring

Activity Work Plans - TIS teams should be required to review their AWPs annually and send them in to NBPU, the National Coordinator, and FAMS for review and feedback. This will allow teams to regularly reflect on what is and is not working, document that evidence and make appropriate adjustments.

Performance report template – CIRCA and NBPU should continue to work together to craft and provide guidance and support to TIS teams to improve their accuracy in reporting reach of activities. For example, making clear that RTCGs should be reporting the number of people they have provided with a written referral to Quitline, rather than including the number of people encouraged to self-refer.

Performance indicators – NBPU, CIRCA, and TIS teams should collaborate to identify appropriate performance indicators: (i) for measuring community support for TIS activities including, but not limited to, manifestation through partnerships and requests to co-host events; and (ii) for measuring impact of electronic media activities.

Offer TIS teams more or different support to develop monitoring and evaluation frameworks and data collection tools so they can create their own evidence for effective population health promotion approaches. While measurement of population level impacts of the TIS program falls within the purview of the ANU Team B evaluation of TIS, TIS teams need to be able to measure other aspects of impact at local and regional levels. Therefore, there is scope for TIS teams and the NBPU to work together to develop standardised data collection tools and frameworks, including for: (i) monitoring data on the impact of activities and community feedback where community participants have low literacy in English; (ii) tracking prevention of smoking uptake among community members.

Establish data storage and analysis systems – As TIS teams are being inspired to put better data collection systems in place, NBPU and the Department of Health should encourage them to also consider putting data storage and data analysis systems into place.

Encourage and create opportunities for assessment and reflection - TIS teams and the national implementation stakeholders should continue to reflect on the approaches that seem to be working and enablers that will help them implement population health promotion approaches so they can plan and strategise to leverage those opportunities. TIS teams and the national implementation stakeholders should also continue to reflect on ways to mitigate and navigate challenges, and reflect on approaches that are less successful or not working.

4. APPENDICES

4.1 Regional Tobacco Control Grant (RTCG) Recipient Discussion Guide

Introduction

I am from the Cultural and Indigenous Research Centre Australia (CIRCA) and we have been engaged by the Department of Health to do an evaluation of the Tackling Indigenous Smoking Program. As part of the evaluation, we are speaking to RTCG recipients and stakeholders involved in the TIS Program to get feedback on how the TIS Program is going, including the appropriateness of the local population approach and the effectiveness of TIS activities. We are conducting a mixture of interviews, discussion groups and surveys with RTCG recipients, community members and stakeholders as part of the evaluation.

Explain:

- Participation in the interview is voluntary, and you can choose not to participate in part or all of the discussion.
- If you don't want to or can't answer any questions, you don't need to worry about it, we will just move on. This is an open discussion and all comments are welcome – there are no right or wrong answers.
- The feedback you provide is confidential and private - we don't record any of your personal details so anything you say will not be linked to you, you will remain anonymous - only the researchers (i.e. the CIRCA team) will have access to the information you tell us.
- We would like to record the interview on a digital recorder. The recording is just for the research team to help us with our notes so that our report includes all your thoughts/ideas. Are you happy for us to record the interview?

The interview will take about 1 hour. The group discussion will take about 1.5 hours. Do you have any questions before we begin? *(If Yes, answer questions)*

Consent:

Do you agree to participate in the interview? Yes/No

Are you happy for the interview to be recorded? Yes/No If no I will take notes.

If yes, commence recording and confirm consent.

Background

1. Can you tell me a little bit about your role with [name of organisation]? How long have you been working with the TIS Program at [name of organisation]?
2. How many dedicated TIS Program staff are there within your organisation and what are their roles? Are these roles full time, part time or shared roles with other programs?
3. Can you tell me about the model for TIS in your organisation: what kind of activities do you undertake; who else do you work with? (Have grant recipients Activity Plan handy and ask specific questions relating to each TIS activity to gain further information about partnerships etc.)
4. Can you tell me about the impacts of COVID-19 on your TIS activities, partnerships, or plans? What changes occurred, when did they go into effect, and how long did they last?

Evidence base

5. Did you have a role in developing your organisation's TIS Activity Plan? If yes, how did you go about developing this Activity Plan? (prompt: Did you conduct community consultations? Did you reflect on previous TIS Program activities and do a strengths and weaknesses analysis? Did you review evidence on tobacco cessation programs (if so, where did you get the information from?)?
6. How has the population health promotion/ evidence-based/outcomes focused approach of the TIS Program worked for you and your organisation? What has worked well? Please give examples. What have been the challenges? Please provide some examples. What does success at this point look like for your organisation?
7. How helpful have you found the routine collection of monitoring data (through the Performance Reports) for your TIS activities in informing your practice? Have you used this data for quality improvements/modifying your work? If yes, please provide examples.
8. What role did the National Best Practice Unit TIS (NBPU TIS) play in developing your Activity Plan and data collection tools? How helpful did you find their support? Has the NBPU provided any other support to your organisation? (Prompt: have you found their support helpful, have there been any challenges etc.)
9. Have you used the material / resources / tools on the TIS Program portal on HealthInfoNet collated and prepared by NPBU? If yes, how useful have you found them? (prompt: have they given you a better understanding of evidence, informed your data collection tools etc.). Which material / resources / tools have you used most frequently? Which parts are the most/least useful? (prompt: workforce info, resources, sharing stories, TIS activities, monitoring and evaluation).

Localised health promotion

10. How involved has the local community been in your TIS activities to date? (Prompt: co-design, participation in event coordination and implementation etc). What examples of

involvement can you provide? What evidence do you have on level of involvement? Has COVID-19 affected community involvement in any way, and if so, how?

11. What impact have your TIS activities had on increasing community support for tobacco control initiatives to date? (e.g. increased support for smoke-free events etc) Can you give me some examples?
12. Have you worked with community leaders/Elders on TIS activities? If yes, can you provide some examples?
13. Have any community leaders/Elders taken on an advocacy role in tobacco cessation in your region as part of your TIS activities? (e.g. Ambassador role in social marketing campaign etc.) If yes, how effective has this approach been to date? (prompt: community response to advocacy role, reach and impact of advocacy approach etc.)
14. What impact do you think your TIS activities have had in terms of building positive attitudes and social norms about the use of tobacco in your region to date? Can you give me some examples? (Prompt: introducing smoke-free policies and spaces, young people not taking up smoking, community involvement in TIS activities?)
15. What impact do you think your TIS activities have had on influencing quitting behaviour in your community to date? Can you give me some examples? Do you collect data on this?

Access to quitting

16. Have you built any partnerships with other organisations to improve access to quit support as part of your TIS activities? If yes, can you tell me a little bit about these partnerships? (prompt: strengths and weakness, how effective are these collaborations, are more referrals now being made, do you have access to data to show referrals uptake or reach etc.) Have any changes in the partnerships occurred due to COVID-19? Do you have access to any monitoring data from external organisations on referrals? If yes, please explain.

17. Have you faced any challenges in providing or enhancing access to quitting support for community members? Explore.
18. Have you or other staff in your organisation participated in Quitskills training? If yes, has it had an impact on your practices? (prompt: now more comfortable discussing smoking with clients and making referrals). If not, do you plan on participating in Quitskills training in the next 6 months? Have there been any barriers to you or staff in your organisation participating in the training? Do you know if clinical staff in your organisation have done the training? Have other organisations in your region participated in Quitskills training?

Partnerships with other organisations

19. What other activities (apart from access to quit support) have you implemented with other organisations? Can you tell me about any successes or challenges to implementing these activities? What has worked well/hasn't worked well? (Refer back to their Activity Plan and ask questions specific to their activities and proposed partnerships. (If this

hasn't been collected yet, ask for information on primary stakeholders for survey distribution).

20. To what extent do you think these partnerships or linkages have helped increase the reach of TIS activities in the broader community in [name of region] to date? Can you give me some examples?

21. What partnerships or linkages have you developed with other parts of your organisation / other programs your organisation runs? (e.g. with the maternal health worker and the mums and bubs group within your service etc.)

TIS Program activities

22. Thinking about TIS activities undertaken to date, how effective do you feel your approach has been? Which elements of your approach do you feel have been most effective/least effective? Discuss evidence base. (probe: preconditions for success? What is necessary for success moving forward?)

23. Overall where do you feel that [name of organisation] TIS Program activities have had the most impact in reducing tobacco smoking in your region to date? Can you provide some examples? (prompt: location, demographic and area of focus).
24. To what extent do you think your TIS activities to date have reduced exposure to second hand smoke? (prompt social marketing activities, partnerships or linkages with other orgs etc.) What evidence do you have of this?
25. To what extent do you think your TIS activities to date are reaching a wider population in your region? (prompt social marketing activities, partnerships or linkages with other orgs etc.) What evidence do you have of this wider reach?
26. To what extent do you think your TIS activities to date are reaching a wider population in your region beyond those people that already attend Aboriginal Community Controlled Health Services? (prompt social marketing activities, partnerships or linkages with other orgs etc.) What evidence do you have of this reach?
27. To what extent do you think your TIS activities to date are reaching priority groups, particularly pregnant women? (prompt social marketing activities, partnerships or linkages with other orgs etc., other priority groups?) What evidence do you have of this reach?

28. What do you think has been your organisations most significant achievement in relation to your TIS activities in the last 6 months?

29. Do you feel there are any areas for improvement with your TIS activities going forward? If yes, please explain.
30. What do you hope to achieve in the next 12 months of the TIS Program?

TIS Program approach

31. Have there been any challenges with the overall TIS approach (evidence based, outcomes focussed, focus on population health promotion)? If so, what have been the main challenges?
32. Have you submitted your 6 monthly Performance Report yet? (If yes) How did you find reporting against the new TIS performance indicators? What was easy/challenging about reporting in this way? (If no) What do you think of the new performance indicators, what might be easy/challenging about reporting in this way?
33. Do you have any comments on the role of the Department of Health in rolling out the current TIS Program?

Thank you and close.

4.2 Regional Tobacco Control Grant Recipient Online Survey

This survey asks you to respond to a series of questions relating to your organisation's Tackling Indigenous Smoking (TIS) activities. It would be useful if you have a copy of your TIS Activity Plan on hand so you can refer to it if need be as you respond to each question.

About you

A. Which of the following describes your role on TIS?

- ❑ Manager
- ❑ Regional Coordinator
- ❑ Educator
- ❑ Counsellor
- ❑ Liaison Officer
- ❑ Project Officer
- ❑ Research/evaluation
- ❑ Other (please describe): _____

B. In which jurisdiction are you located?

- ❑ New South Wales
- ❑ ACT
- ❑ Victoria
- ❑ South Australia
- ❑ Western Australia

- ❑ Northern Territory
- ❑ Tasmania
- ❑ Queensland

C. What is your workplace postcode?

TIS performance indicators (TIS Manager only)

In the next few questions we will be asking how your organisation is prioritising and progressing against the TIS performance indicators. We will firstly ask you to assess the last 6 months of activity and then the next 12 months of activity.

- ~ **Performance Indicator 1**: Implementation of evidence-based population health promotion activities aimed at preventing uptake of smoking and supporting the promotion of cessation.
- ~ **Performance Indicator 2**: Partnerships and collaboration facilitate support for tobacco control.
- ~ **Performance Indicator 3**: Increased access to Quit support through capacity building.
- ~ **Performance Indicator 4**: Reduced exposure to second hand smoke.
- ~ **Performance Indicator 5**: Increased focus on priority groups, e.g. pregnant women.
- ~ **Performance Indicator 6**: Increased reach into communities.

Thinking about the last 6 months of the TIS Program

D. Rank the program performance indicators in order of **budget allocation**, 1 being the greatest budget allocation and 5 being the smallest budget allocation.

E. Rank the program performance indicators in order of time and other non-financial **resource allocation**, 1 being the greatest resource allocation and 5 being the smallest resource allocation.

F. Did COVID-19 affect the amount of budget you allocated to each of the performance indicators? If so, how did it change and when?

G. Did COVID-19 affect how many non-financial resources you allocated to each of the performance indicators? If so, how did it change and when?

H. How much progress have you made towards your expected outcome against each performance indicator? (Likert scale of progress for each indicator – No progress, Very little progress, Some progress, A lot of progress)

I. What do you think has been the most significant achievement of the TIS Program in the last 6 months? Please describe_____

J. What was the greatest challenge you faced in the last 6 months of the TIS Program? Please describe_____

Thinking now about the next 12 months of the TIS Program

K. Rank the program performance indicators in order of time and other non-financial **resource allocation**, 1 being the greatest resource allocation and 5 being the smallest resource allocation

L. Rank the program performance indicators in order of **budget allocation**, 1 being the greatest budget allocation and 5 being the smallest budget allocation

M. How much progress do you expect to make towards your expected outcome against each performance indicator? (Likert scale of expected progress for each indicator - No progress, Very little progress, Some progress, A lot of progress)

TIS performance indicators (Excluding TIS Managers)

N. What do you think has been the most significant achievement of the TIS Program in the last 6 months? Please describe_____

O. What was the greatest challenge you faced in the last 6 months of the TIS Program? Please describe_____

Statements (All)

P. Thinking about the last 6 months of the TIS Program, to what extent do you agree or disagree with the following statements (Likert scale of agreement as indicated below)

- ❑ Agree strongly
- ❑ Agree slightly
- ❑ Neither Agree/Disagree
- ❑ Disagree slightly
- ❑ Disagree strongly
- ❑ Don't know

Localised Health Promotion

- ~ TIS activities are working well alongside other related initiatives
- ~ There has been increased community support for tobacco control initiatives
- ~ There has been increased community involvement in tobacco control initiatives
- ~ TIS activities have led to enhanced leadership and advocacy roles of community leaders in tobacco cessation

- ~ TIS activities have led to an increase in smoke-free homes, events, workplaces and workspaces in the region
- ~ TIS activities have led to increased community understanding of the health impacts of smoking and of quitting pathways
- ~ TIS activities have led to an increase in community members desire to quit
- ~ TIS activities have led to a greater focus on pregnant women
- ~ TIS activities have led to increased geographic reach
- ~ TIS activities have led to a greater reach to Aboriginal and Torres Strait Islander peoples who do not attend ACCHs

TIS Program

- ~ The TIS Program encourages my organisation to develop TIS activities that are based on evidence regarding Aboriginal and Torres Strait Islander smoking behaviour and motivations to quit
- ~ The TIS Program has encouraged a stronger focus on outcomes within my organisation
- ~ The TIS Program has encouraged a population health promotion approach
- ~ The population health approach makes sense to me
- ~ I am confident that we have the monitoring capabilities required to report accurately on how the TIS Program is performing
- ~ The support of the NBPU and the National TIS coordinator have enhanced the effectiveness of the TIS Program and TIS activities within my organisation

Access to Quit Support

- ~ Quitskills training has enhanced staff capacity in tobacco control and prevention activities
- ~ TIS activities have improved community members access to culturally appropriate support to quit
- ~ We have built strong collaborations and partnerships with internal and external stakeholders to increase community members access to quit support

Partnership with other organisations

As part of your TIS activities, which of the following organisations have you formed links and partnerships with over the past 6 months? (Tick all that apply)

- ❑ Other sections or units within my service
- ❑ Other Aboriginal health service/s
- ❑ Mainstream health service/s
- ❑ Other Aboriginal community organisation/s
- ❑ Other community organisation (e.g. sporting clubs)
- ❑ Local, State/Territory, Federal government department

- ❑ Schools
- ❑ Quitline
- ❑ Quitskills
- ❑ Other (please specify)

Personal Perspectives

Q. Thinking about yourself now, has the TIS Program changed your attitude or behaviour towards smoking? Please describe _____

4.3 Discussion guide for Aboriginal and Torres Strait Islander community members

Introduction

I am from the Cultural and Indigenous Research Centre Australia (CIRCA) and we have been engaged by the Department of Health to do an evaluation of the Tackling Indigenous Smoking Program. As part of the evaluation, we are speaking to regional tobacco control grant recipients and stakeholders involved in the TIS Program to get feedback on how the TIS Programme is going, including the appropriateness of the local population approach and the effectiveness of TIS activities.

Explain:

- Participation in the interview is voluntary, and you can choose not to participate in part or all of the discussion.
- If you don't want to or can't answer any questions, you don't need to worry about it, we will just move on. This is an open discussion and all comments are welcome – there are no right or wrong answers.
- The feedback you provide is confidential and private - we don't record any of your personal details so anything you say will not be linked to you, you will remain anonymous - only the researchers (i.e. the CIRCA team) will have access to the information you tell us.
- We would like to record the interview on a digital recorder. The recording is just for the research team to help us with our notes so that our report includes all your thoughts/ideas. Are you happy for us to record the interview?

The interview will take about 1 hour. The group discussion will take about 1.5 hours. Do you have any questions before we begin? *(If Yes, answer questions)*

Consent:

Do you agree to participate in the interview? Yes/No

Are you happy for the interview to be recorded? Yes/No If no I will take notes.

If yes, commence recording and confirm consent.

Community Smoking Attitudes and Behaviours

1. If you'd rather not be identified we can just record your location as urban, regional or remote or, If you don't mind, can you tell me the suburb you live in? Who do you live with?
2. Do many people in your family/community smoke? What about other people you know?
3. What role do family/community/people you know/TIS workers play in supporting/inhibiting attempts to reduce amount smoked/quit smoking? (probe for any stories where people they know have attempted to reduce amount smoked/quit, explore what motivated them/made it hard for them to quit/sustain smoking cessation).
4. Are there individuals in the community who advocate or are role models around not smoking?
5. Are the attitudes towards smoking of community/family/people you know changing? How are they changing and what do you think is driving any changes in attitudes?
6. Do you attend an Aboriginal Community Controlled Health Service? How often?

Second Hand Smoke

7. What do community/family/people you know think about exposure to second hand smoke (explore smoking at home, in the car, at work, around children, at local events & in other public spaces)?
8. Do you see benefits of having smoke-free spaces? What are the challenges that the community/family/people they know face in implementing smoke-free spaces?
9. Are attitudes to exposure to second hand smoke changing? What is driving any changes?
10. Are you aware of smoke-free areas in public spaces? (Prompt for the locations, amount and effectiveness of signage).
11. Do you have smoke-free policies at work and how effective do you think they are?
12. Are you aware of any TIS activities in relation to second hand smoke or smoke-free activities?

Advertising & Promotion

13. Can you tell me about any advertising or information you've seen or heard recently (in the last 6 months) about the dangers of smoking, dangers of smoking in pregnancy or encouraging quitting or smoke-free homes and cars (prompt: local Ambassadors or role models if used by specific TIS grant recipient)? Can you tell me about the messages you saw/heard and any impact this had on you?

14. Are you aware of any local campaigns (Prompt for TV, Radio, Posters, Billboards and Internet/Social media)? What was the message from the activity? What did you learn from this? What did you do as a result of this?

15. Are you aware of any TIS sponsorship of community events (e.g./NAIDOC, local sporting teams)? What was the message and what impact did that have on you?

16. Have you spoken to anyone about the dangers of smoking or encouraging quitting or smoke-free homes and cars (e.g./doctor, Aboriginal Health Worker, other medical professional, family, community)? Can you tell me what was discussed and what impact this had on you?

Quit Support

17. Are you aware of any support services for quitting in your community (e.g. Quitline, yarning groups, culturally appropriate services)?

18. Do you know anyone who has used these services? Do you know what motivated them to use these services? What do you see as the barriers/challenges to using these services?

19. What do you see as the level of awareness, perceptions and usage of nicotine replacement therapy (e.g. gums, patches, lozenges) NRT (prompt: Do you know anyone who has used NRT, what motivated them to use them, any challenges?)

Program Perception

20. How aware are you (or your community/family/people you know) of local TIS activities? (Explore support for and involvement in local TIS activities).

21. What TIS activities are resonating most strongly in changing attitudes/behaviour about smoking among participant/community/family/people you know.

22. What do you see as the important issues around smoking in your community?

23. Do you have any advice on future program priorities for TIS?

Thank you and close.

4.4 Department of Health Discussion guide

TIS Program approach

1. What do you see as the greatest successes of the TIS Program to date? In this funding round?
2. Have you found any challenges or weaknesses in the TIS Program that may impact on program success during this funding round? (e.g. staff retention/recruitment, remote challenges, underspend etc). Any challenges as a result of COVID-19 in particular?
3. How do you think the TIS Program has been improved in this iteration?
4. How do you see this iteration of the TIS Program impacting on women who are exposed to tobacco smoke during pregnancy?
5. How do you see this iteration of the TIS Program impacting on grant recipients in remote locations?
6. What ongoing contact and support is provided to grant recipients through the Department? Do you think this is adequate?
7. How successful do you feel the role of the national TIS coordinator has been as a component of the TIS Program overall? In what areas has the role been most successful/least successful?
8. How do you see the role of the national TIS coordinator evolving?
9. What are your hopes for the future of the TIS Program and / or Indigenous tobacco control?
10. What are your hopes for the future of Indigenous tobacco control?

TIS Grant recipients

11. What impact do you think the TIS Program design has had on the range / scope and focus / type of activities undertaken by grant recipients? (prompt: encouraged diversity in programs, evidence-based, outcomes focused programs, focus on population health promotion approach, etc.)
12. What are your expectations of the new performance indicators in terms of TIS program impacts/outcomes?
13. What would you like to see in terms of outcomes for the increased focus on priority groups, and program reach?

14. Have grant recipients reported any ongoing challenges with the collection and reporting of monitoring data? If yes, how could these issues be addressed?
15. Some grant recipients have requested more detailed guidance and feedback on data presented in the Performance Reports. Who do you see as responsible for providing provide this feedback?

NBPU TIS

16. How effective do you feel the NBPU has been in identifying and promoting evidence based best practice approaches by grant recipients to tobacco control? What has, what has not worked?
17. How effective do you feel the NBPU has been in supporting a population health promotion approach among grant recipients (successes and challenges)?

6. What do you see the role of NBPU going forward? (type of support, advocacy, data collation etc?).

Thank you and close.

4.5 National Best Practice Unit Discussion Guide

Introduction

I am from the Cultural and Indigenous Research Centre Australia (CIRCA), which has been engaged by the Australian Government Department of Health to do an evaluation of the Tackling Indigenous Smoking (TIS) Program. As part of the evaluation, we are speaking to stakeholders involved in and with links to the TIS Program to get feedback on how the TIS Program is going, including the appropriateness of the population health promotion, evidence-based, outcomes focused approach and the effectiveness of TIS activities. We are conducting a mixture of interviews, discussion groups and surveys with a range of stakeholders, including targeted grant recipient representatives, community members and other stakeholders.

Background

1. Can you tell me a little bit about your role/s within the National Best Practice Unit (NBPU)?
2. What type of support do you specifically provide to grant recipients? (prompt: developing and implementing training / workshops, supporting developing data collection tools, providing evidence based literature etc.)
3. Can you tell me about the impacts of COVID-19 on the support you provided to grant recipients? What changes occurred, when did they go into effect, and how long did they last?

TIS Program approach

4. Do you think that the work of the NBPU has continued to influence RTCGs use of evidence and best practice approaches for tobacco control?
5. Do you think the NBPU has had a positive impact on the range and scope of activities undertaken to date? (prompt: encouraged diversity in programs, evidence based approaches, etc.)
6. Have grant recipients had any challenges reaching the population they intended to reach in their TIS activities? (e.g. the population they indicated they would reach in their Activity Plans)? If so, what do you think have been the main challenges for grant recipients achieving a population health promotion approach?

7. How appropriate do you think the program design (flexible funding model, evidence base, population health promotion approach) has been for achieving the TIS Program objectives?
8. Have you seen any changes in activities in response to the new performance indicators? (e.g. increased focus on reach, priority groups). Have grant recipients understood these changes? Can you provide examples?

Evidence base

9. How has the evidence based/ population health promotion approach to the TIS Program worked for grant recipients? Have there been any challenges for them in terms of shifting to an evidence based/population health promotion approach? If yes, can you give me some examples?
10. Were all grant recipients able to provide a rationale based on evidence for their Activity Plans and TIS activities? If not, why not? What sort of evidence was provided – evidence of need or evidence of the effectiveness of an approach, or both?
11. How successfully have grant recipients routinely collected monitoring data against their TIS activities to date? What role did the NBPU play in supporting consistent monitoring of data across all grant recipients?
12. Are you aware of any examples where grant recipients have used monitoring data for quality improvements/modifying their work based on new data? If yes, can you give me an example?
13. Have there been any challenges in the collection of data for the TIS Performance Reports? If yes, can you give me some examples? How have you worked with grant recipients to resolve these issues?
14. Do you have any suggestions on anything that could be improved to assist grant recipients to collect monitoring data against their TIS activities going forward?
15. What influence do you think the NBPU (provision of tailored support and evidence based resources) has had on grant recipients understanding of evidence and evidence based approaches to tobacco control/population health promotion approaches?
16. How important do you think the role of the national TIS Coordinator is? Can you provide examples of successes and challenges for this role?
17. What other supports do you think the RTCG recipients require?

Stakeholder relationships & the future of the TIS Program

18. How have you found working with grant recipients? (Prompt: successes, challenges etc.)
19. How have you found working with the Department of Health? (Prompt: successes, challenges etc.)
20. How have you found working with other TIS stakeholder? (Prompt: successes, challenges etc.)
21. What do you see the role of NBPU going forward? (type of support, advocacy, data collation etc?).

22. The NBPU gets a lot of funding. In what ways to you think you deliver value for money?
23. What are your hopes for the future of the TIS Program?

Thank you and close.

4.6 National Coordinator Discussion Guide

Introduction

I am from the Cultural and Indigenous Research Centre Australia (CIRCA), which has been engaged by the Australian Government Department of Health to do an evaluation of the Tackling Indigenous Smoking (TIS) Program. As part of the evaluation, we are speaking to stakeholders involved in and with links to the TIS Program to get feedback on how the TIS Program is going, including the appropriateness of the population health promotion, evidence-based, outcomes focused approach and the effectiveness of TIS activities.

We are conducting a mixture of interviews, discussion groups and surveys with a range of stakeholders, including targeted grant recipient representatives, community members and other stakeholders.

Background

1. Can you tell me a little bit about your role as the national TIS coordinator? (Prompt: what does it involve? How do you meet with stakeholders, Ministers etc? What key areas do you advocate for?).

2. Can you tell me about any impacts of COVID-19 on your role as national TIS coordinator? What changes occurred, when did they go into effect, and how long did they last?

Grant recipients

3. You regularly visit grant recipient organisations on the ground. What benefits and information do you get from these visits and what benefit do you see grant recipients gaining from your visits?
4. How do you think the evidence-based, outcomes focused approach to the TIS Program has worked for grant recipients and for communities?
5. What are some of the key success stories and challenges you hear from grant recipients during your site visits?
6. Are there themes of successes/challenges for grant recipients depending on where they are located (e.g. urban, regional, remote)?

7. How if at all, do you use data collected by grant recipients in the advocacy work you do?

NBPU role and evidence base

8. In your view, what is the key role for National Best Practice Unit (NBPU) in the implementation of the TIS Program? What do you see as areas that require improvement or strengthening?

9. What do you see as the key role of the NPBU in supporting RTCG recipients given their varying degree of experience in population health promotion?

TIS Program approach

10. Challenges regarding a lack of buy-in to the TIS Program from CEOs and board members of some TIS organisations and other Aboriginal organisations was noted during the previous evaluation. Can you explain the work you are doing in this area? How successful has it been to date? Any suggestions?
11. How appropriate do you think the TIS Program design has been for achieving the TIS Program objectives? What do you see as the key outcomes of the program design? (prompt: encouraged diversity in programs, evidence-based, outcomes focused programs, population health promotion approach etc.)

12. What challenges remain in regard to the population health promotion approach in the TIS Program?

13. What do you think have been some of the key outcomes/successes of the program? And what about challenges?
14. What do you see as the key successes and /or major challenges for grant recipients in remote areas?
15. What are the key successes / challenges to reducing smoking in pregnancy and other priority groups?
16. You have spoken about issues around grant recipients underspending at the jurisdictional workshops. Has this changed since the program has been funded over four years? If it is still major concern, how can this issue be addressed going forward?
17. What are your hopes for the future of the TIS Program and / or Indigenous tobacco control more broadly?
18. Do you have any other thoughts or comments on the TIS Program that we should include in the final report?

Thank you and close.

4.7 Quitline Stakeholder Discussion Guide

Introduction

I am from the Cultural and Indigenous Research Centre Australia (CIRCA), which has been engaged by the Australian Government Department of Health to do an evaluation of the Tackling Indigenous Smoking (TIS) Program. As part of the evaluation, we are speaking to stakeholders involved in and with links to the TIS Program to get feedback on how the TIS Program is going,

including the appropriateness of the population health promotion, evidence-based, outcomes focused approach and the effectiveness of TIS activities.

We are conducting a mixture of interviews, discussion groups and surveys with a range of stakeholders, including targeted grant recipient representatives, community members and other stakeholders.

Background

1. Can you tell me a little bit about your role in Quitline?
2. Can you tell me about the work Quitline does with Indigenous Australians?
3. What is the nature of your outreach work? Do you visit Indigenous communities and to what extent?
4. Could you explain Quitline's involvement with the TIS Program? How do you work with TIS grant recipients? (prompt: strengths and challenges of the relationship, how effective are these collaborations.)
5. Can you tell me about the impacts of COVID-19 on Quitline's involvement with TIS? What changes occurred, when did they go into effect, and how long did they last?
6. Does your work with TIS services and in TIS regions differ from your work that is unconnected with TIS funded services? How?
7. Are there any issues that are specific to TIS services?
8. How does the Quitline ensure culturally appropriate support for Aboriginal and Torres Strait Islander clients? Do you have any evidence that this is working? (Prompt: Aboriginal Quitline counsellor, choice of male or female counsellor, culturally appropriate promotional material).
9. Does Quitline have a specific approach for Aboriginal and Torres Strait Islander pregnant women? Do you have any evidence that this is utilised / working?

Quitline data

10. What has been the impact of TIS activities on the Quitline service? That is, have you seen any changes in caller numbers or knowledge related to TIS activities?
11. What else do you think has impacted on caller numbers (if they have increased/decreased)?
12. How does the referral process work? Where do most of your referrals come from?
13. What monitoring and evaluation data do you routinely collect in relation to the Quitline program?
14. Is there any other specific Quitline data relating to the work of TIS grant recipients that might be relevant to the TIS Program evaluation? If yes, discuss research findings.
15. Do you ever share evaluation data with TIS grant recipients? If yes, what data do you share? If not, why not?

Perceptions of TIS program

16. How useful / helpful do you think the TIS Program is for Aboriginal and Torres Strait Islander communities? Why is that?
17. What do you think are the strengths / positive aspects of the TIS Program? What are the weaknesses/opportunities for improvement?
18. Is there anything else you that would be useful for us to think about when evaluating the TIS Program?

Thank you and close.

4.8 Quitskills Stakeholder Discussion Guide

Introduction

I am from the Cultural and Indigenous Research Centre Australia (CIRCA), which has been engaged by the Australian Government Department of Health to evaluate the Tackling Indigenous Smoking (TIS) Program. As part of the evaluation, we are speaking to stakeholders involved in and with links to the TIS Program to get feedback on how the TIS Program is going, including the appropriateness of the population health promotion, evidence-based, outcomes focused approach and the effectiveness of TIS activities.

We are conducting a mixture of interviews, discussion groups and surveys with a range of stakeholders, including targeted grant recipient representatives, community members and other stakeholders.

Background

1. Can you tell me a little bit about your role in the Quitskills program?
2. Could you explain Quitskills' involvement with the TIS Program? How do you work with TIS grant recipients? (prompt: strengths and challenges of the relationship, how effective are these collaborations, are more staff and community members participating in training etc.)

3. Can you tell me about the impacts of COVID-19 on Quitskills' involvement with TIS? What changes occurred, when did they go into effect, and how long did they last?

4. Are there other organisations otherwise unconnected to the Commonwealth TIS program that request or participate in Quitskills training?

Quitskills training

5. What is the level of participation of TIS regional grant recipients in Quitskills training? Have some TIS regional grant recipients undertaken more/regular training than others? Have you any idea what accounts for this difference? (prompt: differences across urban/regional/remote?) Do you think any of the differences have been due to COVID-19?

6. How do you work with TIS regional grant recipient organisations to promote Quitskills training to internal staff and other organisations? (prompt: strengths and challenges of the relationship, how effective are these collaborations, are more staff and community members participating in training etc.)

7. Do you have specific strategies for increasing participation by TIS grant recipients? Explore.

8. How do you feel the Quitskills program works to meet the needs of TIS grant recipients? What are the strengths of the program in this context?
9. What are some of the challenges to delivering the Quitskills program? (prompt: cost, time required by participants to attend training etc.)
10. Are there any issues you would like to discuss in relation to organisations otherwise unconnected with the TIS Program?

Quitskills data

11. What monitoring and evaluation data do you routinely collect in relation to the Quitskills program?
12. What specific data is available relating to your training of TIS regional grant recipients that can be used for the TIS Program evaluation? If yes, discuss findings.

Thank you and close.

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