

POLICY ANALYSIS

**Health Intervention Analysis: Tackling Indigenous Smoking**

**Indigenous People and Policy**

Nicholas Tanner, April 2023

**Analysis of the Federal Governments Tackling Indigenous Smoking Program**

The Tackling Indigenous Smoking program (TIS) is an Australian Government initiative, designed to reduce the rate of smoking amongst Torres Strait and Aboriginal populations. A module of the larger ‘Closing the Gap’ Indigenous health campaign, the TIS program is an integral component in the pursuit of equal life expectancy with 23% of the health burden gap between non-Indigenous Australians and Aboriginal and Torres Strait Islander peoples attributed to smoking (AHRC, 2021; DoH, 2021). Smoking is a globally recognised priority area due to its innumerable related health concerns and burden on national economies. The Framework Convention on Tobacco Control (FCTC) was established in 2005 and has 168 signatories, one of the most espoused causes in the history of the United Nations (WHO, 2021).

The TIS program has been designed in accordance with a number of regulatory strategies set out in the FCTC. The majority of programs funded by the TIS program centre around public education for rural and remote populations. This public education focuses on enlightening these population groups of the risks associated with the smoking of tobacco due to the failure of traditional media campaigns amongst Indigenous communities (DoH, 2021). Article 12 of the FCTC recognises education as a priority area due to the corollary contribution to disparity and lower socioeconomic status (SES) associated with lower levels of education (WHO, 2021).

The FCTC establishes in its guiding principles the importance of implementing culturally and socially appropriate control programs for disproportionately affected population groups, in particular indigenous peoples. The TIS utilises an online resource and information centre to ensure programs approved for funding have consulted with Indigenous populations prior to their rollout. An example of this process is the QuitLine service, employing counsellors from Aboriginal communities and offering an exclusive hotline for Indigenous persons. These counsellors are uniquely positioned to counsel Indigenous persons due to their understanding of how smoking is embedded in Indigenous cultures, gained through lived experience (Quit Victoria, 2021).

The TIS also targets second hand smoke exposure reduction. Recognised in the FCTC’s Article 8, *Protection from exposure to tobacco smoke,* the initiative seeks to address smoking within the household. This has been a particularly successful component of the overall initiative. The targeted campaigns have specifically targeted maternal instinct, demonstrating the impact of passive smoke on infants and youths. This has resulted in a 16% reduction in household smoking for houses containing a child aged 0-14 in the past 2 years, now at 13%. This population group had been found to be particularly susceptible to cultural aspects of smoking including chain-smoking and kinship bonding. Therefore, the reduction in exposure has served dual purposes, both in reducing passive exposure and reducing the normalcy of culturally related smoking behaviours during a child’s formative years (Greenhalgh, Hanley-Jones & Winstanley, 2020).

The TIS has been explicit in the criteria for funding allocation, with an annual budget of ~$38m AUD, the program supports 40 organisations and their targeted control measures (Van Iersel, 2021). This budget is a significant limiting factor in addressing aspects of the FCTC, and thus many of the recommended measures are ignored by this initiative. A number of the FCTC measures which the TIS doesn’t cover aren’t appropriate for a targeted initiative. Population-wide state and federal governments already target regulatory areas, including; cigarette content regulation, packaging, labelling and other advertising regulation, and pricing and taxation measures to reduce demand (Smoking and tobacco,2021).

A criticism of the TIS program lies in the disparity of its supported organisations. Only 2 out of 40 funded organisations target cessation of existing smokers, with the remaining 38 prioritising reduction in uptake (NBMU, 2021). For a program with a mission directive to reduce the disparity in life expectancy between Indigenous and non-Indigenous populations, this is a particularly slow method of eliminating smoking as a contributing factor and doesn’t acknowledge the inequity suffered by existing Indigenous smokers. The FCTC examines the importance for reduction in tobacco dependence and cessation in Article 14. Another critical concern is the failure of the TIS to address sales to and by minors in remote populations, and provision of economically viable alternative activities. A lack of funding for compliance and enforcement of tobacco retail to minors in remote communities has resulted in 88% of Indigenous smokers aged 13-17 reporting having bought cigarettes over the counter in the past 12 months (Greenhalgh & Parnell, 2021). The TIS also hasn’t targeted programs offering viable alternative activities. The embedding of smoking into Indigenous culture suggests that new cultural norms be established, the value of such measures are recognised by Article 17 of the FCTC.

The Ottawa Charter for Health Promotion (OC) was an initial agreement organised by the WHO with the mission to achieve ‘Health for All’ through measures advancing the promotion of health. The TIS have targeted the 5th key action area of the OC, “re-orienting health care services to ward the prevention of illness and the promotion of health” (WHO OC, 2021). The TIS recognises the significant barriers restricting access to health services in rural and remote areas. Therefore, its focus is on shifting the primarily curative and clinical basis of previous interventions toward programs which centre around establishing an increased emphasis on preventative measures and those which promote health. The numerous targeted educational programs are the greatest reflection in this method shift, lessening the focus on individual health and increasing the recognition of the disparity the Indigenous population experience as a whole. The focus on health promotion as the foremost preventative measure and the move away from reliance on curative health has been a critical step forward in establishing equity between Indigenous and non-Indigenous populations.

It is my contention that the TIS could significantly increase their influence and impact through the approval of programs designed to strengthen community action and create supportive environments, both key action areas of the OC. Through the education of individuals across many isolated population groups, knowledge can be exchanged and therefore become accessible to those able to deliver it in a culturally appropriate manner. The TIS would benefit from recognition of the importance of establishing partnerships between mainstream health services and representatives from remote communities. The cultivation of community partnerships is imperative for the empowerment of disadvantaged and neglected communities, allowing them to advocate on their own behalf and have a voice which can be heard by campaigners and elected representatives. The creation of these partnerships would serve to foster relationships with disadvantaged Indigenous peoples and promote a two-way exchange of information. Relevant medical and health related information can be disseminated across these populations and open communication allows for the capture of sensitive health information within these populations which may previously have had no avenue to disclose their health concerns. Additionally, the establishing of community partnerships and the delivery of health information by community representatives is critical in bypassing deep-seated distrust of non-Indigenous persons and their aims regarding Indigenous health.

 The TIS program appears acutely aware of their limitations in delivering adequate primary care action due to the remote locations of their targeted population group and the associated lack of available resources including personnel. Only 1 of 40 programs falls into the primary care approach, with accessible quick referral pathways being created for nicotine replacement therapies. It Is therefore evident they have predominantly targeted their interventions towards both midstream lifestyle and behavioural approaches and upstream approaches targeting socio-ecological action. Both communication and health education and empowerment are midstream approaches to health promotion action. Educational programs enhancing knowledge of the impacts of smoking to individuals, families and greater population groups as a result of smoking and a translation of this knowledge into an understanding of the dangers smoking presents are common themes in a number of funded programs by the TIS. Additionally, communicative strategies are another focus, recognising that traditional methods of communication are ineffective, alternative interventions are utilised to disseminate and receive relevant information relating to smoking (DoH, 2021). Community action is an upstream factor which the TIS leans heavily on in seeking to address the inequity of Indigenous populations. Recognising the reason for the vast disparity in percentage of aboriginal persons who smoke daily (47%) and non-Indigenous daily smokers (11%) has a basis in culture, upstream population group targeting interventions are the most critical for addressing the imbalance (Purcell, 2015). The afore-discussed passive smoking campaign targeting mothers within Indigenous families is a prime example of the influence these initiatives can have on the population group. Wold and Mittelmark’s 2018 health promotion article examines the socioecological approach and the challenges of implementing the interventions. Their research determined that the development of infrastructure and supporting environments were essential components for success in the socioecological approach to health promotion action. It is in this area the TIS still requires significant further action to capitalise on their whole-community approach to health promotion. They endorsed the whole-community approach and its prime importance in enacting change, but were adamant that this approach is most commonly unsuccessful due to an absence of a supportive environment conducive to empowerment in community-based interventions.

**References:**

Australian Human Rights Commission. (2021). Close the Gap: Indigenous Health Campaign. Retrieved 21 November 2021, from https://humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/projects/close-gap-indigenous-health

Department of Health (AUS). (2021). Smoking and tobacco. Retrieved 19 November 2021, from https://www.health.gov.au/health-topics/smoking-and-tobacco

Department of Health (AUS) (2021). Tackling Indigenous Smoking. Retrieved 19 November 2021, from https://www.health.gov.au/initiatives-and-programs/tackling-indigenous-smoking

Purcell, K. (2015). *Evidence review: Addressing the social determinants of inequities in tobacco use*. Victoria: Victoria State Government. Retrieved from https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/Health-Inequalities/Fair-Foundations/Full-reviews/HealthEquity-Tobacco-review.pdf?la=en&hash=E0FBC9E791F62977BE0B7C664C3FA7B8EB05D236

Quit Victoria. (2021). What is the Aboriginal Quitline? Retrieved 20 November 2021, from https://www.quit.org.au/resources/aboriginal-communities/what-aboriginal-quitline/

Van Iersel, E. (2021). National best Practice Unit for Tackling Indigenous Smoking. Retrieved 21 November 2021, from https://www.nintione.com.au/project/national-best-practice-unit-tackling-indigenous-smoking/

Wold, B., & Mittelmark, M. (2018). Health-promotion research over three decades: The social-ecological model and challenges in implementation of interventions. *Scandinavian Journal Of Public Health*, *46*(20\_suppl), 20-26. doi: 10.1177/1403494817743893

World Health Organisation [WHO OC]. (2021). Health Promotion Retrieved 17 November 2021, from https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference

World Health Organisation. (2005). *WHO Framework Convention on Tobacco Control*. Geneva: World Health Organisation. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/42811/9241591013.pdf;jsessionid=366CB3818FF758406C86B2882A8C994B?sequence=1