Tackling Indigenous Smoking Program

Final Evaluation Report

Prepared for the Australian Government Department of Health

July 2018

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Acknowledgements

List of Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
ACCHS	Aboriginal Community Controlled Health Service
AMS	Aboriginal Medical Service
AOD	Alcohol and Other Drugs
ASGS	Australian Statistical Geography Standard
CEO	Chief Executive Officer
CIRCA	Cultural and Indigenous Research Centre Australia
HG&N	Health Grants and Network
HREC	Human Research Ethics Committee
HSN	Health Services Network
IAHP	Indigenous Australians' Health Programme
M&E	Monitoring and Evaluation
NBPU TIS	National Best Practice Unit Tackling Indigenous Smoking
nKPI	National Key Performance Indicators
NRT	Nicotine Replacement Therapy
PCYC	Police-Citizens Youth Clubs
PHN	Primary Health Network
SAHMRI	South Australian Health and Medical Research Institute
TIS	Tackling Indigenous Smoking
TISRIC	Tackling Indigenous Smoking Resource and Information Centre

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Executive Summary

Tobacco is one of the leading contributors to the burden of disease among Aboriginal and Torres Strait Islander peoples. The overall goal of the Tackling Indigenous Smoking (TIS) program is to improve the health of Aboriginal and Torres Strait Islander peoples through local population specific efforts to reduce harm from tobacco. The program supports culturally appropriate /tailored tobacco control interventions for Aboriginal and Torres Strait Islander peoples that supplement broader measures for tobacco control such as plain packaging and tobacco excise duties. TIS is a component of the Australian Government's Indigenous Australians' Health Programme (IAHP).

Following a review of the Tackling Indigenous Smoking and Health Lifestyle Programme in 2014, the Department of Health (the Department) introduced the redesigned TIS program. The Australian Government provided $116.8 million over three years for the program with a significant proportion of the funding ($93.4m) allocated to regional grants.

The redesigned TIS program shifted funding away from dedicated healthy lifestyles workers delivering broader healthy lifestyle activities, toward funding for programs and activities that have a primary focus on tobacco reduction outcomes. The key program design elements of the revised TIS program include the use of evidence based multi-component tobacco control strategies, using and promoting best practice approaches to tobacco control, use of population health and place-based approaches, and building partnerships and collaborations to support innovation, capacity-building and behaviour change. The current TIS program offers flexibility in how the activities are delivered at local and regional levels, targeting approaches for specific groups with a focus on the outcomes to be achieved, rather than being prescriptive in relation to the activities to be delivered. The program also includes support for effective monitoring and evaluation of activities built into activity planning and linked to activity objectives and outcomes.

The specific objectives of the current iteration of the TIS program are to:

Overall

1. Reduce gap in prevalence of smoking among Aboriginal and Torres Strait Islander people compared to that among non-Indigenous people, through accelerated reductions in the uptake of smoking and an increase in sustained cessation

2. Reduce exposure to second-hand smoke in cars, homes, workplaces, community areas and events

Population health and tobacco control initiatives

3. Increase community involvement and support for tobacco control initiatives by including communities in the design and delivery of programs

4. Increase use of a multi-component and evidence-based intervention approach that includes elements such as community education, quit support groups, and youth-based interventions

5. Build positive attitudes and social norms around reducing tobacco use

6. Increase understanding of health impacts of smoking and pathways to quitting

7. Increase quitting intentions and number of quit attempts among Aboriginal and Torres Strait Islander people, especially among pregnant women

8. Reduce exposure to second-hand tobacco smoke

Access to quit support

9. Increase uptake of services supporting quitting through partnerships and collaborations built through TIS

10. Increase in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people

Capacity development for tobacco control initiatives

11. 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

12. Identify and promote use of evidence to enhance quality and relevance of tobacco control approaches

13. Promote innovation in tobacco control initiatives and contribute to evidence base

Coordination, Leadership and Advocacy

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

TIS program delivery

The key components of the TIS program are outlined below:

◖ **Regional tobacco control grants (grant recipients**): 37 organisations across Australia were provided with funding to undertake multi-level approaches to tobacco control, which combine evidence-based tobacco control activities with a focus on measurable outcomes for reducing smoking rates. Regional grant recipients had the flexibility to select evidence-based approaches that suited the local context and utilised their strengths.

◖ **National Best Practice Unit Tackling Indigenous Smoking (NBPU TIS):** supported regional grant recipients to plan and implement an evidence-based, outcomes-focused approach to reduce smoking among Aboriginal and Torres Strait Islander peoples. NBPU TIS provided support from project planning through to generating evidence that feeds into outcomes that maximise the effectiveness of the TIS program.

- **National Coordinator Tackling Indigenous Smoking:** this role provided high-level advice regarding the approach for the TIS program, and practical leadership and advocacy in the national implementation of the program, having regard for traditional culture and values. This role is currently filled by Professor Tom Calma.

- **Innovation Grants:** aimed to increase the evidence-base on effective tobacco control activities and reduce smoking prevalence in remote areas, for pregnant women and for young people, through collaborative partnerships between research organisations and service providers.

- **Quitline enhancements:** aimed to improve the capacity of Quitline services to provide accessible and appropriate services to Aboriginal and Torres Strait Islander people, including young people, pregnant women and new mothers. The funds supported employment of Indigenous staff, and training and resources for all Quitline staff.

- **Quitskills training:** brief intervention and motivational training in best-practice intervention methods aimed at increasing the number of suitably trained and qualified professionals working with Aboriginal and Torres Strait Islander smokers and their communities.

- **National evaluation:** CIRCA have been independently commissioned by the Department of Health to assess the effectiveness and appropriateness of the TIS program overall and how well the TIS program is progressing towards achieving long-term outcomes.

Evaluation of the TIS program

The Cultural and Indigenous Research Centre Australia (CIRCA) was contracted to conduct an evaluation of the national TIS program, in collaboration with the Incus Group, Renee Williams and Professor Shane Hearn (University of Adelaide). The purpose of this evaluation is to assess the TIS Program in terms of:

- level of change that has occurred through the TIS program (effectiveness)

- fit between the TIS program and the needs of Aboriginal and Torres Strait Islander communities (appropriateness)

- how well the TIS program is progressing towards achieving the long-term outcomes

Long-term impact in relation to a reduction of smoking rates is outside the scope of this evaluation. This evaluation focuses on the short and medium-term impact of the TIS program. In so doing, the national evaluation assesses the progress made by the TIS program towards achieving the long-term outcomes.

There are many local and national tobacco control initiatives and the TIS program operates within this broader environment. This is a key consideration for the national evaluation of the TIS program in relation to attributing change to the program, as other variables impact on outcomes.

The Monitoring & Evaluation (M&E) Framework for the TIS program was finalised in June 2016. The development of the M&E Framework was underpinned by the evidence-base on tobacco control programs, the TIS program design and feedback from key stakeholders on the evidence for, and design of, the TIS program at the time. These sources were utilised to develop a program logic for the TIS program. The TIS program logic represents the intended outcomes of the TIS program, including the various activities and outputs which will lead to the proposed outcomes in the short, medium and longer term (see program logic below). The outcomes for Aboriginal and Torres Strait Islander individuals and communities and at the service system level have been identified, to reflect the broad focus of the TIS program. This fits within the overarching logic for the Indigenous Australians' Health Programme (IAHP).

This M&E Framework provided overall guidance and context for the monitoring and evaluation activities, insofar as it provides:

◖ the questions to be answered by the national evaluation and the data sources that can be used to answer these questions, including data collected periodically by CIRCA, and monitoring data collected on an ongoing basis by grant recipients.

◖ the basis for the development of five nationally consistent performance indicators – TIS Performance Indicators that are based on the objectives of the TIS program, used by grant recipients for compliance and continuous improvement, and which can be used to support the evaluation.

◖ guidance for grant recipients when developing additional indicators with outcome measures for informing their practice and which could also be used for the national evaluation.

Methodology

The evaluation employed a mixed methods design. A combination of qualitative and quantitative evaluation data (data collected specifically as part of the evaluation) and monitoring data (data collected routinely as part of TIS program monitoring) have been used in the evaluation. Data was collected over two years in two waves (September to November 2016 and August to November 2017). CIRCA received ethics approval from ten Human Research Ethics Committees and four research sub-committees for the evaluation. The stages of the evaluation are illustrated below.

Ethics (Jul-Aug 2016) › Wave 1 data collection (Sep-Nov 2016) › Wave 1 analysis and reporting (Dec 2016-Feb 2017) › Preliminary evaluation report (Mar 2017) › Wave 2 data collection (Aug-Nov 2017) › Wave 2 analysis and reporting (Dec 2017-Feb 2018) › **Final report (Apr 2018)**

Data collected in wave 1 was analysed to produce the TIS Preliminary Evaluation Report. This mid-term evaluation of the TIS program was used to inform the ongoing funding of TIS from June 2017 to the end of the funding cycle (June 2018). Wave 2 data collection utilised the same methodologies as wave

1 to expand on the findings described in the TIS Preliminary Evaluation Report. Collectively, data from wave 1 and wave 2 were used to produce this Final Evaluation Report of the TIS program.

Extensive qualitative consultations were conducted over both waves of data collection. Qualitative data was collected during 16 site-visits to TIS grant recipients where consultations were conducted with TIS staff, 102 Aboriginal and Torres Strait Islander community members and 79 primary stakeholders (i.e. internal and external partners). In-depth telephone interviews were conducted with regional TIS grant recipients that did not receive a site visit. In-depth interviews were also conducted with seven innovation grant recipients by telephone in wave 2. Secondary stakeholders were also involved in in-depth interviews over the two waves, including with NBPU TIS staff, National Coordinator TIS and Quitline staff. Consolidated feedback from the Department TIS Policy Team and Health Grants and Network (HG&N) was also provided in the form of a written response over the two waves.

Survey data was collected from an online survey of TIS Managers and staff with a total of 189 responses over two waves, and an online survey of primary stakeholders with a total of 92 responses. Over the two waves, all survey respondents were asked open-ended questions around the achievements and challenges of the TIS program. Respondents were also presented with a series of statements framed around progress against the TIS performance indicators and asked to rate the extent to which they agree on a Likert scale.

Monitoring and evaluation data was collected from 74 regional grant recipient performance reports which included routinely collected monitoring data and information on their TIS activities and report outputs and outcomes against the five national TIS Performance Indicators. In addition, Quitline referral data and a Quitskills evaluation report were also key data sources for this evaluation.

Findings

Community engagement and partnerships

Community trust and support has been integral to the success of the TIS program and the considerable investment made by grant recipients in consultation, collaboration and community engagement has resulted in increases in the number of individuals and organisations involved in tobacco control. Evidence of community consultation and engagement included the development of community reference groups, yarning sessions with Elders, youth leadership groups and participation in key regional advisory groups. The findings from this evaluation suggest that the short-term outcome: 'increased community involvement and support' has been met.

The informal and flexible approach to community engagement adopted by TIS teams, along with the participation of TIS staff from the local community was recognised as important in increasing community support for tobacco control initiatives and influencing positive changes to social norms. While significant progress has been made in this area since the mid-term evaluation, it is important to acknowledge that building and maintaining trust with community is a time intensive and ongoing process that requires significant resource allocation.

Building partnerships and collaboration has resulted in significant growth in the number of local organisations and range of sectors involved in tobacco reduction as the TIS program has linked health services to other initiatives in education, employment, housing, justice, local councils and community-

based organisations. This has enabled the TIS program to share resources, strategies and activities and increase the importance of tobacco control and referral pathways for quitting. The breadth and range of partnerships suggests that the short-term outcome: 'collaborations and partnerships built between TIS operations and external support for quitting' has been met.

Strong internal partnerships in grant recipient organisations have also been developed linking health promotion with clinical services and ensuring that clients receive an integrated pathway of care, with a team of health professionals working together to provide support. This approach has also strengthened referral pathways and increased access to priority populations such as pregnant women.

Localised health promotion

This evaluation has found that the adoption of a localised, multi-level approach has resulted in the TIS program meeting several of its short-term outcomes outlined under localised health promotion in the TIS program logic, this includes an increased focus on priority groups, increased leadership and advocacy role of community leaders, increased understanding of the health impacts of smoking and of quitting pathways and an increase in smoke-free homes, workplaces and public spaces. Collectively, through meeting these short-term outcomes, the TIS program is on track to meeting other short-term outcomes such as the reduction in opportunistic smoking behaviours and medium and long-term outcomes.

Community events and modelling the message

Community events have been a crucial opportunity to build trust and engagement with community, and a key foundation for TIS activities. Events often involved Local champions (i.e. a community member who has recently quit) and Elders, although some grant recipients indicated difficulties with engagement with Elders. Local TIS workers and local champions played an essential role in modelling the message at these events, with opportunities to influence family, peers and community members around smoking cessation.

Social marketing

Grant recipients have developed multiple social marketing campaigns to target different groups such as pregnant women and young people, and different aspects of tobacco control such as smoke-free homes and cars or quitting support. Campaigns largely celebrated 'local faces and local places' and were framed with a strengths-based approach, and included local TIS branding, resources and merchandise. The evaluation found that while awareness of TIS campaigns are high, the extent of their impact is uncertain due to the difficulties in evaluating such campaigns, although some grant recipients have commissioned independent evaluations of campaigns.

Targeted approaches for specific groups

Targeted approaches to priority populations were adopted by grant recipients to ensure a population health approach. Young people featured prominently across the country, with school-based interventions and recreational activities with a tobacco focus adopted to engage this cohort. Pregnant women were targeted through collaborations with antenatal clinics and existing groups such as Mums and Bubs. While progress has been made in engaging this cohort, sensitivities around tobacco use in

pregnancy has presented challenges to accessing this group. Over the course of this evaluation, prison populations have become a growing area of focus, with grant recipients delivering education and group counselling sessions to inmates.

Smoke-free environments

Analysis of qualitative data, survey and performance report data revealed an increase in activity around smoke-free environments. Grant recipients have reported updating internal workplace policy and supporting external workplaces to implement and/or update their workplace policy. Challenges remain in garnering support for smoke-free workplaces where senior leaders or Board members smoke and within organisations where tobacco control is not the main priority. Grant recipients are also contributing to positive changes to social norms (a medium-term outcome of the TIS program) by ensuring all events are smoke-free and promoting smoke-free public spaces and homes and cars. Community members have reported shifts in attitudes around second-hand smoke and shifts in behaviour, for example, no longer smoking around children and delaying a cigarette.

Access to quit support

New referral pathways have been established for community members to achieve cessation including clinic-based referral and referrals made during localised TIS health promotion activities, extending reach and increasing the number of referral access points. External partnerships have further increased referral access points and community engagement with localised TIS programs.

Improving access to culturally appropriate support to quit has been a key focus of the work of grant recipients throughout this iteration of the TIS Program. Typically, this quit support is provided either one-on-one or through a smoking cessation group, with some community members also referred through to Quitline. Evaluation findings suggests one-on-one support is the preferred option for many community members and is widely used by grant recipients in rural and remote areas. However, there is also evidence that smoking cessation groups have been effective in providing opportunities for smoking cessation support.

Quitline enhancements are a component of the TIS program. Data from Quitline bodies across the country indicate that the total number of Aboriginal and Torres Strait Islander referrals to Quitline has increased throughout the evaluation by 12%. Notably, 60% of the referrals continue to be from Queensland. Qualitative consultations suggest Quitline activity is higher in urban and some rural areas in comparison to remote areas. This may be due to infrastructure and language barriers together with a preference for face-to-face cessation support in these contexts. Grant recipients continue to report the need for Quitline to share data on the outcome of their referrals.

Increasing the skills of TIS workers and other professionals in contact with Aboriginal and Torres Strait Islander people to provide smoking cessation education and brief intervention has been a key focus for grant recipients. Quitskills training and to a lesser extent other smoking cessation education programs have been used to broaden the knowledge and skill base of TIS workers and stakeholders. The increases in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people is a key short-term outcome identified in the TIS program logic that has been met and has contributed to the delivery of culturally appropriate, high quality quit support.

Contribution to a larger evidence base

A key finding of this evaluation is that the increased focus on outcomes in the redesigned TIS program has been successfully implemented. Data collection has been a core component of the TIS program with grant recipients working internally to improve data collection systems by embedding measures into existing electronic health records and integrating health promotion and clinical practice. While the quality of performance data has improved significantly, opportunities remain to improve the consistency and quality of data including through the provision of constructive feedback and a more structured reporting template.

There has been an increased focus by grant recipients on evidence-based activities and outcomes-based approaches in response to support provided by NBPU TIS including through the TIS portal, M&E workshops, Quitskills training, national and jurisdictional workshops and one-on-one support. Findings from the evaluation suggest that this has led to the following short-term outcomes being met: increases in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people, and improved local Aboriginal and Torres Strait Islander capability in the collection, analysis and recording of program.

While most grant recipients were appreciative of the support and the education and training opportunities provided by NBPU TIS, some reported a need for more intensive support while others found the support role provided by NBPU less useful, however, these were often organisations that had existing expertise in M&E and data collection.

Throughout the evaluation, attendance at jurisdictional and national workshops has been consistently high, and the workshops were recognised as valuable opportunities for grant recipients to network and learn from each other. NBPU TIS communication with grant recipients has improved since the mid-term evaluation although some grant recipients still had concerns in relation to information requests made to NBPU TIS not being met.

While some innovation grants have been slow to implement project activities due to unforeseen delays, they have gained momentum with some projects producing valuable interim results and on schedule to provide significant data as the projects conclude. The innovation grants are currently seen by regional grants, NBPU TIS and innovation grants themselves as isolated from the rest of the TIS program. Promoting innovation grant findings will be a crucial step in contributing to the evidence base and supporting regional grant activities.

Overarching TIS program

Elements of the redesigned TIS program have been crucial to the success of the program. The transition to tobacco action as the primary focus has allowed grant recipients to be more focused on tobacco reduction and to contribute to measurable tobacco-related outcomes. The flexibility of the TIS program design and place-based approach has also allowed for tailored, culturally appropriate and targeted tobacco control that responds to local situations and areas of highest need, thus maximising impact.

Throughout this evaluation, grant recipients and HG&N have expressed confusion around the TIS program communications, specifically regarding funding parameters and the role and functions of the various 'players', namely the Department, NBPU TIS, HG&N, the evaluator (CIRCA), and regional and innovation grant recipients. Since this was identified in the mid-term evaluation, NBPU TIS and the Department have taken active steps to increase clarity through jurisdictional workshops and National Coordinator monthly messages to TIS grant recipients, and although this has improved understanding, some confusion persists.

The consensus among stakeholders and grant recipients is that the National Coordinator is a pivotal component of the TIS program and Professor Calma's extensive network and access to Ministers, decision-makers and CEOs of Indigenous organisations was seen as instrumental to the success of the role. While work in the first year was focused on supporting grant recipients with the transition, the second year has been focused on site visits to individual grant recipients and strengthening leadership support for tobacco control as this was identified as an issue in the mid-term evaluation. This is in addition to the ongoing advice provided to the Department, national advocacy for TIS and Indigenous tobacco control and support, participation in national and jurisdictional workshops and monthly messages through the NBPU TIS email updates.

Key challenges to overall TIS program success were identified by grant recipients and stakeholders. These included transitioning to the redesigned TIS program (i.e. concurrent process of setting up NBPU TIS, finalising M&E framework, commencing regional grants program and time needed to adjust to new program) short-term funding cycles and staff retention, program underspend and issues around NRT funding. Grant recipients and stakeholders identified senior leadership as a key facilitator for success. Where leadership support was lacking in some areas, grant recipients reported delays and challenges to implementing TIS activities such as smoke-free workplace policies.

The complexities of operating in a remote and some rural contexts was also highlighted and the importance of appreciating this context when evaluating progress was emphasised. A consistent recommendation reported by participants to address most of these challenges is the desire for a commitment to long-term funding (at least four years).

Conclusions

This evaluation concludes that the redesigned TIS program has been successful in meeting its short-term outcomes and consistent with the mid-term evaluation, recommends that the TIS program continue, with reinforcement of some key activities and minor changes to program design to address the challenges to program success identified through the evaluation (see recommendations below). In meeting its short-term outcomes, the TIS program is well on track to achieving its medium-term and long-term outcomes, which include the reduction in exposure to second-hand smoke and a reduction in the gap in prevalence of smoking between Aboriginal and Torres Strait Islander people and non-Indigenous people.

The current iteration of the TIS program, through its flexible design and place-based, population health approach has been found to be appropriate in reducing the high smoking rates among Aboriginal and Torres Strait Islander people. The impact of the regional grants program (the largest component of the

TIS program funding) in the short-term has been demonstrated by the growth in partnerships and community engagement, the delivery of multi-level and locally relevant health promotion for tobacco control, increased access to culturally appropriate quitting support through growing referral networks, and an increase in the use of evidence to inform program design and improvement.

This progress has been facilitated by the ongoing flexibility in funding and the program design elements, including an emphasis on evidence-based activities and outcomes-based reporting, shifting tobacco action as the primary focus, and promotion of targeted approaches for priority groups, specifically young people and pregnant women. In addition, national support provided by Quitline enhancements, Quitskills, the NBPU TIS and leadership and advocacy of the National Coordinator TIS to regional grant recipients has contributed to the overall success of the program. Specifically, the information around best practice, M&E and smoking cessation training, and platforms for communication (i.e. TIS portal and workshops) provided and coordinated by the NBPU TIS and endorsed by the National Coordinator has contributed to building the capacity of regional grant recipients to support quitting, share best practice and monitor and evaluate activities.

While considerable progress has been made throughout this evaluation, challenges have been identified in relation to program delivery, data collection and evidence, and overarching TIS program communications and governance. In terms of local program delivery, competing priorities in community, particularly in some remote and rural settings and a lack of buy-in from senior management in some regions, has delayed the implementation of local TIS activities such as smoke-free policies. Regarding the evidence base, the desire for standardised indicators has been expressed by regional grant recipients, particularly due to challenges in measuring the impact (i.e. behavioural change) around health promotion activities. Some grant recipients also reported that support from the NBPU TIS should come as needed and requested more from the NBPU TIS than is currently in scope of their role (e.g. constructive feedback on performance reports and evidence reviews). The contribution of the innovation grants to the larger evidence base is yet to be seen, this is largely related to delays in implementation and time needed to evaluate such programs.

Although communication about the TIS program has improved, some confusion around funding parameters (NRT and healthy lifestyle activities) and the roles of the various 'players' involved in the TIS program persists which has impacted the provision of support and local program design. Furthermore, the concurrent contracting of regional grants, NBPU TIS and CIRCA evaluators meant that the necessary framework and foundations for the program were not in place prior to local TIS program delivery. Short-term funding cycles continue to be an issue impacting long-term planning, staff retention and concomitant underspend. The challenges presented across the TIS program are magnified for remote and some rural grant recipients, who face additional environmental and socio-cultural challenges.

Despite these challenges the redesigned TIS program has demonstrated considerable progress since 2015 in delivering multi-level health promotion around tobacco control together with culturally appropriate quitting support. This has been supported through the NBPU TIS, the National Coordinator, Quitskills training, and enhanced Quitlines, which have contributed to strengthening an appropriate response to tobacco control in Aboriginal and Torres Strait Islander communities.

On February 11 2018, the Australian Government announced that the TIS program would continue, with a commitment of $183.7 million over 2018-19 to 2021-22. The decision to extend the funding of the TIS program for a longer term, together with the early announcement four months prior to funding contract end dates, addresses key recommendations for the Government from the mid-term evaluation and this final evaluation of the TIS program. The four-year TIS program will have a renewed focus on population health approaches and health promotion, focusing on strengthening the skills and capabilities of TIS employees across the country to bring about changes to social norms to ultimately reduce the impact of smoking on the Aboriginal and Torres Strait Islander population. Recommendations for the future iteration of the TIS program are detailed below.

Recommendations

Community engagement and partnerships

1. **Regional grant recipients:** Continue involving community members in the design, delivery and evaluation of local TIS programs and sustain use of partnerships to broaden reach, strengthen referral pathways, and support other program objectives including preventing uptake, promoting expansion of smoke free spaces, and changing social norms.

Localised health promotion

2. **Regional grant recipients:** Continue delivering targeted, multi-level, tobacco-focused health promotion.

3. **NBPU TIS:** Provide additional training and information on best practice, multi-level, tobacco-focused health promotion for targeted groups including pregnant women.

Access to quit support

4. **Regional grant recipients:** Support organisations across their region to develop capability to provide and / or refer to culturally appropriate quit supports.

5. **Quitline / Regional grant recipients:** Increase data sharing between Quitline and regional grant recipients and collaboration where appropriate.

6. **NBPU TIS:** Consider access issues to workforce development training with suitable training options for different contexts.

7. **Department:** Explore opportunities to support information sharing between Indigenous Quitline Enhancement Project services across Australia.

Contribution to evidence base

8. **Department / Evaluator:** Review performance report and action plan templates to develop consistent data collection and reporting prior to the next iteration of the TIS program.

9. **Department:** Implement a succinct 6-month interim report and more in-depth 12-month annual report to provide a clearer picture of progress.

10. **NBPU TIS:** Provide tiered support to regional grant recipients aligned to their needs.

11. **Department:** Consider broadening the scope of NBPU role to include:
    i.   Constructive feedback to all grant recipients on outcomes from activities in their performance reports
    ii. Provision of evidence summaries of best practic

12. **NBPU TIS:** Implement a national workshop specifically for TIS workers to share and learn best practice.

13. **NBPU TIS:** Increase the promotion of new items on the TIS portal to TIS-funded and other organisations.

14. **Department:** Share innovation grant recipient results with regional grant recipients.

15. **Department:** Review the innovation grant recipient component of the program.

16. **Department:** Consider the inclusion of a comparison group (i.e. regions not resourced through TIS) for future evaluations to examine program outcomes.

Overarching TIS program

17. **Department:** Continue the delivery of the TIS program.

18. **Department:** Commit to funding longer term (at least 4 years) and provide immediate advice about future funding to minimise funding uncertainty and associated staff turnover and underspend.

19. **Department / NBPU TIS:** For regional grant recipients that are at risk of underspend, explore the need for information sharing and early engagement between TIS teams, grant officers and NBPU TIS.

20. **Department / NBPU TIS:** Continue to reinforce the funding parameters and rationale behind these parameters (e.g. no NRT funding, one-one-one interventions) and provide greater clarity about the roles and functions of the various stakeholders in the TIS program, and provide opportunities for greater collaboration where required.

21. **Department:** Ensure future implementation of any redesigned program has the necessary foundations established (i.e. Monitoring &Evaluation Framework, Performance Indicators, and other supporting components), as far as possible, prior to service delivery.

22. **Department:** Explore strategies to address the challenges that are magnified in remote and some rural contexts.

23. **NBPU TIS:** Provide a greater focus on the principles and practices of health promotion in jurisdictional workshops for regional grant recipients.

24. **NBPU TIS:** Continue to support leadership development by engaging CEOs and Board Members from TIS and non-TIS funded organisations in leadership workshops facilitated by the National Coordinator. Monitor the outcomes of these workshops.

25. **Department**: Some Aboriginal and Torres Strait Islander people live in areas not serviced by regional TIS teams. Consider how best to support tobacco control in these regions e.g. national social marketing campaigns, Quitline enhancement, TIS portal and workshops, and activities not funded by TIS.

1. TIS program background

Tobacco is one of the leading contributors to the burden of disease among Aboriginal and Torres Strait Islander peoples. The overall goal of the national Tackling Indigenous Smoking (TIS) program is to improve the health of Aboriginal and Torres Strait Islander peoples through local population specific efforts to reduce harm from tobacco. The program supports culturally appropriate and tailored tobacco control interventions that supplement broader measures for tobacco control such as plain packaging and excise duties.

1.1 The delivery of the TIS program

Between 2010 and 2015, Commonwealth action to address Aboriginal and Torres Strait Islander smoking was delivered through the multi-component Tackling Indigenous Smoking and Healthy Lifestyle (TIS&HL) program, a key element of which were regional grants to establish a dedicated workforce to reduce Indigenous smoking rates and increase healthy behaviours. The TIS&HL program was revised following a review of the program in 2014[1] and focused on: the use of multi-component tobacco control strategies, using and promoting best practice approaches to tobacco control, and building partnerships and collaborations to support innovation, building organisational capability, and behaviour change.

The TIS program consists of several complementary components, including grant funding for regional tobacco control activities, a range of national supports for implementation, performance monitoring and evaluation, enhanced Quitlines, training and leadership and coordination.

Each of the key components of the TIS program are outlined below:

◖ **Regional tobacco control grants (grant recipients**): 37 organisations (see Appendix 1 for list of organisations) across Australia have been provided three year funding to undertake multi-level approaches to tobacco control, which combine a range of evidence-based tobacco control activities with a focus on measurable outcomes for reducing smoking rates. Organisations involved in rolling out the program have flexibility to select evidence-based mechanisms and tools to reduce tobacco use within their region, that suit the local context and utilise their strengths.

◖ **National Best Practice Unit TIS (NBPU TIS):** The objective of the NBPU TIS is to support grant recipients to plan and implement an evidence-based, outcomes-focused approach to reduce smoking by Aboriginal and Torres Strait Islander peoples. Support from the NBPU TIS is being provided from project planning through to generating evidence that feeds into delivery and outcome improvements to maximise the effectiveness of the TIS program.

◖ **National Coordinator Tackling Indigenous Smoking:** The National Coordinator role includes providing high-level advice and insights to assist in the shaping of policy and approach for the TIS program and providing practical leadership and advocacy in the national implementation of the program, having regard for traditional culture and values.

◖ **Innovation Grants:** The Innovation Grants support innovative and intense activities to reduce smoking prevalence in remote areas, for pregnant women and for young people vulnerable to entrenched cultural norms of smoking, through collaborative partnerships between research organisations and service providers. The aim is to increase the evidence-base on the implementation of effective tobacco control activities in regions or sub-populations requiring special attention and enable intense work in these areas of need.

◖ **Quitline enhancements:** The Quitline enhancement grants aim to improve the capacity of Quitline services to provide accessible and appropriate services to Aboriginal and Torres Strait Islander people, including young people, pregnant women and new mothers. The funds support employment of Aboriginal and Torres Strait Islander staff, as well as training and resources for all Quitline staff.

◖ **Quitskills training:** Brief intervention and motivational interviewing training in best-practice intervention methods aimed at increasing the number of suitably trained and qualified professionals working with Aboriginal and Torres Strait Islander smokers and their communities.

◖ **National evaluation:** CIRCA have been independently commissioned to assess the impact and appropriateness of the TIS program overall and how well the TIS program is progressing towards achieving long-term outcomes.

Figure 1. The TIS program components 2015-2018

1.2 TIS program objectives

The principles of the redesigned TIS program provide the rationale for the TIS program objectives, as follows.

Overall objectives of the TIS program (long-term)

	1. Reduce gap in prevalence of smoking among Aboriginal and Torres Strait Islander people compared to that among non-Indigenous people, through accelerated reductions in the uptake of smoking and an increase in sustained cessation
	2. 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	**3.** Increase community involvement and support for tobacco control initiatives by including communities in the design and delivery of programs
	4. Increase use of a multi-component and evidence-based intervention approach that includes elements such as community education, quit support groups, and youth-based interventions
	5. Build positive attitudes and social norms around reducing tobacco use
	6. Increase understanding of health impacts of smoking and pathways to quitting
	7. Increase quitting intentions and number of quit attempts among Aboriginal and Torres Strait Islander people, especially among pregnant women
	8. Reduce exposure to second-hand tobacco smoke
Access to quit support	**9.** Increase uptake of services supporting quitting through partnerships and collaborations built through TIS
	10. Increase in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people
Capacity development for tobacco control initiatives	**11.** 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	**12.** Identify and promote use of evidence to enhance quality and relevance of tobacco control approaches
	13. Promote innovation in tobacco control initiatives and contribute to evidence base
Coordination, Leadership and Advocacy	**14.** Improve leadership and advocacy in tobacco control at the national and regional level

2. Evaluation of the TIS Program

The Cultural and Indigenous Research Centre Australia (CIRCA) was contracted to develop the Monitoring and Evaluation Framework for the TIS program and conduct an evaluation of the national TIS program. The purpose of this evaluation was to assess the TIS program in terms of:

◖ level of change that has occurred through the TIS program (effectiveness)

◖ fit between the TIS program and the needs of Aboriginal and Torres Strait Islander communities (appropriateness)

◖ how well the TIS program is progressing towards achieving the long-term outcomes

Long-term impact in relation to a reduction of smoking rates at the national level is outside the scope of this evaluation. The national evaluation is instead focusing on the short and medium-term impact of the TIS program. In so doing, the national evaluation assesses the progress made by the TIS program towards achieving the long-term outcomes.

2.1 Monitoring and Evaluation Framework

The Monitoring & Evaluation (M&E) Framework for the TIS program was finalised in June 2016. The development of the M&E Framework was underpinned by the evidence-base on tobacco control programs, the TIS program design and, at the same time, feedback from key stakeholders on the evidence for, and design of, the TIS program. These sources were utilised to develop a program logic for the TIS program. The TIS program logic represents the intended outcomes of the TIS program, including the various activities and outputs which will lead to the proposed outcomes in the short, medium and longer term (see program logic below). The outcomes for Aboriginal and Torres Strait Islander individuals and communities and at the service system level have been identified, to reflect the broad focus of the TIS program. This fits within the overarching logic for the Indigenous Australians' Health Programme (IAHP).

This M&E Framework provides overall guidance and context for the monitoring and evaluation activities, insofar as it provides:

◖ the questions for the national evaluation (see Appendix 2), and the data sources that can be used to answer these questions, including data collected periodically by CIRCA, and monitoring data collected on an ongoing basis by grant recipients.

◖ the basis for the development of five nationally consistent performance indicators – TIS Performance Indicators (see Appendix 3) that are based on the objectives of the TIS program, used by grant recipients for compliance and continuous improvement, and which can be used to support the national evaluation.

◖ guidance for grant recipients when developing additional indicators with outcome measures for informing their practice and which could also be used for the national evaluation.

Contextual factors: State and territory tobacco control activities, previous TIS activities, existing service infrastructure, location and population profile variations, regional population coverage, National Tobacco Campaign

Inputs	Outputs	Short term outcomes	Medium term outcomes	Long term outcomes

Localised health promotion

Regional grants health promotion

Innovation grants intense services

Implementation of strategies targeting priority groups including pregnant women and young people

Deliver multi-level, evidence based and locally relevant health promotion for tobacco control

Implementation of community supported strategies

Increased community/ regional involvement and support

Increased understanding of the health impacts of smoking and of quitting pathways

Increased self-efficacy and desire to quit

Increased leadership and advocacy role of community leaders

Increase in smoke free homes, workplaces & public spaces

Increased focus on priority groups

Reduce opportunistic smoking behaviours

National support for regional grants

National Coordinator

National Best Practice Unit

Provide evidence and support to funded organisations to focus on outcomes and use of evidence

Full implementation of the redesigned TIS program outcomes focus

TIS operations guided and supported. Effective approaches adopted through flexible funding and use of evidence

Access to quit support

Enhanced Quitlines

Quitskills funded

Referrals to medical support

Referring to or operating local counselling (individual & group)

Provide range of opportunities for achieving cessation

Deliver training for supporting people to quit

Improved access to culturally appropriate support to quit

Collaborations and partnerships built between TIS operations and external support for quitting

Increases in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people

Larger evidence base

Facilitation of local data collections

National Best Practice Unit

Innovation grant results

National evaluation

Infrastructure in place for collecting, analysing, recording and sharing results

Improved access to information of what works and what does not, particularly for vulnerable populations

Improved local Aboriginal & Torres Strait Islander community capacity in the collection, analyses and recording of program evaluation data.

Medium term outcomes

Positive changes to social norms

Increases in individuals wanting to quit

Increase in number and length of quit attempts

Reductions in amount smoked where cessation not achieved

Reduced exposure to second-hand smoke

Improved quality and relevance to local services of evidence on health promotion

Increased effectiveness of quitting pathways through collaborations and partnerships of various services and organisations

Long term outcomes

Reduced gap in prevalence of smoking among Aboriginal and Torres Strait Islander people compared to that among non-Indigenous, through
- Reducing uptake of smoking
- Increasing smoking cessation

Reduced exposure to second-hand smoke

PROGRAM DESIGN ELEMENTS
- Tobacco action as primary focus
- Flexible and responsive
- Population health approach
- Modelling the message
- Place-based
- Evidence based
- Targeted approaches for specific groups
- Effective monitoring & evaluation
- Outcomes-based
- Sharing best practice
- System building

3. Methodology

The evaluation employed a mixed methods design. A combination of qualitative and quantitative evaluation data (data collected specifically as part of the evaluation) and monitoring data (data collected routinely as part of TIS program monitoring) have been used in the evaluation. Data was collected over two years in two waves (September to November 2016 and August to November 2017). The stages of the evaluation are illustrated below.

3.1 Ethics

CIRCA received ethics approval from ten Human Research Ethics Committees (HREC) and four research sub-committees for the evaluation (see Table 1).

Table 1. *List of ethics committees*

HREC Committee	Jurisdiction
Department of Health	National
Far North QLD HREC	Cape/North QLD
Aboriginal Health and Medical Research Council of NSW (AH&MRC)	NSW
Western Australian Aboriginal Health Ethics Committee (WAAHEC)	WA
Aboriginal Health Council of South Australia (AHREC)	SA
NT Dept of Health/Menzies Committee	NT Top End
Central Australian Committee (CAHREC)	NT Southern and Barkley
UTAS Social Sciences HREC	TAS
St Vincent's Hospital Melbourne HREC	VIC
Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS)	ACT

Research sub-committee	Jurisdiction
Institute for Urban Indigenous Health (IUHI)	South QLD
Central Australia Aboriginal Congress	NT - Alice Springs
Nunkuwarrin Yunti	SA
Kimberley Aboriginal Health Planning Forum (KAHPF)	WA - Kimberley

3.2 Data collection and analysis

Data was collected over two years between September to November 2016 (wave 1) and August to November 2017 (wave 2). Data collected in wave 1 was analysed to produce the TIS Preliminary Evaluation Report. This mid-term evaluation of the TIS program was used to inform the ongoing funding

of the TIS program from June 2017 to the end of the funding cycle (June 2018). Wave 2 data collection utilised the same methodologies as wave 1 to expand on the findings described in the TIS Preliminary Evaluation Report. Collectively, data from wave 1 and wave 2 were used to produce this Final Evaluation Report for the TIS program. A summary of data collection methods and sources can be found in Table 2.

Data was broadly analysed at a national level. Grant recipients and stakeholders have been classified, based on the postcode of their main office, into three categories per the Australian Statistical Geography Standard (ASGS) Remoteness Structure: Remote (includes 'Very Remote' and 'Remote' Australia); Rural (includes 'Outer Regional' and 'Inner Regional' Australia); and Urban (includes 'Major Cities' of Australia).

Table 2. *Wave 1 (Sep-Nov 2016) and wave 2 (Aug-Nov 2017) data collection methods and sources.*

Data collection methods and sources	Wave 1 count	Wave 2 count	Total count
Qualitative data			
Site visits (3-5 days) to regional grant recipient organisations to observe TIS activities and conduct qualitative consultations with:	8 site visits	8 site visits	**16 site visits**
TIS staff	24 consultations (n=59 TIS staff)	11 consultations (n=35 TIS staff)	**35 face-to-face consultations with TIS staff**
Aboriginal and Torres Strait Islander community members	18 consultations (n=71 community members)	19 consultations (n=31 community members)	**37 consultations (n=102 community members)**
Primary stakeholders	27 consultations (n=43 stakeholders)	30 consultations (n=36 stakeholders)	**57 consultations (n=79 primary stakeholders)**
Telephone interviews with representatives from remaining TIS teams	29 consultations (n=73 TIS staff)	29 consultations (n=63 TIS staff)	**58 telephone consultations with TIS staff**
Telephone interviews with innovation grant recipient staff via telephone.	N/A	7 in-depth interviews (n=12 innovation grant staff)	**7 in-depth interviews (n=12 innovation grant staff)**
In-depth interviews with secondary stakeholders:			
NBPU TIS	1 in-depth interview (n=4)	1 in-depth interview (n=3)	**2 in-depth interviews**
National Coordinator TIS	1 in-depth interview	1 in-depth interview	**2 in-depth interviews**
Quitline staff	5 in-depth interviews (n=9 Quitline staff)	4 in-depth interviews (n=5 Quitline staff)	**9 in-depth interviews**

Data collection methods and sources	Wave 1 count	Wave 2 count	Total count
Consolidated written response from Department of Health TIS Policy Team and Health Grants and Network to CIRCA TIS program evaluation questions	1 written response	1 written response	**2 written responses**
Survey data			
Online survey for TIS Managers and staff	108 responses	81 responses	**189 responses**
Online survey for primary stakeholders (i.e. internal and external partners working with TIS team)	46 responses	46 responses	**92 responses**
Monitoring and evaluation data			
Regional grant recipient performance reports	37 performance reports	37 performance reports	**74 performance reports**
Quitline referral data at state/territory level for 2016 and 2017	Jan-Dec 2016 Quitline referral data	Jan-Dec 2017 Quitline referral data	**2016 and 2017 annual Quitline referral data**
SAHMRI Quitskills evaluation report with data from 2012 to 2016.	1 Evaluation report		**1 Evaluation report**

3.2.1   Qualitative data

Extensive qualitative consultations were conducted over both waves of data collection with staff from all 37 regional grant recipients, Aboriginal and Torres Strait Islander community members, primary and secondary stakeholders, and all seven innovation grant recipients (wave 2 only). Consolidated feedback from the Department TIS Policy Team and HG&N was also provided in the form of a written response over the two waves. Throughout this evaluation, a total of 16 regional grant recipients were visited for approximately three to five days (8 in wave 1 and 8 in wave 2). A mixture of locations was selected to ensure balanced representation across state and territory and in terms of level of remoteness (see Table 3).

Table 3. *Distribution of site visit locations by level of remoteness and state/territory.*

	Remote	Rural	Urban	Total
QLD	1	-	1	**2**
NSW	-	2	1	**3**
ACT	-	-	1	**1**
VIC	-	1	1	**2**
TAS	-	1	-	**1**
SA	-	1	1	**2**
NT	2	-	-	**2**
WA	2	1	-	**3**
Total	**5**	**6**	**5**	**16**

Site visits were a crucial means of collecting detailed information about regional grant recipient activities, their impact, and facilitators and barriers to successful program delivery. This information was gauged through qualitative consultations with TIS staff, CEOs and other staff at the organisation, external partners and Aboriginal and Torres Strait Islander community members. Community members and primary stakeholders were recruited by TIS teams. Consultations took the form of a semi-structured in-depth interview or focus group discussion (depending on the number of participants). Consultations were facilitated by a CIRCA researcher, who followed a discussion guide. Where possible, consultations with community were led by an Aboriginal researcher.

TIS staff from regional grant recipients that did not receive a site visit in wave 1 (29 grant recipients) and wave 2 (29 grant recipients) were involved either in a focus group discussion or an in-depth interview by telephone. Consultations were facilitated by a CIRCA researcher, following the same discussion guides used for TIS staff during site visits.

Secondary stakeholders included NBPU TIS, National Coordinator TIS, Quitline staff, Innovation grant staff and the Department. Interviews with secondary stakeholders explored grant recipient progress and advancement of the TIS program overall, together with the facilitators and barriers to success. The Department of Health TIS Policy Team in the Indigenous Health Division and grant officers in the Health Grants and Network (HG&N) provided consolidated feedback to questions around the successes and challenges of the program in the form of a written response.

The number of participants involved in qualitative consultations was higher in wave 1 compared to wave 2 (see Table 2). This is due to a greater focus on in-depth interviews over focus group discussions in wave 2. While focus group discussions functioned to provide a platform for allowing all voices to be heard, group discussions delivered over the phone with regional grant recipients were difficult to facilitate and were often led by the TIS manager. Thus, wave 2 consultations prioritised in-depth interviews with TIS Managers and if required 1-3 TIS staff. Site visits were then used to allow for face-to-face discussions with TIS teams including non-managerial staff. Similarly, most primary stakeholder and community consultations in wave 2 adopted a one-on-one in-depth interview approach to allow for more nuanced discussion.

Thematic analysis of all qualitative research findings was conducted to identify themes across the qualitative consultations. This involved a process of data familiarisation, data coding, and theme development and revision. Data was coded and analysed using qualitative software package NVivo. This enabled the identification of key themes to emerge and the richness of the qualitative data to be explored.

3.2.2   Survey data

A survey of TIS staff (via SurveyMonkey) was distributed by email between September to December 2016 with 108 responses collected and again in between September 2017 to January 2018 with 81 responses collected. One explanation for the higher number of responses in the first survey is the over-representation of one grant recipient, due to the size of the TIS team (n=18). Responses from this sub-sample were analysed separately and results were comparable to the wider sample (see Appendix 4 for sample profile).

A survey for primary stakeholders was also undertaken in the same time periods as the TIS grant recipient survey. TIS Managers were contacted and asked to distribute the survey to key internal and external stakeholders (e.g. CEO, school teacher). In total, 46 responses were collected for the first and second survey respectively.

Over the two waves, all survey respondents were asked open-ended questions around the achievements and challenges of the TIS program. Respondents were also presented with a series of statements framed around progress against the TIS performance indicators and asked to rate the extent to which they agree on a Likert scale.

3.2.3   Performance report data

Regional grant recipients are required to routinely collect monitoring data and information on their TIS activities. This monitoring data is presented in the TIS performance reports. The TIS performance reports allow grant recipients to present outputs and outcomes in their TIS activities by reporting on the five national TIS Performance Indicators (see Appendix 3). Throughout this evaluation period, two waves of performance reports have been submitted and provided to CIRCA by the Department. The first were submitted in the period July to September 2016 and the second in February 2017. A third wave of performance reports are due to be submitted in February 2018, however as this is outside the evaluation timeframes, they will not be analysed as part of this evaluation.

Each statement of evidence, including output and outcome data was coded by theme in addition to its source (state/territory and remoteness level of grant recipient), relevant TIS performance indicator, and an assessment of data quality. Quality of data was assessed on a five-point rating scale: high quality; acceptable; promising; poor quality and no data/unable to rate (for descriptors see Appendix 5). Due to the variability in outcome measures and data collection approaches, data could not be aggregated. The distribution of evidence by quality level, indicator and jurisdiction was analysed descriptively.

3.2.4   Quitline referral data and Quitskills evaluation report

Referral data on the number of Aboriginal and Torres Strait Islander referrals to Quitline is collected by the governing bodies for Quitline across the country. Referral data for the 2016 and 2017 calendar year was requested by the Department on behalf of CIRCA. Where available, additional data around referral source (e.g. self-referral, health service) was also requested and provided by some governing bodies. Data was analysed descriptively.

A 2016 evaluation conducted by the South Australian Health and Medical Research Institute of the Quitskills program was used to complement qualitative data collected around Quitskills training. The evaluation included data collected between 2012 to 2016 and explored the impact of the program on knowledge and confidence. Findings from this evaluation have been included in this report.

3.3 Scope and limitations

3.3.1   Assessing long-term impact

The national evaluation of the TIS program is not focused on the long-term impact in relation to a reduction of smoking rates. This level of long-term impact cannot be measured within the timeframe of this evaluation due to several factors including 1) the lack of baseline data, 2) the absence of

population health surveys in the timeframe of the evaluation, 3) lack of time for population level behaviour change to occur and 4) difficulties in attribution. The national evaluation instead focused on the short-term impact of the TIS program. In so doing, the national evaluation assessed the progress made by the TIS program towards achieving the medium and long-term outcomes.

3.3.2   Standardised measures

Qualitative consultations and survey data capture TIS staff and community perceptions of the acceptability, appropriateness, and effectiveness of the TIS program. However, the absence of standardised quantifiable measures in the TIS performance reporting template has hindered the ability to collate data nationally (N.B. not all regional grant recipients are ACCHSs and have access to nKPI data). As such, the evaluation was not able to quantifiably assess the impact of regional grant activities nationally in terms of the number of Aboriginal and Torres Strait Islander people exposed to TIS activities (reach) and the association between the exposure to TIS activities and outcomes in regions (effectiveness). Consistent data measures may need to be considered for future evaluations of the program and is discussed in further detail in section 4.4 Contribution to larger evidence base. However, flexibility is an important feature of the program and is consistent with best practice in Indigenous health approaches. Setting consistent data measures may be difficult due to the variety of intervention approaches, target groups and evaluation methods adopted by grant recipients.

3.3.3   Absence of comparison group

The evaluation scope did not allow assessment of organisations or regions that were not TIS funded (comparison or control group). While the measurement of effectiveness at a population level was not feasible for this evaluation as stated above, without a comparison group it would not have been possible to definitively conclude that changes in smoking prevalence in regions serviced by a TIS team are due to the TIS program, rather than to other factors. Moreover, as the goal of this program is to reduce Aboriginal and Torres Strait Islander smoking prevalence nationally, it is important to understand what is happening in regions not currently serviced by TIS teams. This will be an important consideration for future evaluations of the program.

3.3.4   Local TIS program analysis

The evaluation did not assess the effectiveness of specific local programs (for this assessment to be made, in-depth evaluation of program-specific outcomes is required). Good practices identified through case studies are highlighted throughout this evaluation to promote good practice and the range of implementation approaches adopted by regional grant recipients. These practices are drawn from different settings and, as such, care is required when considering translation of practices into other contexts.

4. Evaluation Findings

Building on the mid-term evaluation of the TIS program, this section explores the appropriateness and acceptability of the redesigned TIS program (2015-2018) and a discussion of how the TIS program is meeting short term outcomes and working towards the medium and long-term outcomes outlined in the TIS program logic (see section 2.1).

Evaluation findings are structured thematically with reference to key components of the TIS program logic. Key themes include:

- **Community engagement and partnerships:** Community involvement and support of local TIS activities. External and internal partnerships for tobacco control.

- **Localised health promotion:** Tobacco control health promotion activities including community events, social marketing campaigns and promotion of smoke-free environments undertaken at the community level and with specific priority populations.

- **Access to quit support:** Referral pathways and appropriate quit support options, and workforce development to support quitting.

- **Contribution to larger evidence base:** Contribution of TIS grant recipients and innovation grants to evidence base with support from NBPU TIS and TIS portal.

- **Overarching TIS program:** TIS program design, communications and governance, high-level advocacy, and challenges to program success.

4.1 Community engagement and partnerships

Community engagement and partnerships have been the foundation for local TIS program delivery and successful health promotion throughout this evaluation. The key short-term outcomes of the TIS program include increased community involvement and support for tobacco control and the establishment of collaborations and partnerships to support quitting. By achieving these outcomes, it is expected that medium-term outcomes will subsequently be met, namely, increased effectiveness of quitting pathways, increased uptake of services supporting quitting, and reduced exposure to second-hand smoke. This section explores the community engagement activities undertaken by regional grant recipients in garnering community support, the growth in partnerships across the region and strengthening of internal collaborations.

4.1.1 Community consultation and engagement

Community engagement is a broad notion encompassing a range of activities, including community consultation, involvement, collaboration and empowerment [2]. Depending on the context, community engagement can vary in size and scope. Evidence suggests that community engagement and participation plays a crucial role in successful health promotion, with studies indicating greater community involvement in health promotion activities can lead to an increase in community motivation and sustainability of initiatives [3] [4].

Qualitative consultations, performance report data and survey data over the course of this evaluation demonstrates the considerable investment grant recipients have made towards community engagement and gains made in terms of the increase in the number of individuals and organisations involved in tobacco control in the region. Many grant recipients have staged their process of community engagement as a continuous cycle of consultation and collaboration (see Figure 2). Most grant recipients, across remote, rural and urban contexts, are at the stage of collaboration with individual community members, Elders and local organisations, with some grant recipients demonstrating aspects of high-level community engagement through empowerment of individuals and organisations to be decision-makers or advocates for tobacco control in the community (see section 4.2.2 on community leaders for further detail).
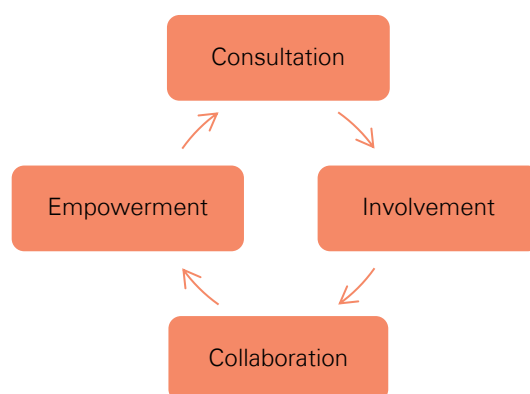
Figure 2. Summary of stages of TIS grant recipient community engagement.

Grant recipients have noted that community trust and support is integral to the success of the TIS program. Within the first year of the revised TIS program, grant recipients invested considerably in building relationships with local services and Aboriginal communities. While progress has been made in this area since the mid-term evaluation, it is important to acknowledge that building trust with community is a time intensive and ongoing process that needs to be allowed for. Responses from the 2017 Grant Recipient survey revealed that maintaining community engagement was cited as one of the most significant challenges. Further, quality and reach of community engagement (indicator 1), remained the highest ranked indicator in terms of resource and budget allocation throughout the evaluation.

> While it has been good to have three years of funding, we are only just at a point of gaining trust and rapport with some communities. Further funding would enable our team to continue to engage with these communities and ensure that we provide sustainable and effective smoking cessation support and smoke-free environments. Grant recipient survey respondent, 2017

The involvement of community members and local organisations in the design, implementation and evaluation of TIS programs featured prominently throughout qualitative consultations and performance report data. This is reinforced by 2017 grant recipient survey data which reported that three quarters (75%) of respondents felt that there has been increased community involvement in tobacco control initiatives in their region.

Primary stakeholders and community members across the country revealed in qualitative consultations that they welcomed the non-didactic, informal approach adopted by TIS teams, as well as the flexibility and adaptability in their approach, as one rural primary stakeholder expressed, 'it's not intruding, it's done in an informal way… questions are asked but not enforced.' Moreover, primary stakeholders and community members indicated that having TIS workers from the community not only strengthened rapport building but facilitated access to Elders and community leaders with whom they have personal relationships.

Evidence of community consultation and involvement included the development of community reference groups, yarning sessions with Elders, youth leadership groups and participation in key regional advisory groups. These consultations ensured that the TIS team responded to the community's needs and were appropriately targeting priority groups. Furthermore, some grant recipients have suggested that this consultative approach, together with community surveys, focus groups and in-depth interviews has strengthened support and community ownership of tobacco control.

> With whatever we do we have always gone to community and consulted with them with what they want … so that we can maximise [community] ownership of it … buy-in of smoke-free environments is slow but steady. Grant recipient, rural, 2017

This is reinforced by grant recipient and primary stakeholder data which showed that 81% and 78% of respondents respectively agreed that there has been increased community support for tobacco control initiatives. This community support and ownership is beneficial for the sustainability of TIS activities and for influencing positive changes to social norms, a medium-term outcome of the TIS program.[5]

> … the community is a driver and supports the programs, it gives and gives back. The support the quit smoking team gives us, we love to advocate for them to help more people from the support given to us. Community member, urban, 2017

WORKING TOGETHER FOR CHANGE

Working together with communities was the key to success for Apunipima Cape York Health Council (remote Queensland) when developing videos, radio, posters and social media resources.

Filming and recording in communities, working with community on scripts and featuring local community members meant resources feature real people and real-life stories.

Young people, pregnant women, and community leaders have participated in the development of resources that have now been shared in communities, on Facebook, YouTube and NITV.

The national 'Don't make smokes your story' campaign was localised and tested to maximise recall and ensure messages were appropriate. Apunipima intend to publish the results of the campaign in a journal article.

4.1.2 Partnerships and collaboration

The population health approach central to the TIS program determines that health promotion activities and referral pathways should be linked to health services and broader inter-sectoral networks (outside the health sector) such as education, employment, housing, justice, and local councils as well as community-based organisations. Through these partnerships, TIS activities can draw on skills and resources, and broaden the reach of TIS messaging by linking activities to other initiatives.

The initial prioritisation of community consultation has established a strong foundation to build partnerships across regions. Over the course of the evaluation, the number of local organisations and range of sectors involved in tobacco reduction in the regions has increased, broadening support for tobacco control and referral pathways for quitting. This increase in collaborations is reflected in the performance report data, qualitative consultations and survey data. External partnerships are being developed and strengthened with a range of organisations, both Indigenous and non-Indigenous and inside and outside the health sector. Since the mid-term evaluation, TIS teams have increased their profile in community and as a result, some have reported being proactively contacted by other organisations for education and support.

> NGOs and other organisations are also contacting us and asking us to run education. Now we have our brand we are starting to see the impact with greater community engagement. Grant recipient, rural, 2017

Performance reports and survey data indicate a broad community approach including Aboriginal community organisations, schools and youth services, maternity services and other health and non-health services (see Figure 3).
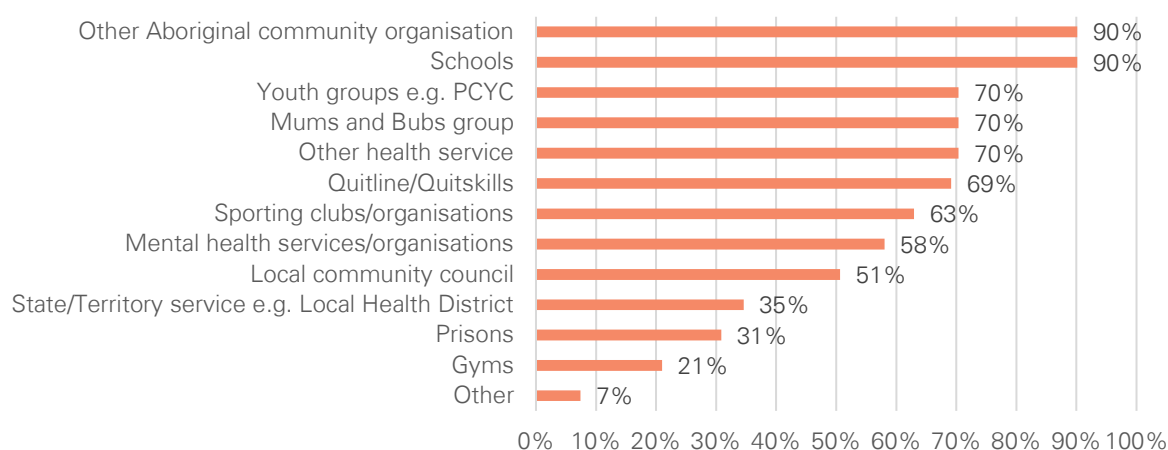

Figure 3. Services grant recipients nominated as having formed a link or partnership with in the 2017 TIS Grant Recipient survey (n=81).

These collaborations and partnerships have resulted in a range of advantages in relation to TIS activities, which are illustrated throughout this report including the establishment of smoke-free public spaces and smoke-free community events (section 4.2.7), increased referral networks (section 4.3.1), and access to priority groups (section 4.2.4-6).

It is also worth highlighting the strong partnerships that have been developed within organisations, particularly clinical services, facilitated by TIS teams, together with strong senior and clinical management. The holistic model of care adopted by ACCHSs ensures clients that enter the service receive an integrated pathway to care, with a team of health professionals working together to support the client. Many TIS teams with the support of senior management have ensured that tobacco control is 'everyone's business' and not a responsibility isolated to the TIS team. This has resulted in greater synergies between health promotion and clinical services which has in turn strengthened health system referral pathways (see section 4.3.1). Access to priority populations such as pregnant women has increased as TIS teams tap into existing groups such as Mums and Bubs to deliver education.

> I think anything that we do, there is a very strong link because we're all dealing with the same clientele, in some way or another, if the person is dealing with pregnancy but they do have smoking issues, we are all wanting to work as one big component, we are all on the same page. Grant recipient, rural, 2016

MAKING TACKLING INDIGENOUS SMOKING EVERYONE'S BUSINESS

The introduction of TIS and the move away from the healthy lifestyles approach stimulated Awabakal in Newcastle NSW to take a systemic approach where every service now considers how they contribute to a reduction in smoking.

Smoking cessation is no longer considered in isolation but is embedded across service delivery including medical services, preschools, aged care services, housing, mental health and community engagement services.

World No Tobacco Day was a key turning point where over 100 Awabakal staff engaged in a staff development day focussed around the delivery of smoking cessation messages and services. The result is that Awabakal clients, the local community and staff have the benefit of an organisation that strongly supports smoking cessation leading the way to better health.

While significant progress has been made in terms of broadening reach of TIS activities, challenges to internal partnerships and intersectoral collaboration highlighted in the mid-term evaluation continue to be an issue in some settings, these challenges included competing health and social priorities in communities and a lack of buy-in for tobacco control efforts. These challenges are discussed in further detail in section 4.5.4: Challenges to program success.

Despite these challenges, evidence from the performance report data, survey data and qualitative consultations with primary stakeholders, community and grant recipients has indicated a growth in the number of organisations involved in tobacco reduction across remote, rural and urban Australia in addition to sustained community engagement. While there is some variation across grant recipients, evidence suggests that the short-term outcome: 'increased community/regional involvement and support' has been met.

KEY FINDINGS: COMMUNITY ENGAGEMENT AND PARTNERSHIPS

Community trust and support is integral to the success of the TIS program and the considerable investment made by grant recipients in consultation, collaboration and community engagement has seen increases in the number of individuals and organisations involved in tobacco control.

Evidence of community consultation and involvement included the development of community reference groups, yarning sessions with Elders, youth leadership groups and participation in key regional advisory groups. The informal and flexible approach to community engagement adopted by TIS teams, along with the participation of TIS staff from the local community was recognised as important in increasing community support for tobacco control initiatives and influencing positive changes to social norms. This suggests that the short-term outcome: 'increased community involvement and support' has been met. While significant progress has been made in this area since the mid-term evaluation, it is important to acknowledge that building and maintaining trust with community is a time intensive and ongoing process that requires significant resource allocation.

Community consultation has established a strong foundation to build partnerships and collaboration. The TIS program has linked health services and broader inter-sectoral networks such as education, employment, housing, justice, local councils and community-based organisations. Building partnerships and collaborations has resulted in significant growth in the number of local organisations and range of sectors involved in tobacco reduction. This has enabled the TIS program to link to other initiatives, sharing resources, strategies and activities and increasing the profile of TIS teams and the importance of tobacco control in the region and referral pathways for quitting. The breadth and range of partnerships suggests that the short-term outcome: 'collaborations and partnerships built between TIS operations and external support for quitting' has been met.

Strong internal partnerships in grant recipient organisations have also been developed linking health promotion with clinical services and ensuring that clients receive an integrated pathway to care, with a team of health professionals working together to provide support. This approach has also strengthened referral pathways and increased access to priority populations such as pregnant women through existing groups such as Mums and Bubs.

4.2 Localised health promotion

Literature suggests that individuals with a sufficient level of health literacy have the ability to take responsibility for their own health as well as the health of their family and community.[6, 7] Similarly, the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 states: 'A person's ability to make informed health related choices is determined by their ability to understand health information and their ability to negotiate the health care system.'[8](p24).

Multi-level, localised health promotion, delivered through the TIS program, ensures the provision of tobacco-related health information in a locally relevant, culturally appropriate way. As outlined in the TIS program logic, it is anticipated that the adoption of this multi-level approach will result in an increased understanding of the health impacts of smoking and quitting pathways and ultimately, positive changes to social norms. Throughout this evaluation, TIS grant recipients have broadened the range of health promotion strategies delivered to community. Such activities are not possible without extensive community engagement and partnerships both internally and with external organisations established over the course of the TIS program as described above in section 4.1. This section explores the range of localised health promotion activities delivered by the regional grant recipients, including community education through events, involvement of community leaders and local champions, social marketing campaigns, targeted approaches to priority groups and promotion of smoke-free environments.

4.2.1 Community education (events and productions)

The most common area of TIS activity focus reported by TIS grant recipients in their performance reports was community health education and promotion, largely in the form of community events. Many grant recipients across all contexts reported that the attendance of the TIS team at community events was a crucial part of their approach to garnering community support, promoting awareness of TIS activities and educating the community around tobacco control. As stated in the mid-term evaluation, grant recipients continue to report setting up stalls with props and educational materials as well as resources such as smokerlyzers[1] to monitor carbon monoxide levels in the body. In some instances, TIS grant recipients have capitalised on this to obtain referrals to their own internal quit support program or to Quitline (see section 4.3.1).

> It's not just about standing and handing out pamphlets. They check the lungs and do that health check to see how lungs are coping … it's very educational and puts things into perspective… you see the ads in your face, but the No Smoking Team are right there with you. They're Indigenous, you're Indigenous and you can do something more, and have something to aim for. Community member, rural, 2017

In addition to events, some grant recipients have used creative mediums and other entertainment platforms such as drama and picture books (see Figure 4) to develop locally relevant health promotion messages around tobacco control, prioritising the use of local places and local faces. Qualitative consultations with community and primary stakeholders indicated that these approaches were

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[1] A smokerlyzer is an instrument which measures the amounts of carbon monoxide (CO) in exhaled breath. CO is absorbed into the blood through the lungs when cigarette smoke is inhaled. The more one smokes, the higher the CO reading will be.

perceived to be less pedagogical and more engaging, as one urban primary stakeholder observed, the messages are 'drummed into your senses in a good way, not preaching.'

Figure 4. Illustration from children's book *Deadly Dan at the League* (2016) produced by the Victorian Aboriginal Health Service Healthy Lifestyle and Tackling Tobacco Team and illustrated by Sarah Campbell. The book promotes smoke free messages and incorporates local places and faces in addition to multiple references to Quitline. Deadly Dan wears a possum skin cloak. Its design tells the story about smoking in Community, the journey towards quitting and staying smoke free. (http://www.healthinfonet.ecu.edu.au/uploads/docs/Deadly%20Dan%20at%20the%20League.compressed.pdf).

Analysis of TIS performance report data that were assessed as 'high quality' (see Appendix 5 for descriptors) revealed that community members were more informed and aware of the harms of smoking after attending a community education session or event, with some community members indicating an increased likelihood to quit. Moreover, evidence from qualitative consultations with community and primary stakeholders suggests that the range of education activities delivered by TIS teams has resulted in an increased awareness of the TIS team and understanding of the harms related with smoking. Open-ended responses from the 2017 Primary Stakeholder and TIS grant recipient survey revealed that the respondents believed that an increase in community understanding of the health impacts of smoking was the most significant achievement in the last six months. This is

supported by the grant recipient survey data which revealed that in 2017 93% of respondents agreed (33%) or strongly agreed (60%) that TIS activities have led to increased community understanding of the health impacts of smoking and of quitting pathways. This suggests that the short-term outcome: 'increased understanding of the health impacts of smoking and of quitting pathways' has been met.

> I love their work in the community and if it wasn't for them, the community would not necessarily know or understand the benefits of quitting. Primary stakeholder, survey respondent, 2016

4.2.2 Local role models and ambassadors

The implementation of community-based health promotion requires support from residents and community leaders to model the message, a key element of the TIS program design. The increased leadership and advocacy role of community leaders is also a crucial short-term outcome of the TIS program outlined in the TIS program logic. Since the mid-term evaluation, qualitative consultations with grant recipients, stakeholders and community suggest that community leadership around tobacco control has increased. The TIS grant recipient survey revealed that 70% of respondents agreed that TIS activities have led to enhanced leadership and advocacy roles of community leaders in tobacco cessation.

> You can tell the mindsets are shifting because you are getting more ambassadors and advocates for non-smoking and healthy lifestyles thanks to the TIS team. Community member, urban, 2017

While there has been an increase in involvement of Elders, some grant recipients reported challenges to engaging this target group, particularly those that are existing smokers. Despite this, community leaders commonly feature at community events and in social marketing campaigns to support TIS messages and promote community support for tobacco control. This is especially evident in urban and some rural settings. Community members expressed that the presence of community leaders and Elders as champions for the program has strengthened awareness around tobacco control, which is contributing to a shift in attitudes. Moreover, community members emphasised the power of the voice of community leaders in adding weight to the message and increasing influence.

> … it's important for us to see and know, people we love and care about advocate for this, as it holds us accountable to some extent especially with blackfellas. If you see Elders come up to you and ask why you smoking for still? It hurts you. Now people are leading the talk. Not just Elders people who walk besides us every day the young ones etc. I feel like the younger generation don't smoke as much, in comparison to mine ...   Community member, urban, 2017

In addition to community leaders and Elders, high-profile ambassadors such as sporting athletes were identified as valuable role models for positive behaviour, equating smoking cessation with success. This featured predominantly in urban and some rural areas where high profile sporting athletes are more accessible.

> I've seen the [campaign] TV ads, they are good because they show strong role models who don't smoke and look after themselves … Our children and young people see them, and I think they want to be strong and healthy and not smoke like them. Community member, urban, 2016

Moreover, grant recipients have sought out local champions who have simultaneously come forward themselves to promote tobacco control. These local champions are predominantly people who have quit smoking and wish to share their quitting journey. This proactivity from the community indicates a level of support and ownership for tackling smoking rates in the region, which is beneficial for the sustainability of TIS activities and for influencing positive changes to social norms.[5]

> What we're seeing more and more of now is people that do want to come forward and act as those change champions … who either want to be interviewed and want a story written about their story or who actually are submitting stories for us to publish, so they want to write it in their own words. Grant recipient, urban, 2016

Local champions also came in the form of TIS employees themselves modelling the message. Several community members identified TIS staff as key role models in the community. TIS staff also spoke about their experience of being part of the community and being involved in the TIS program, explaining that this has increased their knowledge of the harmful effects of smoking and the burden it places on their own community. The 2017 TIS Grant Recipient survey revealed that 80% of respondents agreed that the TIS program has changed their attitude towards smoking. Success stories have emerged throughout the TIS program of TIS staff quitting because of being involved in the TIS program.

> I was a 30 cigarette per day smoker. Since being in the role of TIS Health Worker I eventually began my own quit journey and cut down to quit. I cut down from 30 to 2 cigarettes per day and can now say I have been smoke free for 30 days today! Grant recipient survey respondent, 2017

Furthermore, several TIS workers provided examples of influencing others by sharing their knowledge with peers and family.

> I really enjoy helping my Aboriginal culture fight this ugly habit, the program has taught me so much and it has helped me educate not only community members but also my mum. I kept telling her the dangers and effects of smoking and she finally gave up after months of me pestering her. She was a smoker for 28 years, I couldn't have educated her without the TIS program that has taught me everything. Grant recipient survey respondent, 2017

4.2.3   Social marketing campaigns

Social marketing and mass media campaigns around tobacco control seek to reduce smoking rates through shifting attitudes and beliefs around tobacco use and ultimately smoking-related behaviours. Throughout this evaluation, many grant recipients have showed significant progress in establishing social marketing campaigns to supplement other TIS activities and community health promotion.

Grant recipients have developed multiple campaigns to target different groups such as pregnant women and young people, and different aspects of tobacco control such as smoke-free homes and

cars or quitting support. In these targeted campaigns, grant recipients have harnessed traditional media channels, including television, radio, cinema, billboards, newsletters and newspaper articles to promote their campaigns and activities. Where appropriate, grant recipients have extended their promotion to social media channels such as Facebook, Twitter and YouTube. This was largely evidenced in urban and some rural locations.

Recent evidence suggests that social media is becoming an increasingly important avenue to reach people, particularly youth, and a number of recent studies have suggested that internet and mobile phones are more commonly used by Indigenous youth than more traditional media types.[9, 10] It is not surprising therefore that grant recipients have adopted social media channels to reach young people as well as the wider Aboriginal community. Analysis of performance report data suggests that there has been an increase in the reach of these campaigns reflected by a rise in engagement (e.g. page 'Likes', views and 'impressions').

Local TIS branding and campaigns were further enhanced through the distribution of resources and merchandise (e.g. t-shirts, caps and water bottles) at the local clinic and community events which simultaneously functioned as incentives and rewards for community participating in TIS activities. Importantly, grant recipients have partnered with various organisations including other ACCHSs, the local Council, schools and hospitals to display and promote campaign material, thus broadening awareness.

> I've seen the ads on TV and heard them on Aboriginal radio. I am on Facebook and I've seen the [name of local TIS program] on here too. The ads work for me because they are Aboriginal people who don't smoke and are healthy. Our kids see them, and they want to be like them. You know, we see them [ambassadors and TIS staff] at NAIDOC and big sports days, this is positive. Community member, urban, 2016

LINKING COMMUNTIY TO QUIT SUPPORT THROUGH SOCIAL MEDIA

Awabakal worked with Headjam, a local creative agency, to develop a comprehensive social media campaign, I'm Quitting. The campaign imagery is positive, avoids the stigma attached to smoking, includes a Quit Kit and 17 ads which have been viewed over 920,000 times.
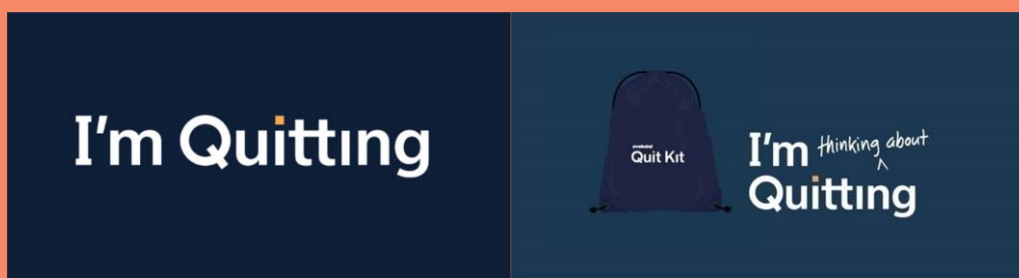
The social media campaign is comprehensive. People visiting the Facebook and website pages can click a link to generate an appointment with the Awabakal medical service, and the results are quantifiable, with 100 appointments made in the first five weeks of the campaign. Clients pick up Quit Kits at appointments with a GP and over 300 Quit Kits were distributed in six months.

The Facebook and website pages are updated regularly and include animations, videos and testimonials by local people who have quit. Interactions on Facebook also generate differentiated responses, for example, a young person or pregnant woman who has 'liked' the page would receive targeted messages about quitting. The campaign also has the capacity to create individual challenges by identifying reasons people quit and sending related information and messages (e.g. women in pregnancy quitting for the health of the baby; Elders quitting to provide an example).

The online campaign has the capacity to react to trends and audience responses and make changes where necessary and highlights the usefulness of measuring results such as website visits, enquiry rates, numbers of appointments, and conversion rates.

Facebook Advert clicks to the campaign website: (imquitting.awabakal.org.au)
5,947

Website form enquiries (people asking for a quit kit)
305

In the development and implementation of social marketing campaigns, grant recipients reported a deviation from a deficit model, promoting instead a strengths-based approach with an emphasis on positive lifestyle choices and the endorsement of success stories and case studies. Popular messages

included the promotion of healthy lifestyle choices, protecting young children from second-hand smoke and disassociating smoking with Aboriginal culture.

> The 'No smoking' message translated from English into [local language] is negative, commanding people to do something … We are instead trying to take a positive message approach and give people tools to quit … our health promotion approach is not to push them into quitting but empower them to make the first steps towards quitting. Grant recipient, remote, 2017

Figure 5. Aboriginal Elder, Aunty Girlie features in Flinders Island Aboriginal Association Inc (FIAAI) tobacco control campaign. In response to this campaign, one community member noted: *'…you look up to those Elders, it's really good it makes us stand up a little bit more and have another think about it. It's good to have someone who has been there and smokes, 'cos you know they have been there and done that, if they can do it I can do it.'*

The importance of incorporating 'local faces for local places' in social marketing campaigns also featured heavily across the country. Grant recipients and community members have indicated that locally, place-based and culturally relevant social marketing campaigns have greater resonance with community in comparison to mainstream mass media campaigns (see Figure 5). This is supported by the literature which indicates that local advertising in Aboriginal and Torres Strait Islander communities is associated with higher levels of motivation to quit.[11] For some grant recipients, stories of local residents quitting smoking formed the basis of their campaigns, effectively transforming community members into local champions. Some grant recipients reported greater recall from community campaigns with local people.

> The stories are good because they are local people and the community know their voices. It is a true story for the community, not a department ad with an actor. People respond better to local ads over government ads. Grant recipient, remote, 2016

Grant recipients also acknowledged that when community members recognise themselves or others in their local community this may in turn lead to increased engagement and a greater sense of pride and community ownership of the issue.

> We find that when it comes to mainstream television it's too often, there's not enough of our people on television. Once they see it, our community own that ad. It's a community initiative. Grant recipient, rural, 2016

While there has been a growth in awareness, demonstrating and attributing changes in smoking behaviour due to social marketing campaigns continues to be a challenge. This is consistent with the literature, where evidence regarding the effectiveness of mass media and social marketing campaigns in reducing smoking rates among Indigenous Australians is limited.[12, 13] To combat this, some grant recipients have reported setting up reference groups to continuously monitor the impact of social marketing campaigns and commissioned independent evaluations to assess impact (see case study below). NBPU TIS have provided additional guidance through jurisdictional workshops around measuring impact however questions remain around the feasibility of grant recipients collecting impact data for social marketing campaigns and other population health approaches (see section 4.4.1 for more detail on grant recipient data collection).

EVALUATING SOCIAL MARKETING CAMPAIGNS

In 2017, rural NSW grant recipient, Galambila Aboriginal Health Service commissioned the evaluation of their social marketing campaigns *Butt Out Kids About* which promotes being smoke free around children and *Deadly N Ready,* a youth led campaign focused on preventing youth uptake of smoking.

The evaluation surveyed 260 Aboriginal and Torres Strait Islander residents of the region. The evaluation found that unprompted, 46% recalled a quit smoking campaign in the past few months. When prompted, 62% recalled the *Butt Out Kids About* campaign and 47% the *Deadly N Ready* campaign, compared to 21% for the national *Break the Chain* campaign. A third of respondents with recall of one or both campaigns said they had encouraged someone to give up smoking, 32% claimed it had led them to talk to a family member or friend about smoking, 27% said it led them to speak with their doctor, and a quarter claimed they had contacted their local ACCHS as a result.

4.2.4   Targeted approaches to young people

The evaluation found that unprompted, 46% recalled seeing or hearing a quit smoking campaign in the past few months. When prompted about Galambila's campaigns, 62% recalled the Butt Out Kids About campaign and 47% the Deadly N Ready campaign. Further, a third of respondents with recall of one or both campaigns said they had encouraged someone to give up smoking, 32% claimed it had led them to talk to a family member or friend about smoking, 27% said it led them to speak with their doctor, and a quarter claimed they had contacted their local ACCHS as a result.

Population health reach includes targeted approaches for specific groups or populations. To ensure a population health approach is maintained, one of the key short-term outcomes set in the TIS program logic is the increased focus on demographic groups, namely young people and pregnant women.

Over the course of this evaluation, qualitative consultations with stakeholders, community members and grant recipients, together with performance report data demonstrated a growth in the implementation of strategies targeting young people. Grant recipients recognised the importance of prioritising young people in shifting social norms around smoking. This is supported by the performance report data which indicated that grant recipients across all contexts are conducting health promotion activities with young people through targeting schools and partnering with sporting clubs and youth groups.

> … if we're going to stop it, we need to get on to this generation and get them to be our crusaders in this fight … all we have to do is stop it in one generation to stop it in its tracks and we've won the war.
> Grant recipient, urban, 2017

Qualitative consultations with grant recipients and community members revealed the impact of localised health promotion activities on increasing a dialogue between young people and adults on smoking related harms. Grant recipients encouraged this discussion through the dissemination of targeted messages around the dangers of second-hand smoke and smoking around young children and the distribution of resources. In a performance report submitted by the Victorian Aboriginal Health Service, data revealed that a third of parents (34%) of children (aged 3-4 years) participating in a healthy lifestyle program had made their homes smoke-free (10 out of 29) and almost a quarter (24%) had cut back on smoking, while 2 had quit entirely. Similar outcomes were revealed in qualitative consultations as expressed by one primary stakeholder:

> I know [name of child], he got to go on the [youth program] and it just has changed his whole family. He's told me his aunt's quit smoking because he's just been at her like a little pup – just all over her.
> Primary stakeholder, teacher, urban, 2016

School-based interventions

Many grant recipients reported that they were working with schools to reach this target population. Throughout this evaluation, grant recipients have increased their presence in schools. Consequently, the profile of TIS teams has grown throughout their jurisdiction which has resulted in some schools now reaching out to their local TIS team for education.

> The more work we do in schools the more traction we get with other schools … 12 months ago, no one knew who we were or what we did so it was hard to engage schools and get them to fit us into their busy schedules. Now, schools are contacting us and asking for us to come in and deliver our education program. Grant recipient, rural, 2017

Given the rising demand, some grant recipients have been strategic in their approach to schools, targeting schools with high numbers of Aboriginal and Torres Strait Islander students and specialised institutions such as the Clontarf Academy[2]. The content of the sessions is largely around educating young people about the chemicals inside a cigarette and the harms they can cause to one's own health and others. Some grant recipients have also incorporated healthy lifestyle choices such as good nutrition and exercise into their sessions as well. The delivery of school-based sessions is often entertaining and interactive, with TIS workers integrating games, comedy and props.

While there is evidence of successful partnerships with schools, high staff turnover and truancy is recognised as a key issue in remote areas and some rural contexts, in addition to busy curriculums, which has repercussions on TIS activities. Grant recipients stressed that having a clear plan and dedicated time to managing relationships is key to successful partnerships with schools.

> When we try to work with the local school it is difficult as they are always in a state of change …We have to work to develop relationships with the school staff, but this is constantly renegotiated due to the high staff turnover at the school. This delays the delivery of TIS activities. Grant recipient, remote, 2016

Furthermore, grant recipients have noted that young people at-risk and disengaged youth can be a hard group to access through school-based interventions as many don't attend. As such, reaching this population requires significant adaptation, with grant recipients acknowledging that a hands-on approach is necessary, as one rural grant recipient expressed, 'getting back to those ground levels, relating to those kids as much as possible and understanding the situations that they're coming from.'

Connecting with young people

In addition to school-based interventions, grant recipients are also adopting indirect approaches to engage young people (particularly disengaged youth), capitalising on existing interests such as sport and hip hop. TIS teams have been making themselves visible in spaces such as the PCYC and other recreational areas (e.g. basketball courts, skate park and football fields) to enter a dialogue with young people about smoking and its related harms. Additionally, education in these spaces simultaneously allows for the encouragement of exercise and promotion of broader healthy choices. Some grant recipients have also partnered with sporting clubs to introduce young people to local sporting heroes and high-profile sporting athletes who serve as role models for this cohort. These sporting ambassadors are also often incorporated in social marketing campaigns or at community events to deliver tobacco control messages.

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[2]Clontarf Academies use football as a school-engagement mechanism for many at-risk students who would otherwise not attend or have low school attendance. The programs are delivered through a network of football academies established in partnership with local schools. Source: <http://www.clontarf.org.au/about/>

> One thing that gets through to the kids a lot is that they're really into their sport and into their rap music, if you can link it into something they have an interest in or somebody that's a role model, they think it's pretty cool. Primary Stakeholder, teacher, rural, 2016

Like broader community education measures discussed previously, grant recipients are adopting creative methods to develop educational messages for young people outside the school setting, such as art and graffiti, YouTube videos, and comics (see Figure 6). Grant recipients acknowledged that many young people are aware of the harms of smoking, thus, interactive and culturally appropriate resources are required for messages to resonate.

> They are thirsty for culture … these boys have innate sense of country even if they are not quite sure what it is, they are incredibly spiritual and cultural…I would think cultural programs must work hand in glove with no smoking … the more culture you feed them the less inclined they are to stray…programs should have a major cultural component to give them that sense of identity and self which they don't otherwise have. Primary stakeholder, teacher, rural, 2016

These programs and resources are often developed in conjunction with local youth or are youth led, as one urban grant recipient expressed, 'we can come up with all this great messaging, but if it's not made by young people for young people the effectiveness is going to be quite slim.'

Figure 6. Still from the Bega Garnbirringu Health Service (Kalgoorlie WA), music video 'Kalgoorlie, Make A Change'. The TIS team partnered with Indigenous Hip Hop Projects to film and launch a hip-hop music video in July 2017 with Kalgoorlie kids taking lead. The video has since been promoted on YouTube and shown at school sessions during outreach programs. Despite not having a specific social media strategy, the YouTube video has garnered

over 7,000 views (as of February 2018) and consultations with community and primary stakeholders indicated awareness of the video in Kalgoorlie and surrounds. Source: https://www.youtube.com/watch?v=ly4cP-clFUQ

4.2.5   Targeted approaches to pregnant women

According to data from the perinatal data set, approximately 45% of Aboriginal and Torres Strait Islander pregnant woman are smoking, with very little change in prevalence in this sub-population group over the past ten years, highlighting the importance of targeting this cohort.[14]

The mid-term evaluation identified that although pregnant women were a difficult group to access, grant recipients were committed to prioritising this group. Since then, grant recipients have made progress in engaging pregnant women, however ongoing challenges remain.

Qualitative consultations together with performance report data suggest that there has been an increase in the collaborations and partnerships with services involving pregnant women since the mid-term evaluation. Many TIS teams have worked closely with midwifery programs, to ensure that appropriate and ongoing care is provided around smoking during pregnancy, and that families are aware of the hazards of second-hand smoke. Many midwife teams in ACCHS do a basic smoking assessment with every woman that comes in for their first pregnancy visit and linked those clients with the TIS team for ongoing smoking cessation support. TIS teams within ACCHS often work in a collaborative way with midwifery teams and social and emotional wellbeing teams, sharing client information so that the client experience is holistic with a guarantee of ongoing continuity of care.

PARTNERING WITH MIDWIVES

The Winnunga Nimmityjah Aboriginal Health Service TIS team in Canberra works closely with the midwifery service which provides support to pregnant and new mothers through a program of six weeks of antenatal and postnatal care. TIS links with the midwifery service, connecting with their clients and supporting pregnant women and new mothers to quit smoking through the No More Boondah program.

Tarni* came in for her fourth pregnancy after a series of unsuccessful pregnancies and a lot of anxiety about this pregnancy. Tarni was a smoker and when the midwife team explained the risk of smoking to her unborn child, she quit smoking with the support of the No More Boondah program. Tarni went on to have a healthy baby and continued to stay off the smokes post pregnancy.

*Name replaced

Grant recipients have also capitalised on existing services and groups such as Mums and Bubs groups, playgroups, Quit for New Life, and Aboriginal Maternal and Infant Health Services to deliver education. This education is supplemented with the distribution of resources including brochures about the harms of second-hand smoke. Some grant recipients have developed their own resource material or

incorporated educational material into existing resources such as the Blue Book[3] to deliver information around the dangers of smoking.

Success stories of pregnant women and new mothers quitting have emerged from qualitative consultations as well as performance report data suggesting progress in this area. For example, in remote NT, Nganampa Health Council delivers an intensive assessment program to all antenatal women across the APY Lands. Within a six-month period, 22 of the 27 antenatal women were visited at least once during their pregnancy. Of these, 10 were current smokers and 5 of these women successfully quit during their pregnancy, most in the early stages of their pregnancy.

ONGOING QUITTING SUPPORT TO PREGNANT WOMEN

Theresa* stopped smoking in April last year before getting pregnant. She used to smoke a lot. She was advised by her aunty, a health worker, to give up the smokes. She started using plain chewing gum and "just stopped".

Theresa has visited the local TIS team to get ongoing support for her quitting and has participated in several TIS activities, like the Pamper Day for pregnant women and young mums and community events such as World No Tobacco Day.

Theresa has tried giving up smoking before but only lasted a few months, this time it is well over a year. She now values the time she can spend with her baby and 4-year-old son.

'All the stuff TIS does, it helps me stay off the smokes, reminds me about all the damage and not to fall into old habits, they are always there to support you and not judgey … I used to be going out of playgroup all the time for a smoke, now I can spend more time with my kids.'

*Name replaced

Despite examples of progress, grant recipients have expressed ongoing challenges, noting that pregnant women and young mothers can be reluctant to discuss issues around smoking. One rural midwife explained that this could be related to feelings of shame, particularly for young mothers, adding that socio-economic issues and problems at home can compound stress, so ultimately 'tobacco [control] is the last thing on their mind'. Cultural factors also influenced access to women's groups. For example, one remote grant recipient noted that male TIS workers were not permitted into a women's group. Therefore, the lack of female staff can be an additional barrier to the provision of support to pregnant women.

Given the challenges that have emerged, some grant recipients have suggested that more training is required in how to approach pregnant women. One TIS manager who had attended the Oceania Tobacco Control Conference 2017 highlighted the value of attending this conference in building capacity to support pregnant women. Since attending the conference, the TIS team is in the process

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[3] The Blue Book (My Personal Health Record) is provided to all new mothers in NSW and retained for child health records.

of trialling an evidence-based intervention (presented at the conference) for pregnant women. This highlights the importance and value of sharing and promoting best practice.

The Department provided TIS funding in 2017-18 to Cancer Council South Australia (CCSA) to develop and pilot training and follow up support in 10 locations for Aboriginal and Torres Strait Islander maternal and other health workers to address smoking during pregnancy for women and their partners in remote and very remote areas. This demonstrates a positive step in promoting best practice with working with this challenging cohort.

4.2.6   Targeted approaches to prison populations

The over-representation of Aboriginal and Torres Strait Islander people incarcerated is well documented. Despite representing 3.3% of Australia's population, Aboriginal and Torres Strait Islander prisoners account for just over a quarter (27%) of the total Australian prisoner population.[15] For juvenile detention the statistics are worse, Aboriginal and Torres Strait Islander young people made up just over half (53%) of all those in detention on an average night in the June quarter 2017.[16]

The flexibility in funding has allowed grant recipients to identify prison populations as a priority and tailor activities accordingly. The mid-term evaluation revealed that some grant recipients had just started or were in the process of working with prisons. Since the mid-term evaluation, at least a third of TIS grant recipients, predominantly in rural and some remote areas, have demonstrated TIS activity in prisons and/or juvenile detention. Activities have involved delivering education sessions and supporting transition back into the community, with support for quitting.

SUPPORTING PRISON POPULATIONS

In October 2016, Pangula Mannamurna Aboriginal Corporation started working with the privately-operated Mt Gambier prison to deliver tobacco education sessions to inmates. Since then, the TIS team have run sessions with 96 inmates, 67 of those were Indigenous. The sessions welcomed Indigenous and non-Indigenous inmates. This approach was deliberate as any segregation can cause issues. Furthermore, it ensured a holistic approach where friends could support each other.

One inmate suggested delivering a Yarning Group to allow inmates to talk about their histories, why they took up smoking, and why they continue, triggers, barriers and motivations. The TIS worker explained that this gives insight into what the men are having trouble with. The Aboriginal Health Worker, Social/Emotional worker and the TIS worker all attend the monthly Yarning sessions. This is important as other issues come up in the sessions that need to be addressed e.g. trauma, need for other medical assistance.

'…it went really well, the inmates appreciated it and kept asking about when the TIS people are coming back.' Aboriginal Health Worker

Due to the stigma associated with calling up Quitline, inmates were reluctant to use it. To mitigate this, the TIS team arranged for Quitline to run a session with the inmates. The inmates worked out questions and Quitline answered them. The TIS worker noted that this helped improve their view of Quitline and their preparedness to call the Quitline.

Grant recipients have acknowledged the challenges of delivering TIS activities in prisons, where support options in the form of NRT and ongoing counselling is limited. Despite this, evidence from qualitative consultations suggests that the response to these activities has been positive. Moreover, some grant recipients have demonstrated outcomes in supporting quitting. In a performance report submitted by Kimberley Aboriginal Medical Services Ltd (KAMS), information sessions delivered to 49 Indigenous inmates at a Derby prison led to 6 people identifying as non-smokers by the end of the reporting period and a third (33%) indicating that they were actively cutting down. Further, 79% indicated they would like to see the prison smoke-free.

While progress has been made in this area, as stated in the mid-term evaluation, access into these institutions can require considerable investment in rapport building and establishing partnerships. Furthermore, under the Australian Constitution, the state and territory governments are responsible for managing public prisons. As TIS is a federally funded initiative, some grant recipients have faced additional barriers to delivering TIS activities in public prisons.

4.2.7   Supporting smoke-free environments

Existing evidence shows smoke-free policies are associated with decreases not only in second-hand smoke exposure, but also in tobacco use prevalence among young people and adults in mainstream populations.[17] Since the redesigned TIS program, establishing smoke-free environments has been a strong focus of grant recipients predominantly in a rural and remote context. While the mid-term evaluation highlighted some progress in this area, since 2016 grant recipients have self-reported considerable gains in establishing smoke-free environments.

In the 2017 TIS Grant Recipient Survey, indicator 5 – supporting smoke-free environments was ranked higher (third) in terms of budget and resource allocation compared to the 2016 survey (ranked fifth), suggesting an increased focus on this indicator in 2017. Furthermore, when TIS managers and coordinators were asked to rate how much progress they think they have made on the five performance indicators, the biggest increase in progress over two years was demonstrated in supporting smoke-free environments, with more than half of respondents (53%) indicating 'a lot of progress' had been made (up from 32%) and 17% nominating 'expected outcome achieved' (up from 7%) for this indicator (see Figure 7). This is not surprising given the increased focus on smoke-free environments revealed by budget and resource allocation in the survey.
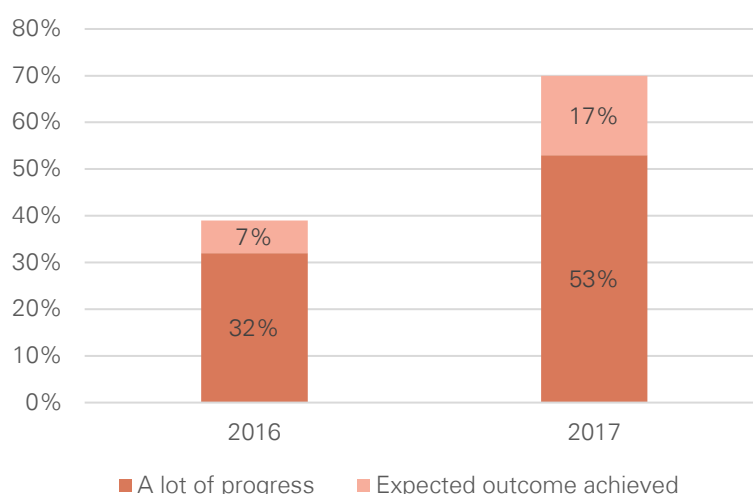

Figure 7. TIS Managers self-reported progress on indicator 5 – supporting smoke-free environments in 2016 (n=28) and 2017 (n=30).

This is reiterated through performance report data which demonstrates a higher level of activity under Indicator 5 – supporting smoke-free environments by rural and remote grant recipients. This would be expected due to the greater normalisation of smoke-free environments in urban contexts.

Due to the challenges in monitoring and evaluating adherence to smoke-free environments, TIS grant recipients are largely reporting output data. This data includes the number of smoke-free events, distribution of smoke-free signage and resource packs for external organisations and families, and the number of organisations grant recipients have worked with to develop and implement or update workplace smoke-free policy. Throughout the evaluation, grant recipients have provided examples of successful smoke-free environments (e.g. smoke-free events) and have indicated a movement towards shifting attitudes towards second-hand smoke with some evidence of behaviour change.

Smoke-free areas are everywhere I go. Shopping centres, doctors, AMS, clubs, sporting events, NAIDOC and community events … it's not cool anymore. It's not acceptable, not a whole lot of places you can [smoke]. Community member, urban, 2017

Smoke-free workplaces and spaces

Smoke-free workplaces were a key priority for many grant recipients throughout this iteration of the redesigned TIS program. Initially, grant recipients focused on ensuring that their own organisation was smoke-free and adhering to smoke-free policies. The focus on ensuring the internal organisation is smoke-free is driven by a desire to lead by example and not appear hypocritical when approaching other organisations, as noted by one rural grant recipient in 2016, 'it's a bit hard to convince other people to become smoke-free when you're not smoke-free yourself.' Evaluation and monitoring data indicate that progress has been made in this area, with grant recipient organisations providing evidence that staff within their workplace and clients are adhering to smoke-free policies. A few community members spoke about the impact the introduction of these policies has had on their own smoking behaviours, including delaying the next cigarette and reducing the number of cigarettes smoked over the work day.

> In a way, it's a good thing because you think nah I won't have a smoke because I don't want to walk outside, so you delay it which is good. Community member, remote, 2016

Since the mid-term evaluation, there has been significant progress made by grant recipients to support external workplaces to become smoke-free and adhere to smoke-free policies. Overall, grant recipients have prioritised working with other Aboriginal health and non-health organisations, with some indicating that they have also approached mainstream organisations that work closely with Aboriginal and Torres Strait Islander communities. Shopping centres, supermarkets, sporting clubs, and hostels were also frequently mentioned as environments and workplaces of priority. Many grant recipients have also received requests from external organisations for no smoking resources and support in implementing smoke-free policies in the workplace. Performance report data revealed considerable distribution of smoke-free signage to external workplaces.

> Second-hand smoke is a reality. The fact local councils and businesses are putting in smoke-free areas is good. It's kinda making smoking a bit outlawed as you must smoke in a certain space … it's changing the mindset. Community member, urban, 2017

Gaining community and local leadership support was identified as a crucial factor in easing the implementation of smoke-free policies in these environments. This is supported by studies in Aboriginal and Torres Strait Islander communities, which indicate that smoke-free policies are more likely to be successfully implemented and sustained where there is local ownership and community participation in their development.[5, 18, 19] Notably, where smoke-free policy was supported by senior management, the impact in terms of implementing stricter smoke-free policies was considerable.

> Today at the management meeting our leader at the top has changed and he is a non-smoker. So today they said there is no more smoking in the laneway. All the butt containers will be removed … They can smoke across the road and they aren't allowed to have their uniform on. Primary stakeholder, grant recipient employee, rural, 2017

Where grant recipients reported challenges to implementing smoke-free policies, it was largely due to different organisational priorities. For organisations focused on issues such as family violence and alcohol and drug misuse for example, there is a sense that banning smoking poses a risk to their clients as it may potentially exacerbate stress and anxiety for clients already experiencing complex issues.

> There has been some resistance from orgs they have approached … reluctant to go smoke free because they felt they didn't want to take that away from their clients who are already dealing with drug and alcohol issues. In the end though the org sent two workers to the Quitskills training organised by [TIS team] so that staff were equipped to offer support to clients who wanted to quit. Grant recipient, remote, 2016

To address these challenges, some grant recipients have voiced their priorities and strategies in Board meetings, consortium meetings, and local Council and regional/community meetings and used their CEOs to communicate with other CEOs about the importance of tobacco control. There are examples throughout the country of successful regional leadership involving TIS regional grants, for example in Victoria through the consortia led by VACCHO and in South East Queensland through regular governance meetings of which IUIH is a part, and in Tasmania, demonstrated by the Tasmania Aboriginal Health Reference Group (TAHRG) detailed in the case study with FIAAI below.

STRENGTHENING LEADERSHIP SUPPORT AND ADVOCACY

The Tasmanian Aboriginal Health Reference Group (TAHRG), of which TIS grant recipient Flinders Island Aboriginal Association Inc (FIAAI) is a part, is a peak body made up of five Aboriginal organisations in Tasmania operating in the health and wellbeing space. FIAAI's engagement with the TAHRG assists the TIS team to effectively meet National Indicators 1 (Quality and reach of community engagement) and 2 (Organisations involved in Tobacco reduction in the region) for the program at a high level.

FIAAI consult with TAHRG on a regular basis, with the group functioning as an advisory role for TIS. Meetings are used as a forum to share resources and information with other Aboriginal organisations, for joint planning and priority setting. FIAAI reported that TARHG has facilitated access to communities and other organisations and they have *'managed to, from those meetings, organise and plan events that have already happened or are in the pipeline with all those organisations…'* In doing so, FIAAI has effectively increased the geographical reach of the program. This is especially pertinent for FIAAI, whose catchment area for TIS is state-wide. Moreover, FIAAI highlighted the importance of having five organisational champions advocating for TIS activities and spreading tobacco control messages across the state.

In addition, through TAHRG, FIAAI has had the opportunity to meet with senior levels of state government and key state tobacco control bodies to advocate for TIS support, these include the State Tobacco Coalition, Department of Health and Human Services, Tobacco Cessation Priority Population Advisory Group, and Primary Health Tasmania.

'TAHRG spreads ownership of the [TIS] program' – FIAAI employee

As a result of these networks, the FIAAI TIS Coordinator became a member of the State Tobacco Coalition, accessing policy and planning structures to ensure Aboriginal smoking cessation remains high on the health agenda across Tasmania. Outputs included information and resources

Outputs included information and resource sharing, joint planning of activities and events, priority setting, and greater access to communities and external organisations. Outcomes include broader population reach, increased advocacy at the state level and regional leadership support.

Throughout the evaluation, policing smoke-free environments has been identified as a significant challenge, with many TIS workers reporting they do not have the authority to reprimand staff or community members. In addition, grant recipients expressed uncertainty around who was responsible for monitoring compliance and enforcing smoke-free spaces. This was reiterated by community members who noted that since 'no one is going to charge you', the effectiveness of smoke-free signage is diminished.

> Unless we're standing there watching people we're never going to know, there's those limits. We can work with the stores to make sure any outdoor eating areas have signage up to say they're smoke-free, but we can't police it on their behalf. Grant recipient, remote, 2016

While grant recipients have expressed challenges in monitoring compliance, some have developed tools such as surveys and assessment forms to measure adherence to smoke-free policies.

Smoke-free events

Since the mid-term evaluation there has been a notable increase in the number of smoke-free events across grant recipient regions as evidenced in performance reporting. In the main, grant recipients capitalise on community events, sporting days and specific dates such as NAIDOC week and World No Tobacco Day to conduct smoke-free events. Analysis of performance report data over the 2016-2017 period, indicates that considerable activity is going towards ensuring the availability of smoke-free signage at events and in public spaces. These health promotion efforts have been a useful approach for some grant recipients in the process of de-normalising smoking behaviours in their community.

While compliance is still a persistent issue, the response from the community to smoke-free events has been mostly positive. In the main, community members noted an increase in the number of smoke-free community events and spaces and recognised their value in supporting people to quit and shifting attitudes.

> You go to any event and there is either [TIS team] right around or no smoking signs around ... we have to go right outside, far away just to light up a cigarette. In a way, it's a good thing because you think nah, I won't have a smoke because I don't want to walk outside, so you delay it which is good … It's helping them delay and reduce the number they smoke. Community member, remote, 2016

Some community members indicated that the perceptions around people who smoke have shifted partly due to the introduction of smoke-free events and areas. Some community members disclosed feeling ostracised because of the introduction of smoke free spaces.

Smoke-free homes and cars

Throughout this iteration of the TIS Program, grant recipients have undertaken a range of activities to promote smoke-free homes and cars, largely through specific smoke-free programs, community events and social marketing campaigns. Data from the 2017 primary stakeholder survey revealed that 83% of respondents strongly agreed (59%) or agreed (24%) that TIS activities are promoting the benefits of smoke-free homes and cars.

Resources distributed throughout community include home support packages and pledge packs to support people in making their home and car smoke-free. Overall, activities and signage are centred around respecting others and building pride in having a smoke-free home and car. These activities are reinforced through social media campaigns. Such campaigns emphasised the dangers of second-hand smoke and the importance of protecting children from second-hand smoke.

Community response to smoke-free homes and cars is encouraging, with many community members recognising that smoking can affect others. Community members acknowledged that there are benefits of having smoke-free homes and cars and there is an awareness of the health impacts of second-hand smoke with particular concern for young children. The positive impact of smoke-free policies and laws on protecting young children's exposure to second-hand smoke was also acknowledged.

> I think it's definitely increased the awareness of [the] importance of having smoke-free homes ... There has been a number of smokers who have quit, but the smokers who still do smoke a majority of them can actually recognise now that the smoking can damage their children and since then they've adopted to having smoke-free homes, to minimise the impact. Grant recipient, urban, 2016

Many community members suggested the shift in attitude regarding smoke free environments in Aboriginal and Torres Strait Islander communities has also resulted in a change to smoking behaviours, including a decrease in the number of people who smoke inside (houses and cars) and around young children.

> I think the attitudes have changed and they [smokers] know people don't want to be near second-hand smoke and [they] are more mindful these days … I don't think it's acceptable to sit in a crowd and have a smoke anymore. Community member, urban, 2017

Overall, the promotion and establishment of smoke-free environments is recognised by grant recipients as an area of importance to reduce smoking rates among Aboriginal and Torres Strait Islander populations. This is especially evident in a rural and remote context. Throughout this evaluation of the redesigned TIS Program, grant recipients have prioritised modelling smoke-free environments within their own organisation first and then focused on supporting external organisations to become smoke-free. Challenges remain however, in garnering support for smoke-free workplaces where senior leaders or Board members smoke and within organisations where tobacco control is not the main priority. Monitoring the compliance of smoke-free environments presented an additional challenge to grant recipients. Despite the challenges, grant recipients have provided examples of adherence to smoke-free organisational policies, smoke-free events and smoke-free spaces. Moreover, qualitative consultations with grant recipients and community members indicate shifting attitudes towards smoking indoors (homes and cars) and around young people with some evidence of behaviour change.

The work done by grant recipients since mid-2015 suggests the short-term outcome 'Increase in smoke free homes, workplaces & public spaces' within the TIS program logic has been met. There is also some evidence to suggest progress is being made towards the medium-term outcome 'Reduce exposure to second-hand smoke'.

KEY FINDINGS: LOCALISED HEALTH PROMOTION

Overall, evidence from qualitative consultations with community members, primary stakeholders and grant recipients, together with data from surveys and performance reports suggests that the adoption of a localised, multi-level approach has resulted in the TIS program meeting a number of its short-term outcomes outlined under localised health promotion in the TIS program logic, this includes an increased focus on priority groups, increased leadership and advocacy role of community leaders, increased community understanding of the health impacts of smoking and of quitting pathways and an increase in smoke-free homes, workplaces and public spaces. Collectively, through meeting these short-term outcomes, the TIS program is on track to meeting other short and medium-term outcomes such as the reduction in opportunistic smoking behaviours and reduced exposure to second-hand smoke.

Community events and local ambassadors

The number one area of TIS activity focus reported by TIS grant recipients in their performance reports was community health education, largely through community events. Events are a crucial opportunity to build trust and engagement with community, a key foundation for TIS activities. Elders are often involved, although some grant recipients indicated difficulties with engagement. Local champions (i.e. community member who has recently quit) were also often promoted at these events as well as within social marketing campaigns. Local TIS employees themselves also played an essential role in modelling the message, and their position as residents in the community has lent credibility to the role and presented opportunities to influence family and peers around smoking cessation.

Social marketing

Grant recipients have developed multiple social marketing campaigns to target different groups such as pregnant women and young people, and different aspects of tobacco control such as smoke-free homes and cars or quitting support. Local TIS branding and campaigns were further enhanced through the distribution of resources and merchandise. Campaigns largely celebrated 'local faces and local places' and were framed with a strength-based approach. The evaluation found that while awareness of TIS campaigns are high, behavioural impact is uncertain due to the difficulties in evaluating such campaigns.

Targeted approaches for specific groups

Targeted approaches to priority populations were also adopted by grant recipients. The prioritisation of young people featured prominently across the country, with school-based interventions and recreational activities with a tobacco focus being delivered to engage this cohort. Targeted approaches to pregnant women were dependent on collaborations with antenatal clinics and existing groups such as Mums and Bubs. While progress is being made in engaging this cohort, sensitivities around tobacco use in pregnancy has rendered challenges to accessing this group.

KEY FINDINGS: LOCALISED HEALTH PROMOTION

Over the course of this evaluation, prison populations have become a growing area of focus, with grant recipients delivering education and group counselling sessions to inmates.

Smoke-free environments

Analysis of qualitative data together with survey and performance report data revealed an increase in activity around smoke-free environments throughout this evaluation. Grant recipients have reported updating internal workplace policy and supporting external workplaces to implement and/or update their workplace policy. Grant recipients are also contributing to positive changes to social norms (a medium-term outcome of the TIS program) by ensuring all events are smoke-free and promoting smoke-free public spaces and homes and cars. Community members have expressed that they have noticed shifts in attitudes around second-hand smoke and subsequent shifts in behaviour, for example, no longer smoking around children and delaying a cigarette.

4.3 Access to quit support

The TIS program is part of a larger preventive health care system, connected in different ways such as through referral pathways, and client appointments. A key component of the TIS Program is therefore enhancement of referral pathways and promoting access to quit support. This section examines the 'Access to quit support' component of the TIS program logic and explores how providing a range of opportunities for achieving cessation and the delivery of training for supporting people to quit has led to the TIS Program achieving short-term outcomes in several areas. It explores how grant recipients have established referral pathways and networks and strengthened the provision of smoking cessation support to Aboriginal and Torres Strait Islander community members since mid-2015. The Quitline enhancement model is discussed and successes and challenges regarding the uptake of Quitline services is explored. The final section discusses workforce development and the uptake and benefits of smoking cessation training by TIS staff, with a focus on Quitskills training.

4.3.1   Referral pathways and networks

A key component of the TIS Program's focus on improving access to quit support is the enhancement of referral pathways, which is designed to ensure Aboriginal and Torres Strait Islander communities have access to culturally appropriate quit support. Over the life of the program, the development and establishment of referral pathways and networks has been a strong focus of the work of grant recipients. Ninety-three percent of respondents (up from 87% in 2016) either agreed (25%) or strongly agreed (68%) that strong collaborations and partnerships with internal and external stakeholders have been built to increase community members access to quit support.

The mid-term evaluation noted that the main referral pathways developed by grant recipients fall into two broad groups: clinic-based referral and referrals made during localised TIS health promotion activities. At this earlier stage in the project lifecycle, there was little integration between these two referral pathways. Since the mid-term evaluation it is evident that referral pathways have strengthened and there is now greater integration of health promotion and clinical services.

Clinic based referral pathways vary between ACCHSs but typically include an Aboriginal or Torres Strait Islander community member doing one or more of the following: a) self-referring into the clinic for a smoking related issue; b) visiting the doctor for a non-smoking related issue; c) undertaking an Aboriginal Health Check; and d) completing a smoking history assessment with an Aboriginal Health Worker or TIS worker. When referrals are made by an ACCHS doctor or Aboriginal Health Worker, patient details (smoking history, whether NRTs have been prescribed etc.) are forwarded onto the TIS team.

If a smoker indicates they would like to quit, many grant recipients have set up systems in the electronic health record to prompt clinical staff to provide quitting support in the form of a brief intervention or a referral to the TIS team or Quitline for additional support. It has been noted that referrals between health services and obtaining smoking status data is easier within regions where electronic health records operate on the same platform. Referrals between health services is critical in some regions where populations are transient, and challenges remain for grant recipients operating in environments where patient information systems differ.

> … organisations can't share data because not all are using Communicare [electronic health record]. Without us all using one system it is hard to share data. Grant recipient, rural, 2017

Despite these challenges, some jurisdictions, particularly Victoria and South Australia are working towards operating on a consistent system. Some grant recipients based in these states reported that this is due to the leadership of Aboriginal peak bodies.

Health promotion referral pathways include referrals through: smoking cessation stalls at community events and outside ACCHSs, existing health lifestyle programs run by TIS teams, education programs and social media campaigns. In this context, the TIS team undertakes a smoking history assessment or brief intervention and then refers interested community members to the ACCHS, local AMS or Quitline. Since the mid-term evaluation, there has been an increase in the number of grant recipients utilising health promotion activities as a referral pathway for community members to access quit support and there is evidence to suggest for some grant recipients this is a successful avenue for linking clients into local TIS programs. For grant recipients that do not have a clinical referral pathway, community members interested in quitting are referred onto Quitline or their local ACCHS or health service.

As grant recipients have grown partnerships with external agencies, external referral pathways into local TIS programs have improved. It is evident that since the mid-term evaluation grant recipients have been successful in further strengthening external referral pathways and the number of referral access points through established partnerships with external agencies. This includes, partnerships with other ACCHS', allied health providers, mainstream, GP's, other Aboriginal organisations, hospitals, Primary Health Networks, Local Health Districts and Alcohol and Other Drug (AOD) services. As suggested by a grant recipient in a rural area in 2016, these partnerships are designed to increase Aboriginal and Torres Strait Islander community knowledge of the smoking cessation support available to them: 'for us it's about everyone knowing that there is support available.' A broader discussion about partnerships can be found in section 7.2. The strengthening of external partnerships and the evidence that they have led to Aboriginal and Torres Strait Islander community members increased access to quit support suggests the short-term outcome 'Collaborations and partnerships built between TIS operations and external support for quitting' within the TIS program logic has been met.

The referral pathways for Aboriginal and Torres Strait Islander people that has been established as part of the TIS Program since mid-2015 can be seen in Figure 8 below.
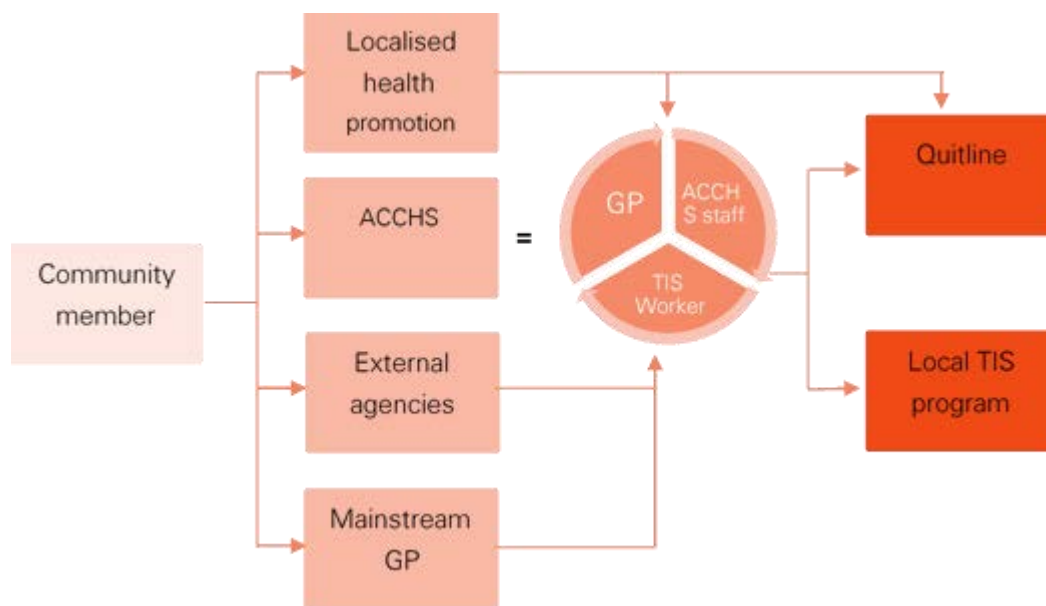
Figure 8. Referral pathways into localised TIS program.

Once referred into a local TIS program, clients receive support to quit smoking in a variety of ways (one-one-one support, group support, referral to Quitline etc.). The TIS team may also refer clients back into the clinic to see a doctor if they express a desire to use NRTs or onto Quitline for additional support. By establishing referral pathways in and out of their local TIS Program, grant recipients have strengthened the delivery of integrated care for clients. Several grant recipients have demonstrated a holistic model of care where the GP, TIS team, and other ACCHS staff/AHW (e.g. oral health staff, midwifery team, AOD worker etc.) work together to support a client through their quit journey as highlighted in section 4.1.2 partnerships and collaboration.

> Having an on-site health service and with our holistic approach to health care makes [our service] a more accessible place for community members. When a patient goes to see the GP or midwife and mentions they are interested in quitting smoking they are straight away introduced to a TIS staff member and the whole service works together to support that client. Grant recipient, urban, 2017.

IMPROVING ACCESS TO QUIT SUPPORT

Poor uptake from clients referred through clinical pathways into the TIS program prompted Broome Regional Aboriginal Medical Service (BRAMS) in remote Western Australia to change their approach to engaging with Aboriginal and Torres Strait Islander community members.

In addition to clinical referral pathways through the medical centre, a drop-in smoking cessation support service was trialled in 2016 at the medical centre reception area to increase smoking history assessments and referrals to their smoking cessation program. Following the success of this approach, two TIS staff members are now based in the clinic between 8.30am and 12.00pm each day. The first staff member is based at the reception desk and their role is to complete smoking history assessments. The advantage of this approach is that the staff member has the background skills and knowledge to provide effective brief intervention, including the provision of information/support about smoking cessation and the TIS program.

The second staff member is the TIS Counsellor. They are also based in the clinic at the same time. Any patients identified as being interested in smoking cessation at the front desk are directly referred to the counsellor. Whilst the patient waits to the see the GP an initial assessment for smoking cessation is conducted. This may include brief intervention, motivational interviewing and an assessment of smoking behaviour and dependence. When medical interventions are thought to be appropriate the TIS Counsellor is then able to directly liaise with their GP prior to their appointment. This has meant that when deemed appropriate a treatment plan could be actioned that day.

This approach has also reduced the often lengthy delays between the patient indicating an interest in quitting smoking and BRAMS being able to make contact. During this initial contact with the patient a welcome pack is also provided which includes; smoking cessation resources, TIS Counselling support contact details and other promotional material.

Patients interested in ongoing support are provided with a range of services to support them. This includes; drop in service (minimal wait times), driver pick up services, quit plans, support counselling, incentives and general education and advice.

Between July to Dec 2017, 34% of patients had a smoking assessment completed. This is up from 31% in the first half of 2017. As this program was only implemented in 2017 this rate is expected to increase significantly in 2018.

A few challenges to implementing referral pathways was noted in the mid-term evaluation. This included limited uptake of local TIS program support by community members referred through clinical pathways and low referral rates by some doctors into the local TIS program. Since the mid-term evaluation it is apparent that grant recipients have strengthened relationships between clinical staff and TIS teams to reduce barriers to referral pathways. To address these challenges, TIS teams have also made improvements to their clinical databases and referrals forms and implemented regular upskilling of clinicians on brief intervention and the importance of referring into the local TIS program. In remote settings, TIS teams also opt to visit the client at their home or community and attempt to reach them in person. As the 'Quality improvement: Access to quit support' vignette highlights, quality improvement approaches within local TIS programs have been utilised by grant recipients to increase the uptake of quit support. These improvements have led to more clients being linked up with the TIS teams since 2016. Some challenges remain, including inconsistent collection of smoking status data by clinical staff in some organisations and high clinical staff turnover, which impacts on referrals into the TIS team.

Although referral data cannot be aggregated at a national level due to inconsistencies in data collection methods, individual analysis and comparison over time of TIS performance reports reveals an overall increase in the number of referrals to appropriate quitting support across the country. Furthermore, analysis of 'high quality' data reported by TIS grant recipients demonstrated progress towards achieving medium-term outcomes of the TIS program logic, including increases in individuals wanting to quit; increase in number and length of quit attempts; and reductions in the amount smoked where cessation is not achieved. One grant recipient in rural Victoria reported receiving 95 community referrals. Of those referred, 93% had an increase in motivation to quit, 65% decreased the number of cigarettes a day, and 5% had completely quit.

4.3.2   Types of quit support

There is a range of quit support options available to Aboriginal and Torres Strait Islander community members through local TIS program activities, including one-one-one support, group support, telephone and text support and referrals to Quitline. This support is provided in conjunction with other local TIS program activities, such as health promotion activities (education programs, social media campaigns and stall at community events etc.).

Culturally appropriate support for quitting

The development of a range of localised quit support options available through the TIS program has resulted in the short-term outcome 'Improved access to culturally appropriate support to quit' within the TIS program logic being met.

A key strength of quit support offered by grant recipients identified in the evaluation is the culturally safe, supportive and trusting environment grant recipients have created for Aboriginal and Torres Strait Islander community members.

> I like coming here, it's non-judgemental. The [TIS] workers are equal to clients, they're supportive and honest and you can trust them. Community member, rural, 2017

> When you have a non-Indigenous person tell you about smoking you're not going to listen – after the wrongs of the past you're not going to listen – from one Indigenous person to another, the message is clearer. Community member, rural, 2017

The 2017 Primary stakeholder survey data revealed that 78% of respondents agreed (28%) or strongly agreed (50%) that TIS activities have improved community members access to culturally appropriate support to quit. Findings from the 2016 and 2017 TIS Grant Recipient surveys also suggested that grant recipients have facilitated access to quit support for Aboriginal and Torres Strait Islander people. Over two years, the surveys revealed growth in the percentage of respondents that agreed that TIS activities have improved community members access to culturally appropriate support to quit (see Figure 9). In 2017, 95% of respondents (up from 88%) either agreed (22%) or strongly agreed (73%) that TIS have improved community members access to culturally appropriate support to quit.
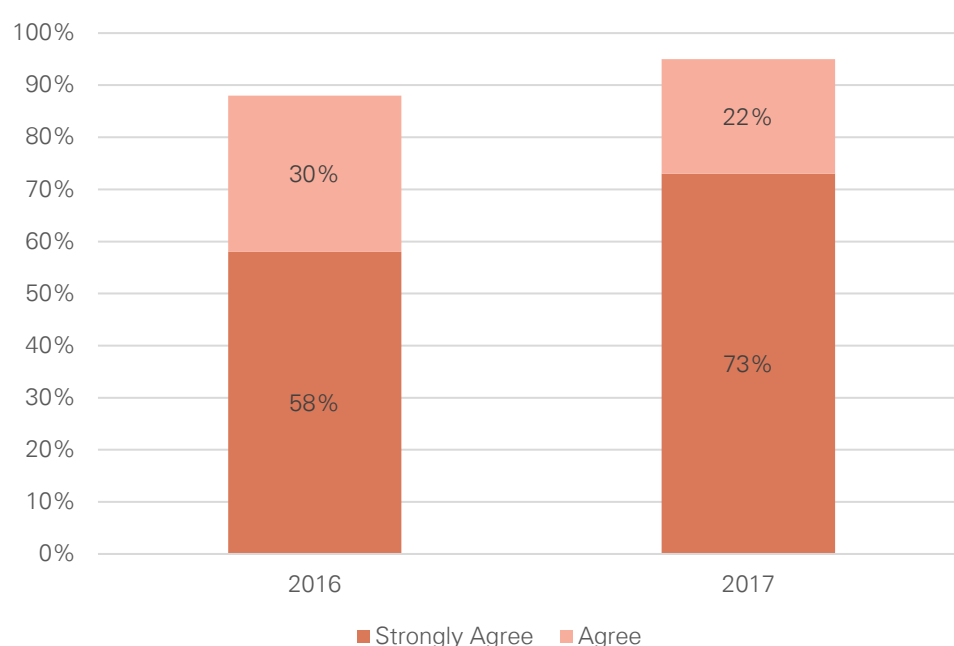

Figure 9. Percentage of respondents who agree or strongly agree that TIS activities have improved community members access to culturally appropriate support to quit in 2016 (n=108) and 2017 (n=81).

The two most common forms of quit support offered by grant recipients are discussed in more detail below.

One-on-one support

The provision of one-on-one support for smoking cessation is one form of quit support offered by grant recipients to Aboriginal and Torres Strait Islander community members, especially in rural and remote areas. One-on-one support typically involves a discussion of cessation options, goal setting, counselling, yarning about the quit journey and follow up regarding NRTs. One-on-one support continues throughout a client's quit journey and in some cases, will continue for a period after the client has successfully quit.

Grant recipients providing one-on-one support report that this form of quit support is necessary to reduce smoking rates among Aboriginal and Torres Strait Islander people in their communities. In very remote areas for example, one-on-one support and visiting community members in their homes is key to local TIS program activities due to the isolation of communities, including limited access to mobile phones and internet coverage. One-on-one support allows grant recipients to invest long-term in a client's quit journey by providing continual, face-to-face tailored support, which is considered by these grant recipients as a culturally appropriate way to provide smoking cessation support to Aboriginal and Torres Strait Islander community members.

> I believe there's nothing better than talking face-to-face. I guess that's a strong thing in Indigenous communities, we all sit around and yarn around the table, around the fire, out the front. I believe our clinics are a strong support for those who want to give up smoking. Grant recipient, rural, 2016

The ability to build strong relationships and trust with community members is seen by grant recipients as a valuable outcome of one-on-one smoking cessation support. Community members also spoke about the value of one-on-one support, which they felt aided their quit attempts by providing continual encouragement and the opportunity to yarn about successes and challenges with TIS staff.

> I found that the strategies that [name of TIS worker] program gave me was really helpful … You know, delay, have a drink, distract yourself. Every time I wanted a smoke I could hear his voice. I thought this isn't going to work, but it did. I thought about it, I'd distract myself … They would ring me randomly and not talk about smoking, [name of TIS worker] would say 'how's it going?' And I'd say 'good'. And I'd feel good … They're some of those things that that program gave me, that I thought was really good. Community member, urban, 2016

TOM'S* QUIT JOURNEY

After 30 years as a smoker Tom began experiencing regular chest pain and decided it was time to quit. Tom opted to quit cold turkey. A week after his last cigarette Tom began experiencing pain in his arms, neck and chest so he visited his local hospital. Whilst in the waiting room, Tom was approached by members of the TIS team from his local remote ACCHS. Tom explained his recent decision to quit and the TIS team referred him into their program. Tom began seeing a TIS team member once a week to have a yarn and to learn strategies to reduce his cravings: '*They gave me tools to help, to take my mind off smoking*'. For Tom, the TIS team became a support system which he could turn to during the first few months of quitting: '*They were a bonus. [They] helped me get through quitting. A support, someone there if needed*'.

Tom has now been smoke-free for eight months. He drops in to see the TIS team every now and then for a yarn. He has also recently become a local champion for their social marketing campaign. Tom hopes sharing his story will inspire others to quit and 'show the community that it's easy to give up!'

*Name replaced

Group support

The delivery of group support for smoking cessation is provided by grant recipients in urban and rural areas, and some remote areas. Since the mid-term evaluation, there has been an increase in the number of grant recipients providing group support. These support groups take on several forms including general quit support groups, women's and men's groups, walking groups and healthy lifestyle groups. These groups include a smoking cessation approach where smoke-free messages, smoking cessation education, counselling, and support and referrals are provided. Since the start of the new redesigned TIS program in mid-2015, grant recipients have established both their own smoking cessation groups as well as building relationships with existing community groups and provide smoking cessation education and information on referral pathways through these groups.

During the evaluation some grant recipients reported facing challenges to engaging community members through quit support groups. Others reported it was a successful medium they used to engage and provide on-going smoking cessation education and support to Aboriginal and Torres Strait Islander people.

> Some of the stuff that's come out of the quit group is that they've … enjoyed listening to each other's stories and how they have made quit attempts over the years. Grant recipient, urban, 2016
>
> Quit groups often have strong outcomes but can be hard to organise, so we work in partnership with other organisations to establish quit groups. Grant recipient, urban, 2017

In addition, some community members highly valued the opportunity to discuss their quit journey as part of a wider group of Aboriginal and Torres Strait Islander people attempting to quit.

> The group atmosphere in the weekly [name of program] group sessions is a great space to share smoking stories in a non-judgemental environment. I also pick up tips on what has or hasn't worked for others on their quit journey. Community member, urban, 2017

The evaluation also identified that since mid-2015 some TIS staff who were smokers have since quit through the one-on-one support provided by their TIS colleagues and group support programs in their organisations.

> I haven't smoked for 12 months now. The previous [TIS] coordinator always encouraged [me]. That's what worked the continuous encouragement and when I gave up there was support after. Grant recipient, rural, 2016

INFORMAL SUPPORT DELIVERED THROUGH QUIT CAFES

Quit Cafes are informal groups that engage community to focus on reducing tobacco consumption and promoting smoke free environments. Quit Cafes are organised across Tasmania by the TIS team at Flinders Island Aboriginal Association (FIAAI) in partnership with Aboriginal or community organisations.

The Quit Cafes provide an opportunity to meet with the TIS team and the Aboriginal Quitline Counsellor in a casual setting to support individual quit attempts, provide NRT and ongoing support. The Smokerlyzer is used to provide carbon monoxide readings and to motivate participants to move towards quitting. In some cases, appointments are pre-booked with the local GP to ensure participants have timely access to discuss their Quit journey.

Prior to Quit Cafés, FIAAI contacts the local GP and chemist to ensure adequate NRT supplies are in stock and that they are prepared for potential clients seeking support; this is particularly important in remote settings. Feedback sheets are provided so participants can register for follow-up by TIS staff or Quitline and participants are given 'I'm ready to quit' cards which they can give to their GP or pharmacist.

A survey conducted by FIAAI found that knowledge of the risks of smoking, benefits of quitting, and knowledge of support services had increased as a result of the Quit Cafes. The survey found that 80% of respondents reported that they were 'a lot more likely to quit', 78% of respondents reported being 'a lot more informed of risks of smoking and benefits of quitting' and 89% of respondents reported being 'a lot more informed about support services'.

4.3.3   Quitline

Quitline is a telephone helpline service that provides support to people who would like to quit smoking. The TIS program provides funding to Quitlines to support their capability and capacity to provide accessible and appropriate services to Aboriginal and Torres Strait Islander people. The funding has also supported employment of Aboriginal and Torres Strait Islander staff. Aboriginal Quitline services are available across Australia and provide Aboriginal counsellors or counsellors that have specialist training to assist Aboriginal and Torres Strait Islander people with smoking cessation in a culturally appropriate way. Callers are provided with information on different quitting methods and products, available resources and a plan for quitting is tailored to their individual needs.

Grant recipients refer community members onto Quitline during health promotion activities (community events, smoking cessation education etc.) or as an additional support network when one-on-one or group support is being provided. Doctors working in grant recipient organisations with a clinical service may also refer clients directly to Quitline. Some grant recipients are incentivising the use of Quitline by providing those clients who utilise the service with free NRTs.

Over the course of the 2016 and 2017 calendar years, a total of 7,629 Aboriginal and Torres Strait Islander referrals were made to Quitline nationally, 3,598 between January to December 2016 and 4,031 between January to December 2017, demonstrating a 12% increase in the number of overall referrals over two years. In 2017, most referrals overall were self-referred (58%). Referral sources were provided for three Quitline jurisdictions. Of these jurisdictions, 11% of their referrals were directly from an ACCHS (356 out of 3,368).

Analysis by jurisdiction revealed that most referrals came from Queensland (60%), followed by NSW (17%) (see Figure 10). This is not surprising given that these states contain some of Australia's largest metropolitan cities where grant recipient activities have a stronger focus on health promotion activities and where one-on-one support is limited. Queensland's exceptionally high rates may also be explained by the presence of four grant recipients, one of which is the Institute of Urban Indigenous Health (IUIH) which covers a broad catchment area throughout urban and regional Queensland and has a well-established program that includes consistent referrals to Quitline. However, total referrals to Quitline cannot be attributed to local TIS programs alone and should be interpreted with respect to a broad range of tobacco control initiatives occurring at local and national levels.

Across jurisdictions, Queensland, Tasmania, Victoria and Western Australia saw a 17%, 21%, 33% and 36% increase respectively in Aboriginal and Torres Strait Islander referrals to Quitline from 2016 to 2017. The remaining states remained relatively stable over the two years with the Northern Territory demonstrating an increase by 13% and NSW/ACT declining by 13%.
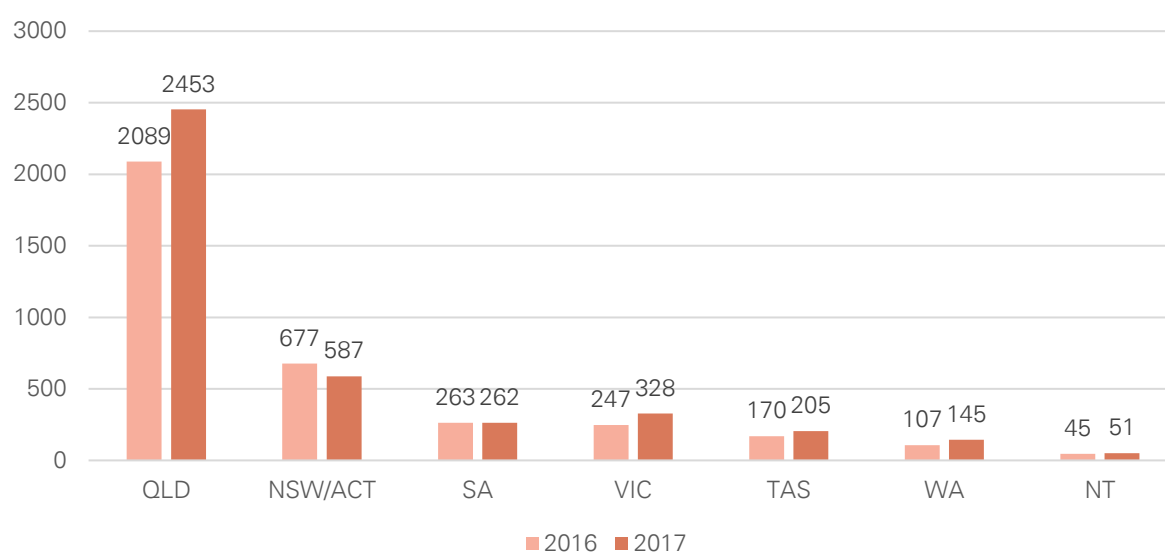

Figure 10. Total number of Aboriginal and Torres Strait Islander referrals to Quitline in 2016 and 2017 by jurisdiction.

Analysis of trends throughout 2016 and 2017 revealed spikes in Aboriginal and Torres Strait Islander referrals (see Figure 11). Given the high referral rates in Queensland, results were analysed separately and national trends excluding Queensland were found to be consistent with those including Queensland. In 2016, peaks were seen in May and September. These months coincided with key dates related to Aboriginal and Torres Strait Islander communities and tobacco control, including National Reconciliation Week (27 May – 3 June) and World No Tobacco Day (31 May). The Australian

Government implemented annual tobacco excise increases in September during the period of the current TIS program. March 2017 also saw a rise in referrals which coincided with National Close the Gap Day (16 March) and the application of the tobacco excise to five leading brands of manufactured cigarettes. Declines in referrals were seen during holiday months between December to January and April.

Many grant recipients capitalised on significant dates to organise community events to deliver education on tobacco related harms and promotion of quit support including Quitline (as discussed in section 4.2.1: Community education). The rise in referrals during specific periods suggests that localised health promotion, together with broader measures of tobacco control likely contribute to increases in individuals wanting to quit, a medium-term outcome of the TIS program, although direct attribution is not possible.
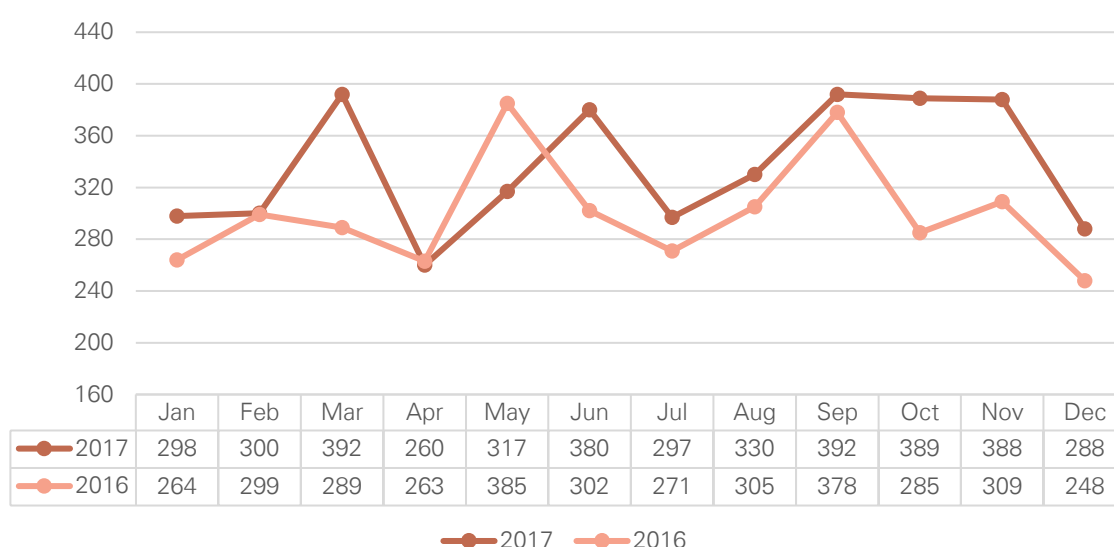

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2017	298	300	392	260	317	380	297	330	392	389	388	288
2016	264	299	289	263	385	302	271	305	378	285	309	248

Figure 11. Number of referrals each month for Aboriginal and Torres Strait Islander people between January 2016 to December 2016 across each state and territory.

Qualitative consultations with Quitline staff revealed that they acknowledged the importance of engaging and building strong relationships with grant recipients (especially in rural and remote areas) and adapting service delivery to ensure it is culturally appropriate and meet the needs of Aboriginal and Torres Strait Islander people as key to increasing referrals to Quitline. The evaluation determined that there are several strong partnerships between Quitline and grant recipients. These partnerships involve site exchanges, shared-care approaches (see case study below) and introducing Quitline Aboriginal Counsellors to community during TIS health promotion events. Some Quitline staff emphasised the importance of building trust with grant recipients and community.

Since being out in community and meeting so many different people, meeting the workers who often have that key relationship with community, for them to be able to say look we have met someone from Quitline, this is what they do, I think that is helping build the relationships a little bit more. Quitline employee, 2016

One Quitline Coordinator also highlighted that referrals for non-Indigenous people who have relationships with Aboriginal people (e.g. parent or partner) have also been made by TIS grant recipients, emphasising that grant recipients are 'capturing the community as a whole, and the environment around the Aboriginal person.'

PARTNERING WITH QUITLINE FOR A SHARED CARE APPROACH

Lakes Entrance Aboriginal Health Association (LEAHA) in rural Victoria in partnership with Quit Victoria are delivering a shared care approach to supporting Aboriginal and Torres Strait Islander people from the Gippsland region of Victoria to quit smoking.

LEAHA covers a large geographic area with limited capacity to provide smoking cessation support to individuals. Quit Victoria was receiving limited calls from Aboriginal people in the region and Aboriginal clients were rarely accessing Quitline support through their local TIS program.

In response to this, in 2016, LEAHA and Quit Victoria agreed to a shared care approach. The Quitline referral was embedded into LEAHA's intake form thus integrating an opt-out system. This approach ensures clients will automatically receive support from Aboriginal Quitline with their informed consent. After 9 months of adopting this shared care approach, 86% (50 out of 58) of clients eligible for the service went onto receive a call from Aboriginal Quitline, contributing to the rise in overall referrals in Victoria between 2016 to 2017.

This approach has embedded best practice treatment (a brief intervention, support with NRT when appropriate, referral for specialist behavioural treatment) into routine care at a local level, enabling the smoker to have face to face support plus additional support over the phone from the Aboriginal Quitline. This approach allows LEAHA and Quit Victoria to communicate regularly and share the responsibility for the client's care, providing clients with every chance to receive the assistance they need to quit and stay quit.

Since the mid-term evaluation, there is further evidence that a range of improvements have been made by Quitline to increase TIS grant recipients referrals to Quitline. This includes moves to remove the private number that currently appears when calls are made to clients, a shift towards email referrals, increased community engagement and exploring ways to reduce barriers to sharing data and client information.

The services Quitline offers to Aboriginal and Torres Strait Islander communities, including the provision of Aboriginal counsellors was highly valued by some grant recipients. The resources provided by Quitline were also noted as valuable. Throughout the evaluation, community members who have accessed Quitline also discussed positive experiences utilising Quitline services, including the confidential nature of the service and the encouragement and support they received from Aboriginal counsellors on their quit journey.

> [name of TIS worker] put me onto Quitline. They are good, and I spoke to an Aboriginal worker there. They call me every week to encourage me to stay away from smokes. But I'm doing well, and I don't miss smoking. Community member, urban, 2016

> It's brilliant, they'll have a yarn to you about what you're going through. They talk to you like a real person, [they] don't judge you. I feel more comfortable with the Aboriginal Quitline. Community member, rural, 2017

Despite the positive response to Quitline by some grant recipients and community members, throughout the evaluation grant recipients, largely in remote and some rural contexts discussed the shortcomings of this model of smoking cessation support for Aboriginal and Torres Strait Islander people in their region. These grant recipients reported that referral of clients to Quitline was low because clients disclosed that they preferred to speak to a familiar person face-to-face and were unwilling to talk about smoking over the phone. Some also noted that talking to a stranger over the phone about smoking is considered 'shameful' by some Aboriginal community members. Grant recipients in remote areas discussed additional challenges to utilising Quitline as part of their local TIS program, including language barriers and community members limited access to phones and phone credit. Concern that Quitline staff are not always aware of specific issues or contexts within a community (e.g. a death in community) and may contact clients at inappropriate times was also highlighted by remote grant recipients as a concern. A few grant recipients reported addressing the limited applicability of Quitline for their communities by setting up their own internal phone counselling service, which emulates the services offered by Quitline. That is, a telephone support service that clients can call to have a yarn about smoking and smoking cessation options.

> We don't really refer to Quitline as community doesn't always speak English so not viable. We are not going to refer to Quitline if the counsellor doesn't speak communities first language. Grant recipient, remote, 2017

Some community members also spoke about their aversion to Quitline services and their preference for one-on-one and face-to-face smoking cessation support. This included community members feeling uncomfortable speaking with a counsellor who is located a long way from their own community. Some also noted that because counsellors are from 'the city' they feel they won't be able to connect or understand their experiences.

> With TIS [team] you can tell they are genuine but over the phone [Quitline], no body language, no trust. Maybe they couldn't give a toss, [it] puts me on edge. Community member, rural, 2017

Quitline staff also acknowledged that Quitline services may not be an appropriate support service for all Aboriginal and Torres Strait Islander community members seeking quit support. In response to these challenges, Quitline staff suggested that Quitline should not be considered an alternative to local TIS programs but rather should be considered a supplementary support service that can complement the work of local TIS programs.

> Quitline is not always an appropriate service for Aboriginal clients or mainstream clients. There are a certain group of people who are comfortable with speaking over the phone to an anonymous counsellor and there are others for whom that is not appropriate. Quitline employee, 2016
>
> Whilst the face-to-face work [of TIS teams] is so vital for our communities, we are an extra support system that can be there for after hours, weekends, public holidays when their face-to-face workers

may not be available for community … it's not about us taking away from their work, it's about us supporting the work they are already doing. Quitline employee, 2016

Despite one urban grant recipient in 2016 establishing an MOU with Quitline to allow for the easy sharing of referral data between the organisations, it was evident that there is a greater need for Quitline to share referral and outcome data with grant recipient organisations. The need for Quitline to refer clients back into local TIS teams that have the capacity to provide ongoing support for comprehensive health care was also noted as important by some grant recipients. This two-way support system is highlighted in the case study 'Partnering with Quitline for a shared care approach' above.

If we refer [to Quitline] we never hear anything back. We need to know what happened with our clients, so we can support them and do follow-up but [it] seems impossible to get that information. Grant recipient, urban 2017

4.3.4   Workforce development

A key short-term outcome of the TIS program is to increase specific skills of professionals in contact with Aboriginal and Torres Strait Islander peoples to ultimately strengthen the quality and appropriateness of services. TIS grant recipients have reported extensively on workforce development activities for TIS staff, other health professionals and for professionals outside their service in performance reports, surveys and qualitative consultations. According to the 2017 TIS Grant Recipient survey, all TIS Managers responding to the survey (n=30) reported that staff had undergone some form of training in the last 12 months to support people to quit.

Quitskills

The Cancer Council SA runs Quitskills training across Australia for people working with Aboriginal and Torres Strait Islander communities. There are three parts to the Quitskills program: the main Quitskills Training Course (undertaken over three days); a one-day Quitskills Refresher Course; and Quitskills Motivational Interviewing Training (undertaken over two days). A key function of Quitskills is to increase the knowledge, skills and capacity of professionals in contact with Aboriginal and Torres Strait Islander people to deliver smoking cessation information and support, which is an expected short-term outcome of the TIS Program. A few other smoking cessation courses are run throughout Australia, some of which are discussed below.

An evaluation of Quitskills programs was conducted by the South Australian Health and Medical Research Institute (SAHMRI) in July 2016 to investigate the effectiveness of Quitskills training in increasing the knowledge, skills and confidence of Aboriginal Health Workers to support Aboriginal and Torres Strait Islander people to quit smoking.[20] Some of these evaluation findings are presented below. Between February 2012 and May 2016, 102 Quitskills Training (879 participants), four Quitskills Refresher (24 participants) and seven Motivational Interviewing (39 participants) courses were delivered across Australia (see Figure 12).

Figure 12. Map of Quitskills sessions delivered in each Australian jurisdiction between February 2012 and May 2016 (SAHMRI, 2016).

It is worth noting that in Queensland, the Menzies School of Health Research has been working in partnership with Cancer Council Queensland to deliver Aboriginal and Torres Strait Islander brief intervention training (B.strong). In 2017, 26 workshops were delivered to 380 participants, 41% from the ACCHS sector. This may explain the small number of Quitskills workshops in Queensland (see Figure 12).

To date, most TIS staff have undergone Quitskills training, both the Quitskills Brief Intervention and Motivational Interviewing training as well as refresher courses for those staff with prior Quitskills training. According to the 2017 TIS Grant recipient survey, 77% of TIS Managers indicated staff in their organisation had undergone Quitskills training.

Grant recipients have also extended the opportunity to other staff (clinical and non-clinical) within their organisation as well as stakeholders from other organisations to participate in Quitskills training. Out of the 46 respondents to the 2017 Primary Stakeholder survey (21 of which did not belong to a TIS funded organisation), 60% reported that staff within their organisation had undertaken quit support/smoking cessation training in the last 12 months. This represents a substantial increase from last year, where 30% of primary stakeholder respondents reported staff in their organisation had undergone training. It should be noted that not all organisations that grant recipients partner with are suitable for quit support training. In 2017, close to a third of respondents (29%) indicated that quit support training was not applicable to their organisation.

> We've got a lot of Aboriginal Health Workers who completed Quitskills as well, which is important because they're the first point of call for our clients when they come in for a doctor's appointment. But they are all aware of brief interventions and the referral process that the team can put in place so … in every way, shape or form that they come in, they're covered with how they can best help them. Grant recipient, rural, 2016

Throughout this evaluation, grant recipients and other stakeholders were overwhelmingly positive about Quitskills programs and their relevance to the Aboriginal and Torres Strait Islander health workforce. Education regarding NRTs and the informal approach used to deliver Quitskills training was highly valued. Findings from the SAHMRI evaluation of Quitskills training similarly reported positive feedback from workshop participants, including the cultural relevance of the training (the use of Aboriginal and Torres Strait Islander facilitators and Elders and story-telling as a key element) and its usefulness for workplace and practice (SAHMRI, 2016). The evaluation reported a significant increase in participant's knowledge to assist clients with tobacco related issues (53.3% to 98.1%) and confidence in ability to address tobacco use (55.8% to 98.0%) after the completion of the Quitskills training. In addition, 83.7% of participants from the Quitskills training reported that they use their knowledge gained at least weekly (with 30.5% using it daily) and 10.8% less than weekly since they attended the course (SAHMRI, 2016).

Grant recipients also reported that the Brief Intervention and Motivation Interviewing course was beneficial in increasing their technical skills, capacity and confidence to deliver smoking cessation advice and support. In relation to the Motivational Interviewing course, the SAHMRI evaluation noted significant increases in confidence of Aboriginal Health Workers post workshop in four areas: a) using their acquired counselling skills (54.6% to 93.8%); b) using their Motivational Interviewing skills (54.6% to 100%); c) identifying and responding to change talk (54.6% to 93.7%) and; d) undertaking brief interventions (69.7% to 96.9%) (SAHMRI, 2016).

> I think it helped them [TIS staff] with feeling more confident with smoking cessation stuff. Quitskills was really good, they're a great team and the way they deliver. There were a few of us who had a lot more experience in terms of tobacco and there were the ones that had very little. They were able to tailor it to suit. Grant recipient, remote, 2016
>
> I liked the [Quitskills] training. It was good knowledge for me [and] I came it realising there were things I didn't know … I'm more aware of things now … it's building my knowledge. Grant recipient, rural, 2017

Other training

In addition to Quitskills training, TIS staff have participated in a range of other smoking cessation courses. According to the 2017 TIS Grant Recipient survey, 47% of TIS Managers reported staff had undergone No Smokes training, and 67% reported staff had undergone some other form of training (e.g. intensive smoking cessation courses, and other Brief Intervention training). Other forms of training that have emerged from qualitative consultations include Deadly Choices training; Smoking Cessation Facilitator's course at the Alfred Hospital; and the Fresh Start Cancer Council training. Associate Professor Renee Bittoun, a tobacco treatment specialist conducted a series of webinars in 2017 around specific topics in relation to smoking cessation. Some grant recipients reported positive experiences

and increased knowledge as a result of attending the training, while others reported concerns over the relevance and appropriateness of the training.

> The Renee Bittoun training was extremely beneficial. After that training things seemed to click for TIS staff and they started to do their job better. Grant recipient, remote 2017
>
> Our staff found this training too high level. Best practice wasn't in line with the realities of where we work. Grant recipient, remote 2017

Despite a strong commitment to improving workforce development through increasing opportunities for TIS staff to undergo Quitskills and other smoking cessation training, the administration of training is a challenge for some grant recipient organisations, especially those from remote locations. This includes limited access to training opportunities, the time commitment required to undertake training (especially if staff must travel to attend training) and high staff turnover resulting in the need for regular training of staff.

> [It's] hard to get clinical staff to attend Quitskills training. They are so busy, and [the] training is too long. Grant recipient, remote 2017

A few grant recipients have also developed their own brief intervention and smoking cessation training, which they deliver internally to clinical and non-clinical staff and stakeholders from external organisations. For example, in 2016 a rural grant recipient building the capacity of frontline staff to provide brief intervention and referrals into the TIS program reported delivering 26 education sessions with 117 staff in their performance report. In 2017, some grant recipients continued to report the delivery of education sessions in performance reports. This included training to 67 staff in rural NSW and presentations to 110 professionals in urban WA. The option of a shorter Quitskills course or the training being made available as an online course was suggested by grant recipients as a possible solution to the time commitment required for TIS staff and other stakeholders to participate in training in the future.

> I think with the brief intervention package that we've just developed and we're starting to deliver that we're really ticking off on what we see are key footprint that we can leave behind, is that up-skilling of our health worker staff. Grant recipient, remote 2016
>
> … we have trained 30 Aboriginal community members to do brief interventions across a wide geographical area to be advocates for not smoking. Grant recipient, urban, 2017

This evaluation has found that smoking cessation training, and in particular Quitskills training, has strengthened TIS staff knowledge, skills and confidence to provide brief intervention and quit support to community members. It was also noted to have improved the confidence and capacity of clinical and non-clinical staff within grant recipient organisations, for example, a remote grant recipient in WA has developed a Brief Intervention package. The increases in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people is a key short-term outcome identified in the TIS program logic that has been met and has contributed to the delivery of culturally appropriate quit support.

Throughout the course of this evaluation, workforce development has prioritised training around smoking cessation support. While TIS workers did not themselves report a need for health promotion training in qualitative consultations, the evaluation notes there is currently no formal training in health promotion theory and practice provided to grant recipients. Information regarding health promotion activities undertaken by grant recipients is shared through NBPU TIS jurisdictional workshops and TIS portal (see section 4.4). However, given the extent of health promotion activities undertaken, training in health promotion theory and skills, particularly in Aboriginal and Torres Strait Islander community settings would be of value to ensure grant recipients are equipped with the knowledge and skills to strengthen the activities currently undertaken.

BUILDING CAPACITY TO SUPPORT QUITTING

TIS grant recipient, Kimberley Aboriginal Medical Services (KAMS) is the peak body for Aboriginal Community Controlled Health Services (ACCHS) across the Kimberley region of Western Australia. KAMS is working in partnership with its member services to deliver the TIS program.

KAMS have developed a TIS specific service level agreement (SLA) with each member service to guide the delivery of the TIS program. The TIS SLA outlines each party's roles and responsibilities in delivering the TIS program and in meeting key outcome measures. Broadly speaking, member services are responsible for the day to day delivery of the TIS program across their region and KAMS, via the TIS Manager, is responsible for ensuring the program is regionally consistent, quality focussed, and capable of demonstrating outcomes. Within the SLA is a commitment to improving the number of smoking assessments that are completed at each of the ACCHS across the Kimberley by 10% per financial year.

In addition to increasing the number of smoking assessments completed per year, KAMS and Broome Regional Aboriginal Medical Service (BRAMS) have worked to develop a two-hour brief intervention training package which guides health professionals on how to use the smoking assessment as a mechanism to engage clients in a conversation around their smoking behaviours and offer brief advice and a TIS referral. The aim is that by training staff to use the smoking assessment as an opportunity for delivering brief intervention, a consistent language and practise around how Kimberley ACCHS respond to patients who smoke is developed, which in turn develops a culture within the ACCHS that values the provision of advice, support and where appropriate referrals to the local TIS team.

Over 140 health professionals across the Kimberley region including Aboriginal Health Workers, Doctors and Nurses have participated in the training since first implemented. In addition, Aboriginal Health Workers undertaking Certificate III and IV with KAMS have also been trained. The training has been embedded into the TIS Activity Plans as part of the workforce support and development pillar.

KAMS, BRAMS and the Ord Valley Aboriginal Health Service (OVAHS) presented on the Kimberley Brief Intervention package at the WA NBPU TIS workshop in July 2016 and since then BRAMS, the Aboriginal Health Council of WA (AHCWA); Australian Council on Smoking & Health (ACOSH) and Quitline Aboriginal Liaison Team have joined forces to develop a state wide Aboriginal Health Worker Smoking Cessation and Brief Intervention Training Package.

KEY FINDINGS: ACCESS TO QUIT SUPPORT

The evaluation identified a range of opportunities grant recipients have developed for community members to achieve cessation. A range of referral pathways have been established, including clinic-based referral and referrals made during localised TIS health promotion activities. This approach allows grant recipients to extend their reach and increase the number of referral access points. External partnerships have further increased referral access points and community engagement with localised TIS programs.

Improving access to culturally appropriate support to quit has been a key focus of the work of grant recipients throughout this iteration of the TIS Program. Typically, this quit support is provided either one-on-one or through a smoking cessation group, with some community members also referred through to Quitline. Several grant recipients are also tapping into existing community groups and providing smoking cessation education and support through these networks. Evaluation findings suggests one-on-one support is the preferred option for many community members and is widely used by grant recipients in rural and remote areas. However, there is also evidence that smoking cessation groups have been an effective medium to increase knowledge of smoking related harms and opportunity for smoking cessation support.

Quitline enhancements are a component of the TIS program. Evaluation findings together with data from Quitline suggest that referrals to Quitline are higher in urban and some rural areas. This may be due to infrastructure and language barriers in remote areas together with a preference for face-to-face cessation support by many Aboriginal and Torres Strait Islander people. Continuing to build strong partnerships between Quitline and grant recipients will be key to increasing referrals from local TIS programs to Quitline going forward.

Increasing the skills of TIS workers and other professionals in contact with Aboriginal and Torres Strait Islander people to provide smoking cessation education and brief intervention has been a key focus for grant recipients. Quitskills training and to a lesser extent other smoking cessation education programs have been utilised to broaden the knowledge and skill base of TIS workers and in some instances, stakeholders who are working closely with TIS teams. The increases in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people is a key short-term outcome identified in the TIS program logic that has been met and has contributed to the delivery of culturally appropriate, high quality quit support.

4.4 Contribution to larger evidence base

Evidence-based policy and practice has been a prevailing factor in the Australian health sector in recent years. Public agencies have committed to collect and analyse information, represented by a shift towards outcomes-based reporting, to internally assess impact and to further improve services.[21] Consistent with this movement, the redesigned TIS program emphasises the importance of evidence-based practice and outcomes-focused activities. This shift also serves to contribute to the larger evidence base around tobacco control in Aboriginal and Torres Strait Islander communities, as articulated in the TIS program logic. This section explores the contribution of TIS grant recipients and innovation grants to the evidence base around tobacco control and examines the guidance provided by the NBPU TIS and TIS portal to support the use of evidence and a focus on outcomes.

4.4.1 TIS grant recipients using and building evidence around tobacco control

A significant finding of this evaluation is the implementation of the redesigned TIS program outcomes focus, a key short-term outcome of the TIS program. While there is acknowledgement that collecting and presenting outcome data is challenging, overall, grant recipients recognise the value of the transition in terms of informing program design, internal quality improvement and demonstrating the impact of TIS activities. The increased focus on evidence-based activities and outcomes-based approaches in response to support from the NBPU TIS was also seen as a positive development by grant officers in the HG&N.

To ensure activities are based in evidence and outcomes focused, grant recipients initially developed Action Plans to articulate their activities, evidence behind these activities, intended outcomes and data collection methods to measure these outcomes. Throughout this evaluation, grant recipients have adopted a range of approaches to data collection. These approaches can be broadly categorised into two forms; population level data collection and activity level data collection.

Health service data collection

The influence of TIS teams across the country to bring about organisational change in terms of data collection around smoking should not be understated. Most TIS teams attached to a clinical service[4] have capitalised on existing electronic health records used within the service (e.g. Communicare, MMEx) to embed smoking measures and establish systems of referrals and follow up. By embedding questions around smoking status, as well as quit attempts and intention to quit, grant recipients can gauge the burden and needs of their community to inform their TIS activities and monitor change.

> We've got a series of structured reports in Communicare that are gradually providing us with better information on trends across the population … things like the number of people who smoke, what their smoking status is … Grant recipient, urban, 2016

While advancements have been made regarding embedding smoking measures within patient information systems, this data collection is dependent upon health workers' accurate recording. If data

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[4] It is important to note that not all TIS teams are attached to a clinical service or can access clinical databases. For these TIS teams, reporting on population level smoking data is not feasible or appropriate.

is not input correctly, the quality of the data is diminished. Some grant recipients have indicated the development of guidelines and administration of training to staff around the importance of inputting data. Moreover, grant recipients, particularly those not attached to an ACCHS have expressed frustration over the inability to access nKPI[5] data from their local ACCHS due to confidentiality issues which has impacted TIS planning. Despite this, as noted by one HG&N, grant recipients have developed relationships with other ACCHSs allowing the provision of some data, such as the proportion of smokers who have registered an interest in quitting.

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[5] The national Key Performance Indicators are a set of indicators that provide information on process of care and health outcomes (including smoking status), currently reported for aboriginal and Torres Strait Islander patients of Commonwealth funded Aboriginal primary health care services.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is Victoria's peak representative Aboriginal health body and responsible for the coordination of the Western and Mallee District Aboriginal Community Controlled Organisation (ACCO) consortia (ten ACCOs) funded to develop and deliver the TIS Program in Western and North Western Victoria. The TIS consortium members are already members of VACCHO as the peak body for Aboriginal health and wellbeing in Victoria.

Background to the initiative

One of VACCHO's roles as the coordinator of the consortia is to strengthen and support TIS programs using evidence-based and best practice models to improve smoking cessation and reduce uptake. VACCHO's experience in delivering tobacco control programs in the region has enabled it to identify that looking only at the currently collected nKPI of smoking status is not a good indicator in the short term of how smoking cessation programs are being evaluated. It is therefore not an effective measure in terms of assessing and communicating the success of these initiatives usually funded for short time frames.

The current challenge

To more realistically assess the progress of programs, VACCHO wanted to be collecting stages of change data that articulated participants' intention to quit. With this data consistently collected over time, it would be possible to see the subtle shifts in individual behaviour change which is a more sensitive short-term measure of progress made towards smoking cessation in Aboriginal and Torres Strait Islander populations. Various members across the consortium and other ACCOs in the state were inconsistent in collecting stages of change data, with only some currently doing so. Where this was being done, it was likely that members were collecting this information through different means and time periods not allowing for a central data source to analyse results. Accuracy of data is a vital component of proving and improving the success of programs and VACCHO have worked closely with members of the consortium to improve data collection in this area.

OVERVIEW

The need

Strengthen the evidence base around smoking cessation in Aboriginal and Torres Strait Islander populations.

The solution

Database to collect consistent data across regions covered by Victorian ACCOs.

The benefit

Consistent data to assist ACCOs in identifying priority populations and geographic burden and demonstrate outcomes.

Overcoming the challenge

Most Victorian ACCOs collect clinical data on one of three Patient Information and Recall Systems (PIRS); Medical Director 3, Communicare and Best Practice Premier. Data from these PIRS is then compared through aggregation using Pen Computer Systems' CAT4 and PATCAT software. In order to overcome the issue of varied and inconsistent data sources, VACCHO has commissioned PEN CS to further develop these systems to capture the stages of change smoking data within the Patient Information and Recall System (PIRS) during every client visit for transmission to and analysis by the Health Evidence team within VACCHO. This data can be accessed through PATCAT, a web-based program that aggregates de-identified general practice data and displays the information through a comprehensive collection of graphs, charts and reports. The outcome of this upgrade was the enhancement of Tobacco Cessation reports which now includes not only smoking status data but new data for Daily and Irregular Smokers displaying their readiness to quit status (Ready to quit / Intends to quit / Not ready to quit / Unknown).

Using the data aggregated through the new system across multiple sites, users can compare apples with apples with respect to behaviour change data across various demographics. Given that most services in Victoria have CAT4 licenses, they all have access to the additional CAT4 reports. There are currently 23 services across Victoria that have adopted this system.

VACCHO and partner organisations are now starting to see the benefit of establishing baseline data to assess change over time by having access to indicators to more realistically monitor program outcomes.

- ✓ PATCAT data is essentially an extension of existing evaluation measures. It can guide services to see if programs that are being delivered are effective or not.

- ✓ CAT4 now provides additional behaviour change data and the ability to look at behaviour change across various population demographics, allowing organisations to identify groups that require varying degrees of support.

- ✓ The data collected reveals the importance of engaging additional support services at an appropriate time for people requiring assistance in their quitting journey. Organisations can now modify programs and make changes early instead of waiting until the end of a program.

Benefits to consortium partners

Looking over the past eleven months of collecting data, VACCHO and the consortium have continued to see the benefits of utilising this system.

- ✓ All organisations have more accurate data regarding clients through reports that are easy to access and aggregate.
- ✓ VACCHO are continuing to work with organisations to provide knowledge and skills that enable them to use this data to monitor progress through evaluation master classes.
- ✓ Programs are working by targeting clients to bring smoking rates down.
- ✓ An analysis of the data comparing January 2017 to December 2017 has shown 14% of clients are ready to quit, 45% are intending to quit at some point, and 27% are not ready to quit.
- ✓ With a two and a half year target of 100%, smoking status of pregnant women has increased by 4% and is now at 89%.
- ✓ Recording of smoking status of community members aged 10-15 years is up by 27% to 77%, while smoking status of community members 15 and older has increased by 9% to an average of 92%.
- ✓ Regular smokers in the system have reduced by 5% from 58% to 53%.
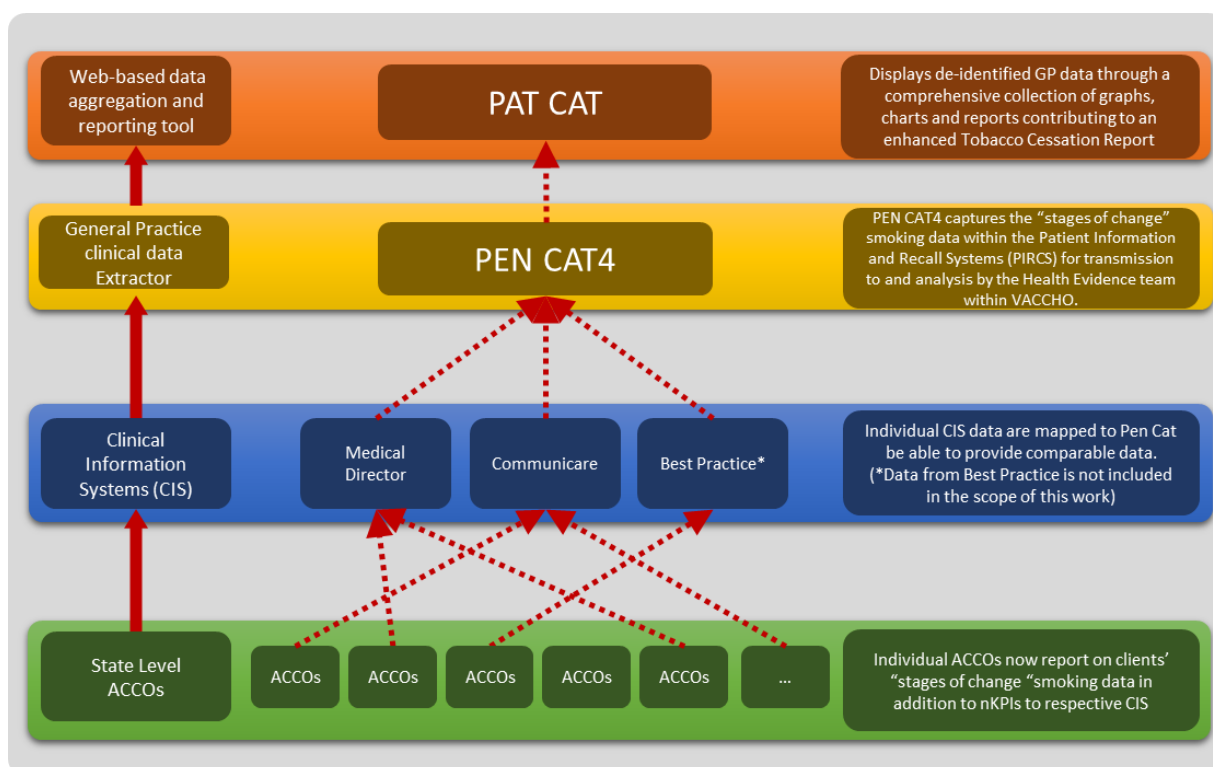
Activity level data collection

In many cases, grant recipients have developed and adapted their own data collection tools to suit target audiences. Pre and post surveys, focus groups and in-depth interviews feature prominently in performance reports and qualitative consultations. This data was used to inform local TIS program design, quality improvement and demonstrate impact.

Grant recipients reported that evaluation tools such as surveys required significant adaptation to satisfy varying health and literacy levels, particularly for grant recipients whose jurisdiction covers remote and very remote contexts where English can be the second or third language spoken. Grant recipients have also harnessed innovative solutions for efficient data collection, for instance, the use of tablets (e.g. iPad) at community events. While this approach was acknowledged as useful, paper-based surveys were a more suitable option in contexts where online access and digital literacy was limited.

Reporting data

Data that is collected by grant recipients are interpreted and presented in performance reports submitted to the Department. The performance report template requires grant recipients to provide a narrative summary on the five national TIS performance indicators. The TIS Performance Indicators are linked to the TIS program objectives and cover the five areas considered to be essential to effective tobacco control programs (see Appendix 3).

The mid-term evaluation highlighted a degree of variation in the collection and reporting of data. Since the mid-term evaluation, analysis of performance report data revealed that the quality of data reported by grant recipients has increased (see Figure 13). The increase in the quality of data reported was matched by a decrease in the data assessed as 'Poor quality' (see Appendix 5 for examples) and 'No data/Unable to rate' over the two waves. This trend was reflected across performance reports from remote, rural and urban contexts.
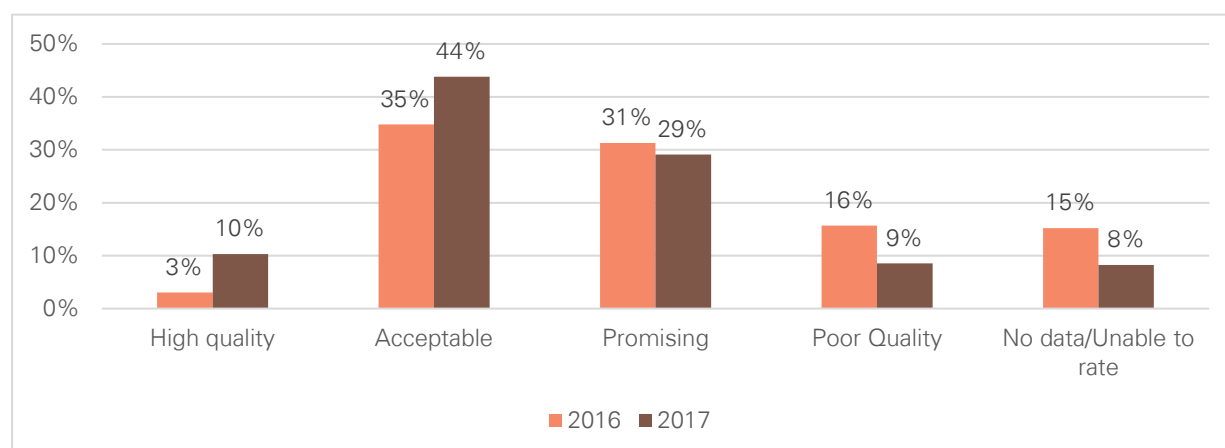

Figure 13. Improvement in quality of performance report data over two waves of TIS performance reports (July 2016 and February 2017).

This improvement is matched by an increase in percentage from 45% in 2016 to 54% in 2017 of grant recipient survey respondents who strongly agreed to the statement: I am confident that we have the monitoring capabilities required to evaluate how the TIS program is performing. This growth in confidence and improvements in quality of reporting, could be attributed to a range of supports including affiliations with a university or research institute, internal research and evaluation expertise, M&E workshops and ongoing support from NBPU TIS, resources provided on the TIS portal, and the TIS performance report guidelines provided by the Department. While confidence and the quality of reporting has improved, variation in the quality of reporting remains.

Challenges to measuring impact

While there has been an overall improvement in grant recipients' reporting, since the mid-term review, variation in the quality of reporting remains with some reports continuing to lack detail and focus too heavily on outputs. Furthermore, tracking outcomes for lifestyle changes and health promotion activities such as social marketing campaigns, school education sessions, and community events continues to be a challenge. Since this issue was identified in the mid-term evaluation, the NBPU TIS has delivered workshops targeting the evaluation of health promotion activities such as social media campaigns. While reporting has improved, some grant recipients have expressed frustration at the inability to demonstrate change.

> Events and social media is difficult to evaluate. People may not engage with a post or a stall at an event, but it can still impact or change behaviour. Grant recipient, remote, 2017

Grant officers in the HG&N similarly noted concerns around seeing the impact of TIS funding and measuring outcomes relating to lifestyle changes. Such interventions require rigorous long-term evaluations to demonstrate impact. This has raised concerns among the HG&N around whether it is appropriate and/or feasible for grant recipients to be responsible for this level of data collection and reporting and emphasises the importance of articulating realistic expectations and outcomes for grant recipients given the timeframes for implementation.

TIS performance report template

The TIS performance report template was designed to be flexible enough to allow for organisations to report on locally relevant activities. It was determined that a standardised data collection tool would not be able to capture meaningful outcome measures for the range of population level activities being delivered across clinical and non-clinical settings. While views towards the performance report template were initially mixed, with some welcoming the flexibility in its format and others noting the word limit as an issue, since the mid-term evaluation several grant recipients have emphasised the need for a more structured reporting template. Grant recipients noted that a more standardised, structured template would be valuable in providing direction and supporting teams measure their outcomes in an effective and time efficient way, particularly regarding health promotion activities. Furthermore, due to the lack of standardised measures, grant recipients are not able to review their performance compared to other organisations in similar settings to facilitate quality improvement discussions and planning. This was echoed by the HG&N who suggested that more consistent data would allow for assessment at a national level.

While many grant recipients, shared this view, some also highlighted the importance of maintaining flexibility, with one rural TIS Manager noting that the 'performance report needs to be flexible enough to reflect flexible models.' This suggests that a review of the TIS performance report template is required, with consideration of flexibility and more standardised, quantifiable indicators. Future templates should be developed in close consultation with grant recipients to ensure they are responsive to their needs and are as user-friendly as possible, while also able to produce consistent and valuable data across locations. HG&N have also noted that consideration should also be given to a 12-month reporting time-frame instead of six-months to allow time to document progress.

Many grant recipients expressed frustration at the lack of constructive feedback on their performance reports, particularly as considerable time is invested in reporting. Currently, the provision of constructive feedback on performance reports has not been allowed for in the roles of HG&N and NBPU TIS. If appropriately funded, there was consensus among NBPU TIS and HG&N that the role of providing feedback to grant recipients on their performance reports should sit within NBPU TIS.

4.4.2   NBPU TIS support

The NBPU TIS has had a critical role in disseminating evidence on best practice, building a community of practice, and promoting a culture of evaluation and continuous improvement for the TIS program. The NBPU TIS is operated by a consortium led by Ninti One, including the University of Canberra, and Edith Cowan University. To support an outcomes-focused approach to the TIS program, the NBPU TIS provided guidance to grant recipients on available evidence, adaptation to meet local needs, and tools to monitor and measure activities.

NBPU TIS provided support to enable grant recipients to:

◖ plan and implement evidence-based approaches to tobacco control which are adapted to meet local needs;

◖ minimise duplication through network building and information sharing;

◖ undertake ongoing monitoring and evaluation to enable continuous improvement;

◖ develop relevant performance measures and data collection methods to measure the impact of tobacco control activities funded under TIS; and

◖ build the evidence base for tobacco control in Aboriginal and Torres Strait Islander communities.

Most grant recipients recognised the valuable role played by NBPU TIS in providing support and advice when needed. TIS Grant Recipient survey data revealed a rise in the percentage of respondents who

agreed that the support of the NBPU has enhanced the effectiveness of the program and TIS activities within their organisation, from 67% in 2016 to 76% in 2017 (see Figure 14).
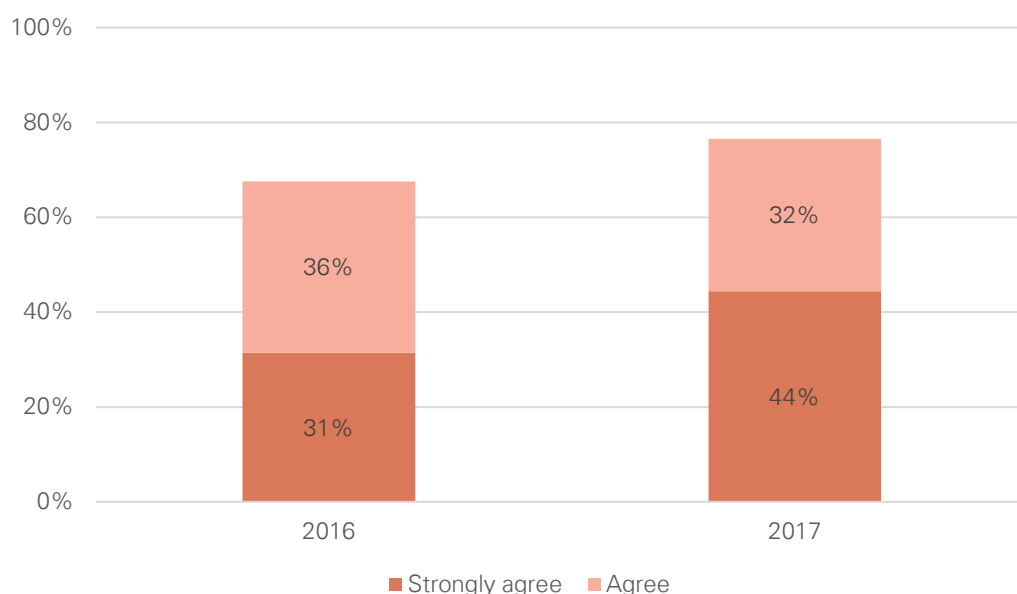

Figure 14. Percentage of grant recipient respondents who agreed with the statement: the support of the NBPU has enhanced the effectiveness of the TIS program and TIS activities within my organisation in 2016 (n=108) and 2017 (n=81).

Qualitative consultations with grant recipients suggests that the support provided in building competence in M&E and the networking opportunities provided by the national and jurisdictional workshops were especially valued. While many grant recipients were appreciative of this support, they also recognised the initial challenges NBPU TIS faced in establishing themselves.

> They (NBPU) had to recruit and establish themselves, anything like that takes time but we have certainly received support in terms of linkages and sharing of knowledge, training, assistance with portal. Grant recipient, rural, 2017

Grant recipients that found the support role provided by NBPU less useful were often organisations that had existing expertise in M&E and data collection. Overall, NBPU TIS communication with grant recipients was seen to have improved since the mid-term evaluation but some grant recipients still had concerns in relation to inadequate responses to information requests by NBPU TIS and ongoing communication issues.

It should be recognised that the NBPU TIS itself was launched in December 2015 with the first half of 2016 largely focused on establishment. Grant recipients indicated that they now have a greater understanding of the TIS program, NBPU TIS role, and M&E activities. Social media channels of communication have shown considerable growth and the number of subscribers to social media channels suggests an increased awareness of NBPU TIS over time.

Jurisdictional and National Workshops

The NBPU TIS organised and delivered jurisdictional workshops and an annual national TIS workshop for grant recipients, relevant partners and other key stakeholders. The workshops provided an opportunity to build a community of practice by supporting the sharing of evidence and best practice.

Throughout the evaluation, attendance at jurisdictional and national workshops has been consistently high, and the workshops were recognised as valuable opportunities for grant recipients to network and learn from each other. Some grant recipients requested a national conference specifically for TIS staff to expand the opportunities to network, collaborate and share ideas.

> We're all facing the same issues, you come back feeling more inspired, more passionate, sharing ideas and networking has been valuable. Grant recipient, rural, 2017

Programs for jurisdictional workshops were developed in conjunction with a working party that included representatives of the participating TIS organisations to ensure the workshops met the needs of grant recipients and supported capacity development. Participants indicated a very positive response to the jurisdictional workshops with between 57% and 100% rating their workshops as 'excellent' as represented in the feedback forms aggregated by NBPU TIS.

> I've had trouble understanding what's best practice and what's evidence based so the workshops have been fantastic, makes you feel competent and shows you the kind of things you could be doing. Grant recipient, rural, 2017

NBPU have also conducted Leadership Workshops with CEOs and Board Members of grant recipient organisations to encourage support for action on smoking cessation (see section 4.5.4 for more detail). It is anticipated that these workshops will continue in 2018.

Workforce development

To build the capacity of grant recipients to achieve TIS program outcomes, NBPU TIS worked closely with grant recipients to assess their workforce development and training needs, and to facilitate access to training and professional development. A workforce development analysis undertaken by NBPU TIS revealed the need for:

◖ support in a range of monitoring and evaluation tasks, including gathering evidence, measuring change and resource development; and

◖ quit-smoking related training, including smoking cessation, brief intervention, smoking related diseases and NRT.

The NBPU TIS responded to these two identified needs through the delivery of Monitoring and Evaluation Workshops and comprehensive Quitskills training, as outlined in detail below.

Monitoring and Evaluation support

NBPU TIS had a key role in supporting a culture of evaluation and continuous improvement for the TIS program by providing M&E workshops and ongoing one-on-one support to grant recipients. NBPU TIS assisted grant recipients to review, refine and finalise their Action Plans which led to the development of valuable outcomes focussed and evidence-based Action Plans.

In the first year, NBPU TIS delivered a series of highly structured, on-site M&E workshops for grant recipients that requested them. The workshops adopted a 'hands-on' approach using local Action Plans and local examples and drawing on the support available through the TIS portal (see section 4.4.2 NBPU TIS portal for further information).

Grant recipient responses to the M&E workshops were mixed with grant recipients with less experience in M&E more likely to find the workshops beneficial. Following the M&E workshop, some grant recipients reported greater clarity around data collection methods, collecting data against key performance indicators and a greater sense of confidence in measuring and reporting outcomes.

The mid-term evaluation recommended that NBPU TIS continue to respond to grant recipient M&E needs and NBPU TIS has provided ongoing support for grant recipients through site visits, face-to-face support and communication by phone, email and through the TIS portal. In 2017, NBPU TIS have been contracted to carry out site visits to all grant recipients and this occupies a significant amount of NBPU TIS time. However, the varying needs of grant recipients mean that while some organisations require additional support, others noted that they did not require support from NBPU at all (often organisations that had existing expertise in M&E and data collection).

> We have a good relationship with NBPU, but we are a high functioning grant recipient with M&E expertise and we don't need all that much support. Grant recipient, urban, 2017

Grant recipients also noted that feedback from NBPU TIS could be more constructive and focus on assisting them to improve outcomes, rather than focussing on what was seen by some as 'more bureaucracy'. Consultations with some grant recipients and NBPU TIS suggested a disconnect in the interpretation of 'tailored support'. NBPU TIS have reported that the provision of tailored support for grant recipient underpins their work, while grant recipients have indicated a need for more bespoke monitoring and evaluation training. Reconciling the different interpretations of one-on-one tailored support, within their contracted scope, remains a key priority for the NBPU TIS going forward.

Quitskills and other smoking cessation training

NBPU TIS collaborated with Cancer Council SA to support the delivery of Quitskills training, including the promotion of the Quitskills program, introductory sessions at TIS jurisdictional workshops, and facilitating contact between Cancer Council SA and grant recipients. In addition, NBPU TIS has facilitated access to *No Smokes* training[6] across the country along with tobacco related training options (short-course or online) which have been identified through the TIS portal. Some TIS Managers have

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[6] *No Smokes* project aims to increase awareness of the benefits of not smoking and reduce smoking rates among young Aboriginal and Torres Strait Islander people and includes delivering short, non-accredited training sessions based on resources developed by the Menzies School of Health Research.

been proactive in seeking training for their TIS team and have not required the additional support of NBPU TIS in this area (see section 4.3.4 Workforce development including Quitskills training for discussion of impact).

Best practice in Indigenous tobacco control and knowledge

NBPU TIS provides support to grant recipients to build best practice in Indigenous tobacco control and knowledge through site visits and continuing direct contact. However, some grant participants reported a need for more support from NBPU TIS and specifically for more information on available evidence and best practice in accessible and useful formats such as evidence briefs and summaries of successful models. Some grant recipients were frustrated in their lack of access to prevalence data and information on effective Indigenous community approaches to tobacco control, particularly in a remote context. Two grant recipients reported that they had to find other sources of support because NBPU TIS had not been able to assist them with questions in relation to research and evidence on Indigenous tobacco control. It should be acknowledged that the supply of prevalence data and evidence reviews is currently not within the scope of NBPU TIS's role. Furthermore, while prevalence data may be ascertained through the ABS' triennial surveys, the samples are not large enough to be accurate at the regional level.

4.4.3   NBPU TIS Portal

NBPU TIS capitalised on the existing Health*InfoNet*[7] platform to host the TIS portal. The TIS portal provides a range of information and resources to support grant recipients in planning, monitoring, and evaluating activities. A crucial section of the TIS portal is the Tackling Indigenous Smoking Resource and Information Centre (TISRIC). TISRIC is a series of web-pages hosted on the TIS portal containing information and evidence on what works for tackling smoking in Aboriginal and Torres Strait Islander communities.

The portal also provides access to workforce information including job opportunities and events such as courses and training, conferences, and workshops. In addition, it contains links to NBPU social media platforms and the TIS Yarning Place, an online forum that enables grant recipients from across the country to share information and ask questions of each other.

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[7] Health*InfoNet* is a workforce support web resource. It makes, published, unpublished and specially-developed material about Aboriginal and Torres Strait Islander health available to people working in the area to enhance their knowledge and skills and improve their practice and policy work. Access to information on the site is free and available to the public.
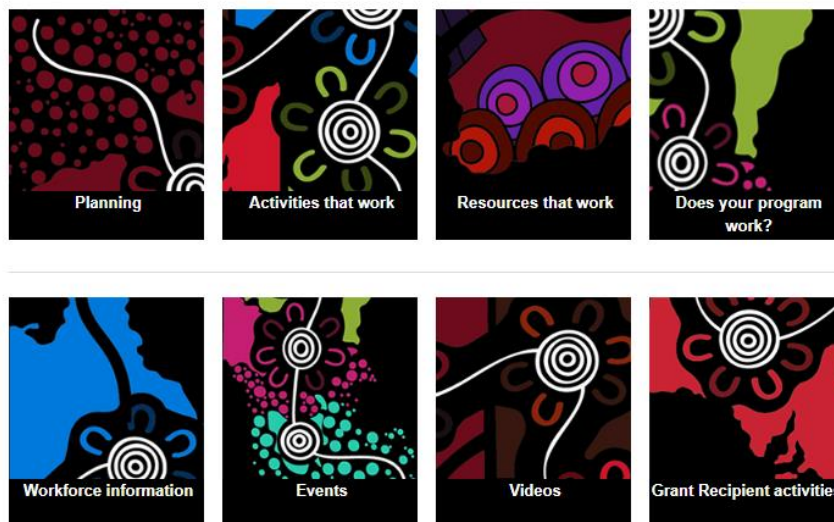
Figure 15. Excerpt of the home page of the TIS portal.

In the main, grant recipients acknowledged the value of having a platform to share resources, knowledge and experiences with other grant recipients and access information and resources related to the TIS program, particularly in the planning stage of program design. In a survey undertaken by NBPU TIS for grant recipients, it was reported that 97% of respondents knew about the portal and 87% found the content useful.

> I really appreciate the effort that's gone into the portal and into providing us with research and evidence to formulate pilot programs that work. Grant recipient, urban, 2017

The NBPU TIS survey for grant recipients also revealed that 88% of respondents nominated 'resources that work' as the most useful section of the TIS portal (up from 50% in December 2016). This is supported by Google analytic data which indicated that throughout the evaluation, 'resources that work' and 'activities that work' are amongst the most viewed pages on the TIS portal. Qualitative consultations also identified the value of the 'workforce information' section for training opportunities.

The mid-term evaluation highlighted a desire from grant recipients to share their work on the portal. Since the mid-term evaluation, the NBPU TIS have responded to this request by developing a 'Grant Recipient activities' page for TIS teams to showcase promising practice and promote peer-to-peer learning. Between 1 June to 31 October 2017, the grant recipient activities page was the most viewed page on the portal (excluding the home page). In the NBPU TIS survey for grant recipients, 76% of respondents reported that they found the information in this section useful and a fifth (20%) reported using it to get new ideas for their own programs.

While the TIS portal has been useful in urban and rural contexts, the usefulness of resources on the TIS portal is limited in some remote contexts, where activities require considerable adaptation.

> It has been an eye opener on other commercial resources, but on the same note, it's not useful for anything we can use remotely, we've had to create our own resources, and that's been time consuming, because we have to have everything pictorial, or in simple language … that's obviously culturally appropriate. Grant recipient, remote, 2016

Additional challenges to TIS portal use was the layout. Throughout the evaluation grant recipients have expressed difficulties in navigating through the TIS portal, noting that the experience of using the portal, felt arduous and time consuming. NBPU TIS have acknowledged that 'it's really important that we have a product that the grant recipients like and are going to want to use'. As a result, NBPU TIS continued to seek feedback from grant recipients through Jurisdictional workshops, site visits and surveys and have updated the portal to improve content, design and usability as recommended in the mid-term evaluation. To address ongoing issues around navigation, NBPU TIS is working with Health*InfoNet* to create a separate website for the TIS portal with a more flexible, responsive design. The website will retain the current content but with a more intuitive structure to make navigation to material easier for users.

The Department TIS Policy Team and HG&N have indicated that many non TIS-funded organisations would benefit from the resources available on the TIS portal. Although the TIS portal is a publicly accessible resource, these stakeholders suggested that greater efforts to promote the TIS portal would be of value to other organisations outside the TIS program.

4.4.4   Innovation grants

The innovation grants supported innovative projects aimed at reducing smoking prevalence and building the evidence base, through collaborative partnerships between research organisations and service providers. The innovation grants focused on regions or sub-populations which had specific needs and required attention, these were identified as remote and very remote geographical areas, pregnant women and young people, especially in remote areas. The approach included the design, development, delivery and evaluation of the interventions. The innovation grant recipients were announced in January 2017 (see Appendix 6 for list of innovation grants and activities).

While the data from innovation grants is currently limited, and many of the studies are exploratory in nature, there have been insights into the impacts of broader social determinants of health on smoking, and the importance of a deeper understanding of Indigenous culture and the social practices that inform smoking and quitting behaviours. Since data collection has been a key feature of the innovation grants, culturally safe research methodologies have been developed through collaboration with Indigenous community members in the design and delivery of programs.

> The innovation grant allowed [our] team to stretch ourselves, to try a new approach that we really hope will see reductions in the harm from smoking. Innovation Grant recipient, remote, 2017

Some innovation grants have been slow to implement project activities, with projects delayed due to ethics approvals, and recruitment issues, particularly in remote locations. Some organisations misjudged the time and cost involved in implementing projects which resulted in delays. However, the

innovation grants appear to be gaining momentum, and while most data will emerge towards the end of projects, a range of project activities have been conducted and some projects have produced some valuable interim results (see case study). Consideration should be given to the dissemination of valuable findings to regional grant recipients who may benefit from the findings.

Innovation grants were required to engage with TIS organisations but most of the projects have remained isolated from the TIS program, and many expressed a desire to be more connected with the TIS program. While most organisations have appreciated the flexibility provided through the innovation grants, some organisations noted a need for greater clarity and clearer communication with the Department, particularly at the beginning of projects.

TALKING ABOUT SMOKE FREE SPACES

Innovation grant recipient, Aboriginal Resource and Development Services (ARDS) supported Aboriginal people in three remote NT Top End communities, Ramingining, Gapuwiyak, and Minjilang, to establish and extend smoke free spaces in their homes and communities. The project works with three key partners: ALPA (Arnhem Land Progress Association) stores who promoted smoke free stores and outside spaces, local Quit programs and James Cook University as the research partner.

ARDS Indigenous staff, skilled in effective dialogue techniques, built relationships around conversations in traditional languages, using culturally appropriate ways to talk about smoking and smoke free spaces. While the process is slow, it effectively engaged people in areas that interest them such as traditional cultural protocols around smoking or understandings of health and disease. There was no blame attributed to smoking, a recognition that people struggle to give up, and a focus on where people smoke and reducing smoking in households and community spaces.

The measurable objective for the project was to increase the numbers of smoke free households and spaces by 50% with that number already exceeded in Ramingining, where smoke free households had increased from 38 to 100. Baseline data was collected in relation to airborne particles and ALPA tobacco sales. The project correlated householder statements about smoke-free policies that apply in their home with quantitative measures of airborne particles in the home. The secondary outcome measure was lower sales in ALPA stores after the project ends. ALPA data was tracked throughout the project to assess whether an extension of smoke free spaces leads to a decline in tobacco sales.

KEY FINDINGS: CONTRIBUTION TO LARGER EVIDENCE BASE

A key finding of this evaluation is the full implementation of the redesigned TIS program outcomes focus, a short-term outcome of the TIS program. Data collection has been a core component of the TIS program with grant recipients working internally to improve data collection systems by embedding measures into existing electronic health records and integrating health promotion and clinical practice. While the quality of performance data has improved significantly, opportunities remain to improve data quality including through the provision of constructive feedback and a more structured reporting template.

There has been an increased focus by grant recipients on evidence-based activities and outcomes-based approaches in response to support provided by NBPU TIS including through the TIS portal, M&E workshops, training, national and jurisdictional workshops and one-on-one support. This suggests that the following short-term outcomes have been met: 'Increases in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people' and 'Improved local Aboriginal and Torres Strait Islander capacity in the collection, analyses and recording of program'.

While most grant recipients were appreciative of the support and the education and training opportunities provided by NBPU TIS, some found the support role provided by NBPU less useful, however, these were often organisations that had existing expertise in M&E and data collection.

Throughout the evaluation, attendance at jurisdictional and national workshops has been consistently high, and the workshops were recognised as valuable opportunities for grant recipients to network and learn from each other. NBPU TIS communication with grant recipients has improved since the mid-term evaluation although some grant recipients still had concerns in relation to information requests made to NBPU TIS.

While some innovation grants have been slow to implement project activities due to unforeseen delays, they have gained momentum with some projects producing valuable interim results. The innovation grants are currently seen as isolated from the rest of the TIS program and promoting useful innovation grant findings could contribute to the evidence base and thereby support regional grant recipients.

4.5 Overarching TIS program

4.5.1 TIS program design

Tobacco action as primary focus

Qualitative consultations with grant recipients, primary and secondary stakeholders, together with analysis of performance reports, suggest that a noticeable change, i.e. the prioritisation of tobacco reduction, has taken place for grant recipients since January 2016. Feedback from the Department suggests that this is a significant shift from the previous program which was 'less targeted, with organisations delivering a broader range of healthy lifestyles activities which in some cases did not address smoking, and with fewer activities in tobacco reduction'.

Overall, grant recipients are now delivering more targeted and tailored activities to directly address smoking within their communities. Several grant recipients emphasised that the shift allowed them to be more focused on tobacco reduction and to contribute to measurable tobacco-related outcomes.

> Tobacco being the main focus compared to the past tobacco and healthy lifestyle program has made a huge impact when it comes to delivering program and activities. Education and awareness of tobacco delivery has been more effective and now community members are more happy to talk about tobacco as well. Grant recipient survey respondent, 2017

The first year of the revised TIS program saw a range of interpretations of the new TIS program guidelines and the extent to which tobacco reduction initiatives funded under the TIS program can be positioned within healthy lifestyle activities. The uncertainty around what is permissible was identified in the mid-term evaluation and has subsequently been addressed through NBPU TIS jurisdictional workshops and through communications from the National Coordinator, Professor Tom Calma. Since the mid-term evaluation, organisations delivering healthy lifestyle programs have shifted the focus around tobacco reduction or incorporated healthy lifestyle components into their TIS activities. A minority of grant recipients continue to express confusion around the parameters of the program, highlighting the importance of ongoing reinforcement of funding parameters.

Flexible and responsive

Throughout the evaluation, the flexible funding approach was welcomed by grant recipients and other stakeholders, who noted it allowed for locally tailored, culturally appropriate and targeted smoking cessation activities. This was considered particularly important given the diversity within the Aboriginal and Torres Strait Islander population across Australian and within communities. Flexibility was also noted as important in relation to TIS performance indicators to allow grant recipients to respond to local situations and areas of highest need.

> I think it's a good way of approaching it…Nobody knows each other's community more than themselves. Everybody knows intimately what the community's about and what works best for them and [are] able to consult with everybody. Grant recipient, urban, 2017

Place-based approach

Given that grant recipients are operating across remote, rural and urban Australia, a place-based approach allows TIS teams to modify and adapt their programs and activities to suit their context. In rural and remote contexts, the importance of grant recipients employing local Aboriginal and Torres Strait Islander TIS workers and embedding them within their local community was noted. Where a local community member couldn't be recruited, employing an Indigenous worker was desired as they are considered to increase levels of engagement and rapport with community. Being able to adapt TIS activities and approaches to the different lore, family and community protocols and needs within a grant recipient region was noted by stakeholders as important to the success of local TIS programs.

> Out here you really need someone that's on the ground that knows the community to have that conversation. Primary stakeholder, remote, 2017

4.5.2 TIS program communications

Clear communication of the TIS program governance, key players, and parameters is essential to ensure all activities are delivered in line with the objectives of the program. Throughout this evaluation, especially within the first year, grant recipients have expressed confusion around the roles and responsibilities of the multiple 'players' in the TIS program (i.e. NBPU TIS, HG&N, Department, CIRCA etc.) and the distinction between who to go to for what has not always been clear.

> There are so many players, and that creates a challenge and how information is delivered and to: Tom; NBPU; Health; [grant recipient organisation]; CIRCA, RSGs [HG&N], other grant recipients. How are we supposed to be delivering and communicating to all these groups? Grant recipient, urban 2016

While there has been increased clarity in the second year, according to the HG&N, information flows between the Department TIS Policy Team, NBPU TIS, grant recipients and grant officers in the HG&N requires improvement, particularly the role and functions of the NBPU TIS versus the HG&N and the Department's TIS Policy Team with regards to grant recipients.

In response to the overall issues around communication, the roles and responsibilities of the Department's Preventive Health Section, HG&N, NBPU TIS, National Coordinator and CIRCA were reinforced at the NBPU TIS National Conference, jurisdictional workshops and TIS portal. The 'Monthly Message' delivered to grant recipients by the National Coordinator has also been used to clarify aspects of the TIS program and grant requirements, and to ensure consistency of messaging between the NBPU TIS and the Department.

The Department has indicated a need to improve the visibility of the NBPU TIS' operations for the Department's state-based grant managers and is looking at opportunities to improve information sharing to support the HG&N in understanding grant recipients' needs, the issues they are facing and where the NBPU is assisting.

Should the TIS program continue, additional information and clarification would be beneficial. This may include sending out program guidelines in plain English articulating the parameters of the TIS program and the rationale behind these parameters.

4.5.3 High-level leadership and advocacy (National Coordinator TIS)

The role of the National Coordinator TIS is to deliver advice to the Australian Government regarding policy development and implementation in relation to Closing the Gap through Tackling Indigenous Smoking, and to provide leadership, support and mentoring to TIS program grant recipients. It is a funded position (ten days per month) within the Department and has been held by Professor Tom Calma AO[8] since it commenced in 2010.

The consensus among stakeholders and grant recipients is that the National Coordinator is a pivotal component of the TIS program and the extent of activities throughout this evaluation suggest that the role has been a success. Throughout this evaluation, the National Coordinator undertook a range of work:

◖ Participated in the TIS National and jurisdictional workshops as an Elder and leader to provide encouragement and advice to TIS grant recipients

◖ Participated in the NBPU TIS Advisory Group as a member

◖ Delivered monthly messages to TIS grant recipients through NBPU TIS email update, updating on tobacco control policy, new evidence and resources available, TIS activities and significant events

◖ Advocated for TIS and Indigenous tobacco control through national and regional presentations, conferences and stakeholder meetings e.g. National Expert Reference Group on Tobacco

◖ Provided mentoring and advice to some TIS grant recipients through site visits, email or over the phone or via the Yarning Place on the TIS portal

◖ Provided advice to the Department on Indigenous tobacco control

◖ Provided advice to and contributed to media around the National Tobacco Campaign *Don't Make Smokes Your Story*

Over the past two years, as the program has evolved the role of the National Coordinator has evolved. The mid-term evaluation noted that one of the key roles of the National Coordinator in 2016 had been ensuring all TIS grant recipients had consistent information about the TIS program redesign by attending and presenting at the NBPU TIS National Conference in Adelaide, as well as NBPU TIS jurisdictional workshops in Queensland, Northern Territory, Victoria, New South Wales, Western Australia and South Australia.

In 2017, the focus on the National Coordinator's work was to continue communications with grant recipients through jurisdictional workshops in addition to more individual visits to TIS teams, with a particular focus on assessing how relationships are developing at a leadership level across regions. The National Coordinator is valued as having an important role in brokering this support through meeting with CEOs and senior managers during site visits and presenting at NBPU TIS leadership workshops. The HG&N have suggested that ensuring the National Coordinator is allowed time to visit grant

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[8] Professor Calma is a respected Aboriginal Elder who has been involved in Indigenous affairs at a local, community, state, national and international level and worked in the public sector for 40 years. He is currently on several boards and committees focussing on rural and remote Australia, health, education and economic development.

recipients and focus on supporting leadership across regions would be beneficial to the program going forward.

Overall, grant recipients and other stakeholders highly value the National Coordinator's role, both in terms of his capacity to provide practical advice and leadership around individual grant recipient activities, as well as providing high-level advocacy, insights and leadership to assist in the shaping of policy and approach for the TIS program.

> I think he has kept Aboriginal organisations focus and on aside. Tom was able to reach out across Australia and to connect people. Primary stakeholder, rural 2017

Through both one-to-one conversations with grant recipient staff, presentations and via the 'Monthly Message' through the NBPU TIS Newsletter, the National Coordinator has been able to communicate and reinforce messages and information relating to the national implementation of the TIS program. Analysis of 2016 and 2017 grant recipient survey data revealed that over two years almost three quarters (73%) of grant recipient respondents agreed that the support of the National Coordinator has enhanced the effectiveness of the TIS program and TIS activities within their organisation.

Grant recipients and other stakeholders noted that it is important that the National Coordinator TIS is a prominent Aboriginal and Torres Strait Islander leader with standing and connections across Australia. Professor Calma's extensive network and access to Ministers, decision-makers and CEOs of Indigenous organisations was seen as instrumental to the success of the role.

> The National Coordinator would only be useful if they are a well-regarded Aboriginal person who could reach across multiple regions and communities. Primary stakeholder, rural, 2017

4.5.4   Challenges to program success

Transitioning to the redesigned TIS program

As noted in the mid-term evaluation, a significant challenge for the TIS program getting up and running was the concurrent contracting of the grant recipients (early 2016), the national evaluators (late 2015) and the NBPU TIS (late 2015). This meant that NBPU TIS, the M&E Framework and TIS performance indicators and the final Action Plan templates were not available when grant recipients were contracted, making it difficult for grant recipients to plan activity. A key learning of the evaluation is to allow time for the necessary foundations to be established prior to the commencement of the regional grants program.

Although most of the 37 grant recipients had been funded though previous rounds of funding since 2010, challenges in transitioning from the previous program to the new were noted in the mid-term evaluation. This included: delays in finalisation of funding agreements, subsequent loss of experienced staff, difficulty recruiting new staff, and associated delays in initiating activities or expanding on activities already commenced. Many grant recipients reported they were 'starting from scratch again'.

> We had this huge period of uncertainty, we lost some team members who couldn't deal with it, family commitments so they took other jobs. And also with the new program, we had to restructure the team, there aren't any healthy lifestyle workers anymore. It gave us an opportunity to look at what we were doing. It takes a while to establish a team again. Grant recipient, urban 2016

Subsequently, many grant recipients focused on planning and development of tools and recruitment of staff in 2016. The results from the 2016 survey of grant recipients confirmed that recruiting and retaining staff was both one of the greatest program achievements for grant recipients so far, as well as one of their biggest challenges identified.

Since the mid-term evaluation, most grant recipients have successfully overcome these initial challenges and are now implementing a range of TIS activities.

Short-term funding cycles and staff recruitment and retention

The lack of security and limited ability to plan long-term caused by short-term funding of the TIS program were considered barriers to program success. This view was supported by grant officers in the HG&N who noted that the length of the program did not consider the time needed to transition to the new TIS outcomes focus and evidence-based framework, to build staff capacity, and to gather data. The HG&N also suggested that longer-term contracts can embed TIS objectives in schools, in community workplaces and help make smoke-free events the norm, a view shared by reginal grant recipients.

> The TIS program has allowed us to achieve many great things within our community and I would love to see the funding continued so we can build on this and make even more changes. These programs need ongoing funding to keep the appropriate staff on board who are passionate about their community and have strong community who are respected also. Grant recipient survey respondent, 2017

As noted in the mid-term evaluation, staff recruitment and retention are an ongoing challenge for many grant recipients, especially in rural and remote areas and is exacerbated by the short-term funding cycles. Staff turnover, coupled with a lack of consistency, was also cited by primary stakeholders as the greatest challenge to the TIS program in the 2017 Primary Stakeholder survey. Staff recruitment and retention issues were also reported by grant recipients as a catalyst for other potential issues for program success, including program underspend and lack of staff training. This view was shared by grant officers in the HG&N and the National Coordinator TIS.

> We constantly get feedback…about concerns around funding and the loss of staff. I feel that it's a bit of a vicious cycle that they [grant recipients] are not spending funds because they don't have staff because they have no guarantee that they are going to be refunded. So, it's just an endless cycle. National TIS Coordinator 2017

Detailed handover of local TIS program activities and processes from an outgoing TIS staff member was reported as almost non-existent by a few grant recipients. This has led to TIS staff having to start from scratch and redesign TIS activities. Given the continued staff retention issues within some grant

recipient organisations, organisations would benefit from having more effective handover processes going forward.

It should be acknowledged that the Department's TIS Policy Team have been responsive to these issues and have supported the provision of timely advice regarding funding, and longer terms for funding.

Underspend

Throughout the evaluation, it was noted that a minority of grant recipients have underspent their TIS Program funding. This was largely due to staff recruitment and retention issues, which lead to unspent funds allocated to wages. Some grant recipients reported they were successful in shifting unspent funds into other activities or resources, such as resources and social marketing campaigns. Other grant recipients have been less effective with redistributing unspent funds, with some reporting it has been difficult to find ways to spend the money or to determine what they can spend the unused funds on.

Establishing a clear, straightforward and systematic process for handling unspent funds was also seen as important by the HG&N, with details provided to organisations as early as possible to mitigate or avoid potential underspends. Ensuring TIS Managers are aware of potential underspent funds should be a priority.

NRT funding

The inability to spend TIS Program funding on NRTs continues to be another challenge for grant recipients. The high cost of NRTs that aren't available on the Pharmaceutical Benefits Scheme was noted as a significant barrier to Aboriginal and Torres Strait Islander community members purchasing NRTs. In remote areas, limited inventory of NRTs was noted as another barrier to access. Several grant recipients disclosed that not being able to provide NRT or samples of NRT to clients has reduced community engagement into their local TIS program. NRT is still viewed by grant recipients as central to a continuum of care for community members, who felt it was problematic to suggest combination therapy to clients without supplying NRTs.

> We are starting to have a lot of disengagement due to people knowing the message and options [NRTs] but not being able to access these resources through the TIS team. Grant recipient, rural 2017

To ensure clients still have access to NRTs and to attract potential clients into local TIS Programs, some grant recipients are seeking funding elsewhere to supply community members with NRTs. This includes one grant recipient who purchased NRT vouchers for clients through the local pharmacy. However, these grant recipients noted it would be better if they could utilise TIS funding to purchase NRTs to meet client needs.

> We have to find additional funding for NRTs. If we could use some of our funds for NRTs rather than relying on [local government health department] to have the range of products available, we could better respond to client demands. Grant recipient, remote, 2017

It is important to note that this evaluation did not explore the effectiveness of NRTs and other tobacco specialist healthcare interventions in reducing smoking prevalence.

Leadership support

While there are examples across the country of strong leadership support and buy-in for tobacco control, a lack of buy-in from some senior Aboriginal management and Board members internally and externally (who may be smokers) to advocate for tobacco control was identified by some grant recipients over the two years as impacting the delivery of TIS activities. This view was shared by the National Coordinator and grant officers within the HG&N who noted that a lack of buy-in from senior management has implications particularly for smoke-free policies, smoking cessation role-modelling, and engagement with external organisations.

> If they don't have good senior leadership that is supervising them, and they don't understand what the program is about, then it really makes it difficult for the program to be successful. Therefore, it is a priority for the success of the program to have strong leadership from the top down. National TIS Coordinator, 2017

As discussed previously, the positive impact and strength of leadership support in increasing ownership for tobacco control has been demonstrated in jurisdictions across the country. Governance groups which included CEOs from Aboriginal organisations across a region have been identified as valuable in keeping tobacco control on the agenda, distributing ownership of the program by ensuring that tobacco control is 'everyone's business'. This approach will be crucial in maintaining population level health promotion for tobacco control. In 2017, NBPU TIS commenced the delivery of a series of leadership workshops to grant recipient CEOs and Board members. These workshops aimed to enhance organisational commitment and support for addressing Indigenous smoking, promoting smoke free spaces and encouraging healthy lifestyle choices among leaders. The National Coordinator, Professor Calma, played a pivotal role in the workshops and in providing follow-up support to participants.

Competing priorities and jurisdictions

For communities facing a range of complex issues which demand attention, for example, family and domestic violence, trauma and depression, and drug and alcohol misuse, prioritising smoking can be a significant challenge. In practical terms, simply scheduling the time to engage with other organisations can be problematic.

> … there are other issues in the community that overshadow the issue of smoking … TIS gets crowded out with other things. Primary stakeholder, CEO, rural, 2017

Some TIS grant recipients have indicated a reluctance to seek collaboration in communities where other non-grant recipient funded ACCHS operate, citing distinct jurisdictional coverage and politics around funding as a reason for this reluctance. These strategic-level challenges have been identified and discussed by NBPU TIS and links closely with their strategies to strengthen leadership support.

Complexities of remote contexts

> I mean it's remote, people aren't always batting with the same bat. Primary stakeholder, clinic nurse, remote, 2017

A range of additional barriers and challenges for remote and some rural grant recipients were noted during the evaluation. In addition to staff recruitment and retention issues, which was noted to be a higher issue in remote areas, other challenges identified in the evaluation that impact program delivery include:

◖ Geographical barriers. Most TIS teams operating in remote and some rural areas cover vast areas that involve significant travel which is labour intensive. Moreover, wet seasons can render some communities inaccessible for 4 months of the year.

◖ The cultural context in which TIS teams operate, including the normalisation of smoking in community and high rates of smoking. In addition, language groups, gender, cultural custom and community politics can influence what activities can be conducted and by whom.

◖ Complex social issues including domestic and family violence, substance misuse, housing issues and food insecurity, which are often prioritised over smoking cessation.

◖ Transient populations.

◖ Technology issues, including limited and variable internet and mobile phone use and coverage.

◖ English as second or third language resulting in challenges to program evaluation and lack of appropriate resources.

◖ Health workforce shortage resulting in reduced access to primary health care providers and health services.

Some remote grant recipients emphasised the immense responsibility that is placed on remote Aboriginal staff, including being able to speak multiple local languages, understanding cultural and kinship practices and navigating through community, whilst also aiming to meet the TIS performance indicators.

> They not only work for these programs but live in the community. So, their experience does not end when they leave the office at the end of the day as the health issues being described in reports like closing the gap affect these people and their families too. Grant recipient, remote, 2017

Many of these challenges have disrupted or delayed local TIS program delivery, including the ability to engage community, build partnerships, implement targeted strategies and health promotion and provide quit support. This highlights the importance of prioritising the specific challenges of service delivery in these contexts and the importance of appreciating context in any evaluation that involves service delivery in remote and rural contexts.

KEY FINDINGS: TIS PROGRAM DESIGN AND GOVERNANCE

Elements of the redesigned TIS program have been crucial to the success of the program. The transition to tobacco action as the primary focus has allowed grant recipients to be more focused on tobacco reduction and to contribute to measurable tobacco-related outcomes. The flexibility of the TIS program design and place-based approach has also allowed for tailored, culturally appropriate and targeted tobacco control that responds to local situations and areas of highest need, thus maximising impact.

Throughout this evaluation, grant recipients and HG&N have expressed confusion around the TIS program communications, specifically regarding funding parameters and the role and functions of the various 'players', namely the Department, NBPU TIS, HG&N, CIRCA, and regional and innovation grant recipients. Since this was identified in the mid-term evaluation, NBPU TIS and the Department have taken active steps to increase clarity through jurisdictional workshops and National Coordinator monthly messages to TIS grant recipients, although some confusion persists.

The consensus among stakeholders and grant recipients is that the National Coordinator is a pivotal component of the TIS program and Professor Calma's extensive network and access to decision-makers and CEOs of Indigenous organisations was seen as instrumental to the success of the role. As the TIS program has evolved over the past two years, the role of the National Coordinator TIS has also evolved. While work in the first year was focused on supporting grant recipients with the transition, the second year has been focused on site visits to individual grant recipients and strengthening leadership support for tobacco control as this was identified as an issue in the mid-term evaluation. This is in addition to the ongoing advice provided to the Department, national advocacy for TIS and Indigenous tobacco control and support, participation in national and jurisdictional workshops and monthly messages through the NBPU TIS email updates.

Key challenges to overall TIS program success were identified by grant recipients and stakeholders. These included transitioning to the redesigned TIS program (i.e. concurrent process of setting up NBPU TIS, finalising M&E framework, commencing regional grants program and time needed to adjust to new program) short-term funding cycles and staff recruitment and retention, program underspend and issues around NRT funding. The complexities of operating in a remote context were also highlighted and the importance of appreciating this context when evaluating progress was emphasised.

Senior leadership was identified as important for the ongoing success of the TIS program. Engagement of leadership was identified as a significant challenge in the mid-term evaluation and NBPU TIS responded by delivering a series of leadership workshops to grant recipient CEOs and Board members to enhance organisational commitment and support for addressing Indigenous smoking, promoting smoke free spaces and encouraging healthy lifestyle choices among leaders.

5. Conclusions

> The TIS program is a program that will change the lives of those Indigenous peoples in my area, it won't happen overnight, but it will happen if the program continues in its current form. Grant recipient survey respondent, 2017

This evaluation concludes that the current iteration of the TIS program has been successful in meeting its short-term outcomes and consistent with the mid-term evaluation, recommends that the TIS program continue, with reinforcement of some key activities and minor changes to program design to address the challenges to program success identified through the evaluation (see recommendations below). In meeting its short-term outcomes, the TIS program is well on track to achieving its medium-term and long-term outcomes, which include the reduction in exposure to second-hand smoke and a reduction in the prevalence of smoking among Aboriginal and Torres Strait Islander people.

The current iteration of the TIS program, through its flexible design and place-based, population health approach has been found to be appropriate in reducing the high smoking rates among Aboriginal and Torres Strait Islander people. The impact of the regional grants program (the largest component of the TIS program funding) in the short-term has been demonstrated by the growth in partnerships and community engagement, the delivery of multi-level and locally relevant health promotion for tobacco control, increased access to culturally appropriate quitting support through growing referral networks, and an increase in the use of evidence to inform program design and improvement.

This progress has been facilitated by the ongoing flexibility in funding and the program design elements, including an emphasis on evidence-based activities and outcomes-based reporting, shifting to tobacco action as the primary focus, and promotion of targeted approaches for priority groups, specifically young people and pregnant women. In addition, national support provided by Quitline enhancements, Quitskills, the NBPU TIS and leadership and advocacy of the National Coordinator TIS to regional grant recipients has contributed to the overall success of the program. Specifically, the information around best practice, M&E and smoking cessation training, and platforms for communication (i.e. TIS portal and workshops) provided and coordinated by the NBPU TIS and endorsed by the National Coordinator has contributed to building the capacity of regional grant recipients to support quitting, share best practice and monitor and evaluate activities.

While considerable progress has been made throughout this evaluation, challenges have been identified in relation to program delivery, data collection and evidence, and overarching TIS program communications and governance. In terms of local program delivery, competing priorities in community, particularly in some remote and rural settings and a lack of buy-in from senior management in some regions, has delayed the implementation of local TIS activities such as smoke-free policies. Regarding the evidence base, the desire for standardised indicators has been expressed by regional grant recipients, particularly due to challenges in measuring the impact (i.e. behavioural change) around health promotion activities. Some grant recipients also reported that support from the NBPU TIS should come as needed and requested more from the NBPU TIS than is currently in scope of their role (e.g. constructive feedback on performance reports and evidence reviews). The contribution of the

innovation grants to the larger evidence base is yet to be seen, this is largely related to delays in implementation and time needed to evaluate such programs.

Although communication about the TIS program has improved, some confusion around funding parameters (NRT and healthy lifestyle activities) and the roles of the various 'players' involved in the TIS program persists which has impacted the provision of support and local program design. Furthermore, the concurrent contracting of regional grants, NBPU TIS and CIRCA evaluators meant that the necessary framework and foundations for the program were not in place prior to local TIS program delivery. Short-term funding cycles continue to be an issue impacting long-term planning, staff retention and concomitant underspend. The challenges presented across the TIS program are magnified for remote and some rural grant recipients, who face additional environmental and socio-cultural challenges.

Despite these challenges the redesigned TIS program has demonstrated considerable progress since 2015 in delivering multi-level health promotion around tobacco control together with culturally appropriate quitting support. This has been supported through the NBPU TIS, the National Coordinator, Quitskills training, and enhanced Quitlines, which have contributed to strengthening an appropriate response to tobacco control in Aboriginal and Torres Strait Islander communities.

On February 11 2018, the Australian Government announced that the TIS program would continue, with a commitment of $183.7 million over 2018-19 to 2021-22. The decision to extend the funding of the TIS program for a longer term, together with the early announcement four months prior to funding contract end dates, directly address key recommendations for the Government in the TIS mid-term evaluation and in this final evaluation.

The four-year TIS program will have a renewed focus on population health approaches and health promotion, focusing on strengthening the skills and capabilities of TIS employees across the country to bring about changes to social norms to ultimately reduce the impact of smoking on the Aboriginal and Torres Strait Islander population. Recommendations for the future iteration of the TIS program are detailed below.

6. Recommendations

Community engagement and partnerships

1. **Regional grant recipients:** Continue involving community members in the design, delivery and evaluation of local TIS programs and sustain use of partnerships to broaden reach, strengthen referral pathways, and support other program objectives including preventing uptake, promoting expansion of smoke free spaces, and changing social norms.

Localised health promotion

2. **Regional grant recipients:** Continue delivering targeted, multi-level, tobacco-focused health promotion.

3. **NBPU TIS:** Provide additional training and information on best practice, multi-level, tobacco-focused health promotion for targeted groups including pregnant women.

Access to quit support

4. **Regional grant recipients:** Support organisations across their region to develop capability to provide and / or refer to culturally appropriate quit supports.

5. **Quitline / Regional grant recipients:** Increase data sharing between Quitline and regional grant recipients and collaboration where appropriate.

6. **NBPU TIS:** Consider access issues to workforce development training with suitable training options for different contexts.

7. **Department:** Explore opportunities to support information sharing between Indigenous Quitline Enhancement Project services across Australia.

Contribution to evidence base

8. **Department / Evaluator:** Review performance report and action plan templates to develop consistent data collection and reporting prior to the next iteration of the TIS program.

9. **Department:** Implement a succinct 6-month interim report and more in-depth 12-month annual report to provide a clearer picture of progress.

10. **NBPU TIS:** Provide tiered support to regional grant recipients aligned to their needs.

11. **Department:** Consider broadening the scope of NBPU role to include:
    i.   Constructive feedback to all grant recipients on outcomes from activities in their performance reports
    ii. Provision of evidence summaries of best practice

12. **NBPU TIS:** Implement a national workshop specifically for TIS workers to share and learn best practice.

13. **NBPU TIS:** Increase the promotion of new items on the TIS portal to TIS-funded and other organisations.

14. **Department:** Share innovation grant recipient results with regional grant recipients.

15. **Department:** Review the innovation grant recipient component of the program.

16. **Department:** Consider the inclusion of a comparison group (i.e. regions not resourced through TIS) for future evaluations to examine program outcomes.

Overarching TIS program

17. **Department:** Continue the delivery of the TIS program.

18. **Department:** Commit to funding longer term (at least 4 years) and provide immediate advice about future funding to minimise funding uncertainty and associated staff turnover and underspend.

19. **Department / NBPU TIS:** For regional grant recipients that are at risk of underspend, explore the need for information sharing and early engagement between TIS teams, grant officers and NBPU TIS.

20. **Department / NBPU TIS:** Continue to reinforce the funding parameters and rationale behind these parameters (e.g. no NRT funding, one-one-one interventions) and provide greater clarity about the roles and functions of the various stakeholders in the TIS program, and provide opportunities for greater collaboration where required.

21. **Department:** Ensure future implementation of any redesigned program has the necessary foundations established (i.e. Monitoring &Evaluation Framework, Performance Indicators, and other supporting components), as far as possible, prior to service delivery.

22. **Department:** Explore strategies to address the challenges that are magnified in remote and some rural contexts.

23. **NBPU TIS:** Provide a greater focus on the principles and practices of health promotion in jurisdictional workshops for regional grant recipients.

24. **NBPU TIS:** Continue to support leadership development by engaging CEOs and Board Members from TIS and non-TIS funded organisations in leadership workshops facilitated by the National Coordinator. Monitor the outcomes of these workshops.

25. **Department**: Some Aboriginal and Torres Strait Islander people live in areas not serviced by regional TIS teams. Consider how best to support tobacco control in these regions e.g. national social marketing campaigns, Quitline enhancement, TIS portal and workshops, and activities not funded by TIS.

APPENDIX

Appendix 1: Regional TIS grant recipients

Organisation name	State/Territory
Winnunga Nimmityjah Aboriginal Health Clinic / Health Service (ACT) Incorporated	ACT
National Centre of Indigenous Excellence Limited	NSW
Grand Pacific Health Limited	NSW
Awabakal Ltd.	NSW
Bullinah Aboriginal Health Service Aboriginal Corporation	NSW
Galambila Aboriginal Health Service Incorporated	NSW
Griffith Aboriginal Medical Service Inc.	NSW
Maari Ma Health Aboriginal Corporation - trading as Maari Ma Health	NSW
South Coast Aboriginal Medical Service Aboriginal Corporation	NSW
Wellington Aboriginal Corporation Health Service	NSW
Anyinginyi Health Aboriginal Corporation - trading as AHA	NT
Central Australian Aboriginal Congress Aboriginal Corporation	NT
Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation	NT
Katherine West Health Board Aboriginal Corporation	NT
Miwatj Health Aboriginal Corporation	NT
Nganampa Health Council Inc.	NT
Sunrise Health Service Aboriginal Corporation	NT
Ngaanyatjarra Health Service (Aboriginal Corporation)	NT
Darling Downs Shared Care Incorporated (Carbal Medical Centre)	QLD
Apunipima Cape York Health Council Limited	QLD
Institute for Urban Indigenous Health Ltd.	QLD
North Coast Aboriginal Corporation for Community Health	QLD
Aboriginal Health Council of SA Inc.	SA
Nunkuwarrin Yunti of SA Inc.	SA
Pangula Mannamurna Incorporated	SA
Flinders Island Aboriginal Assoc Inc.	TAS
Lakes Entrance Aboriginal Health Service	VIC
Dandenong & District Aboriginal Co operative Ltd	VIC
Victorian Aboriginal Community Controlled Health Organisation Inc	VIC
Victorian Aboriginal Health Service Co operative	VIC
Aboriginal Health Council of Western Australia	WA
WA Country Health Service	WA
Bega Garnbirringu Health Services Incorporated	WA
Geraldton Regional Aboriginal Medical Service	WA
Kimberley Aboriginal Medical Services Council Inc	WA
Mawarnkarra Health Service	WA
Puntukurnu Aboriginal Medical Service	WA

Appendix 2: Evaluation questions

The national evaluation has a few critical areas for investigation, including the fit between the TIS program and the needs of local communities and other stakeholders and the policy context (appropriateness); and the level of change that the TIS program has brought about including the level of systems capacity and capability development facilitated from the TIS program (effectiveness). As noted earlier, the national evaluation does not look at long-term impact in relation to a reduction of smoking rates at a national level, although the evaluation does assess the likelihood that the TIS program is contributing to these long-term goals.

Evaluation domain	Key evaluation question
Appropriateness	1. Is the local population health approach appropriate as a supplementary effort to reduce the high smoking rates among Aboriginal and Torres Strait Islander people
Effectiveness Localised health promotion	2. To what extent did the grants approach meet its objectives? 3. How effective were the changes to the grants in implementing successful strategies?
Effectiveness National support for regional grants	4. To what extent did the support of the NBPU TIS and the National Coordinator enhance the effectiveness of the program?
Effectiveness Access to quit support	5. How effectively were regional grants able to increase access through the range of possible services?
Effectiveness Improved evidence base	6. To what extent are grant recipients using evidence to improve program design and/or implementation?
Effectiveness Overarching TIS program	7. Is the program as implemented worth maintaining?

Appendix 3: TIS Performance Indicators

The M&E Framework is the basis for the five nationally consistent performance indicators finalised through consultation with regional grant recipients and the M&E Advisory Group. The process involved consideration of a range of outcome metrics used to measure performance towards the potential outcomes identified and captured in the program logic. The National TIS Performance Indicators are used by grant recipients in Action Plans and performance reports for IAHP funding.

Grant recipient reporting on the National TIS Performance Indicators aims to:

◖ enhance consistency in information from one report to another and between grant recipients
◖ document progress throughout the life of the grant
◖ encourage measurement for an outcomes focus (to show what changes have been achieved)

Performance indicator	Outcome area related to indicator
Indicator 1:	
Quality and reach of community engagement	Increased community/regional involvement and support
	Increased leadership and advocacy role of community leaders in tobacco cessation
	Increased focus on priority groups
	Increased understanding by the community of the health impacts of smoking
	Increased understanding by the community of quitting pathways
Indicator 2:	
Organisations involved in tobacco reduction in the region	Improved access to culturally appropriate support to quit.
(proxy for stronger relationships)	Collaborations and partnerships built between TIS operations and external support for quitting.
Indicator 3:	
Building capacity to support quitting	Increases in skills among those professionals in contact with Aboriginal and Torres Strait Islander people
Indicator 4:	
Referrals to appropriate quitting support	Improved access to culturally appropriate support to quit.
(proxy for improved access to quitting support)	
Indicator 5:	
Supporting smoke-free environments	Increase in smoke free homes, workplaces and public spaces.
(proxy for environmental tobacco smoke)	

Appendix 4: Sample profile of survey respondents

Profile of regional grant recipient survey responses

Role	2016	2017
Manager/Regional Coordinator	39	30
TIS Worker, Project Officer, Educator	64	42
Other	5	9
Total responses	**108***	**81**

* Due to the size of the TIS team, an urban grant recipient was over-represented in the sample. Responses from this sub-sample (n=18) were analysed separately and results were comparable to the wider sample.

State / Territory	Remote	Rural	Urban	Total
2016				
QLD	4	8	18	**30**
NSW	4	19	6	**29**
ACT	0	0	4	**4**
VIC	0	4	4	**8**
TAS	0	3	0	**3**
SA	1	1	7	**9**
NT	9	2	0	**11**
WA	5	4	5	**14**
Total	**23 (21%)**	**41 (38%)**	**44 (41%)**	**108**
2017				
QLD	3	11	5	**19**
NSW	3	11	4	**18**
ACT	0	1	0	**1**
VIC	0	0	7	**7**
TAS	0	0	0	**0**
SA	2	2	3	**7**
NT	8	1	1	**10**
WA	14	5	0	**19**
Total	**30 (37%)**	**31 (38%)**	**20 (25%)**	**81**

Profile of primary stakeholder survey responses

Organisation	2016	2017
ACCHS	17	16
Aboriginal organisation	4	5
Other health service (mainstream)	11	5
School institution	2	7
NGO	Not an option in 2016 survey	7
Other	12	6
Total	**46**	**46**

TIS funded organisation	2016	2017
Yes	22	21
No	21	21
Unsure	3	4
Total	46	46

State / Territory	Remote	Rural	Urban	Total
2016				
QLD	0	0	1	**1**
NSW	1	18	5	**24**
ACT	0	0	2	**2**
VIC	0	0	1	**1**
TAS	0	0	0	**0**
SA	6	0	5	**11**
NT	1	0	0	**1**
WA	4	2	0	**6**
Total	**12 (26%)**	**20 (44%)**	**14 (31%)**	**46**
2017				
QLD	10	2	1	**13**
NSW	5	18	1	**24**
ACT	0	0	0	**0**
VIC	0	0	1	**1**
TAS	1	0	0	**1**
SA	0	2	1	**3**
NT	1	1	1	**3**
WA	1	0	0	**1**
Total	**18 (39%)**	**23 (50%)**	**5 (11%)**	**46**

Appendix 5: Quality assessment of data in TIS performance reports

Quantitative data

Assessment	Descriptor	Example
High quality	Provides extensive detail: numerator, denominator, sample size, time period, trends if available; data terms and collection methods are defined;	Indicator 1 – Quality and reach of community engagement: *'3 schools, 44 students participated [in school education program]; Pre survey 20.5% (9 of 44) showed knowledge about tobacco consumption, post survey 70.5% (31 of 44) showed same knowledge; 84.1% (37 of 44) indicated they would pass along messages to family and 86.4% (38 of 44) indicated they would not take up smoking in the future.'*
Acceptable	Provides most detail: numerator, trends if available; may include denominator; data terms not clearly defined	Indicator 1 – Quality and reach of community engagement: *'9 events; 372 community members engaged; identified 90 as smokers, 10 expressed interest in quitting; 4 of 9 events were smoke free.'*
Promising	Provides some detail: numerator or percentage only; does not include denominator or trends; data terms not defined; output data	Indicator 1 – Quality and reach of community engagement: *'Monthly [event], more than 30 community members attend, 80 members received brief intervention in the reporting period'*
Poor quality	Provides minimal detail: number without context; data terms not defined; output data or description only	Indicator 1 – Quality and reach of community engagement: *'Attendance at events with stalls and merchandise'*
No data/unable to rate	No data can be collected/reported	Indicator 4 – Referrals to appropriate quitting support: *'Developing leaflet on quit smoking pathways'*

Qualitative data (case studies) – it should be noted that grant recipients largely reported quantitative data. Qualitative data was mostly reported by way of individual case studies e.g. successful quit story or quit journey.

Assessment	Descriptor
High quality	Provides full narrative: number of years smoking, length of time as non-smoker, outcomes to quitting, may provide details of how they quit, why they quit; quotes
Acceptable	Provides most of a narrative: length of time quit, reason for quitting, how they quit, may include number of years smoking; Quotes
Promising	Provides some of a narrative: Length of time quit, how they quit, does not include number of years smoking or outcomes
Poor quality	May only include that they used TIS services to quit; May include a quote
No data/unable to rate	No information can be provided

Appendix 6: Innovation Grant Recipients

Innovation Grant Recipient	Project	Target population	Study Design	Key Intended Outcome
Aboriginal Health Council of South Australia	This project will establish a socially attractive gathering space, a Male Health Shed. The Shed will be dedicated to males where Aboriginal art, social and cultural activities can be practised. It will promote smoking cessation and preventative health. The project plans to provide Aboriginal males with a multi-faceted holistic tobacco cessation program (i.e. assessment, brief intervention, counselling, behaviour therapy, access to smoking cessation pharmacotherapy, health education, family support, skills building) that is tailored to their individual needs.	Aboriginal males aged 15 years and older who live in the two remote SA communities of Yalata and Coober Pedy. A secondary target group is Aboriginal men and women aged 15 years and older.	The project will be evaluated through a quasi-experimental matched comparison group design. Each community will be matched to a comparison community in terms of (i) smoking prevalence (ii) age and gender profile and (iii) remoteness index. The primary outcome measure is self-reported smoking status for two sets of samples (i) Aboriginal males aged 15 years and older, as exposed to the program, and (ii) Aboriginal men and women aged 15 years and older at the community level.	Observed change in the proportion of ex-smokers who quit less than 12 months ago and 12 months or more ago in the communities receiving the program, compared to the communities not receiving the program.
Metro South Hospital and Health Service, Queensland Health	The aim of the Project is to grow a smoke-free story in Inala. The Project will adopt a holistic approach to smoking cessation and prevention of uptake during pregnancy for Aboriginal and Torres Strait Islander youth.	Pregnant women aged 14-30 years attending the CoE group, their partners or key family members, and their social circles.	This is an exploratory study. The overarching research question is to determine if a holistic and ecological approach to reducing barriers to smoking behavioural change decreases rates of smoking amongst young women pregnant with an Aboriginal baby, their partners, and their social circles.	Program feasibility will be determined through levels of participation in the program, as well as participants' satisfaction with the program. Program effectiveness will be determined through recorded changes in smoking behaviours amongst all participants.
Aboriginal Resource and Development Services (ARDS)	The Project aims to support householders in three Top-End Aboriginal communities to establish or extend smoke-free spaces in the home.	The target group for this project is Aboriginal people residing in remote or very remote	The project aims to capture a set of baseline data in each participating household.	Primary outcome: The project will achieve a 50% increase on the baseline in the number of

Innovation Grant Recipient	Project	Target population	Study Design	Key Intended Outcome
Aboriginal Corporation	Households will be invited to participate in the program and receive ongoing support from ARDS team members and local project workers to take up strategies that render their homes - or parts of their homes - smoke-free.	communities in the Top End of Australia.

The project will be delivered in communities hosting stores owned by the Arnhem Land Progress Aboriginal Corporation (ALPA). ALPA currently owns stores in East, Central and West Arnhem Land, in Far North Queensland, and in a number of other regions in the Northern Territory. | As support for each household continues, the project team will capture information on any new or expanded smoke-free spaces and the key motivators and social mechanisms by which these spaces were established and maintained.

At the conclusion of the project, in each household a final snapshot of smoke-free spaces will be captured along with a further particle count to allow comparison with baseline data. This comparison will allow identification of the most successful strategies for promoting smoke-free spaces.

Tobacco sales data through the ALPA retail outlet in each community will be tracked across the project period to identify whether an extension of smoke free spaces leads to a corresponding decline in tobacco sales. This information will be compared with reported weekly household expenditure. | households in the community with active policies and strategies in place to control ETS. The project will correlate householder statements about smoke-free policies that apply in their home with a quantitative measure of airborne particles in the home using a Dylos 1700 particle counter.

Secondary outcome: Tobacco sales in ALPA outlets in the 12 months after the project ends will be lower than before the project and will show continuing decline. |
| **National Drug and Alcohol Research Centre, UNSW** | Smoking Nutrition, Alcohol and Physical Activity 'SNAP' program | Inmates in NT prisons | The study is randomised controlled trial with a sample size of 864 NT prisoners. They will be interviewed at baseline and at follow up in the community. The | Prevent relapse to smoking after release from prison. |

Innovation Grant Recipient	Project	Target population	Study Design	Key Intended Outcome
			treated group will receive the SNAP brief intervention.	
South Coast Women's Health & Welfare Aboriginal Corporation	Project provides ongoing, positive, gender-specific engagement with Aboriginal women who are pregnant, and Aboriginal young women. • encourage and support attendance at Aboriginal women's and young women's groups (process); • reduce psychological distress (outcome); and • reduce nicotine dependence and increase quit attempts (impact).	The two primary target populations are teenage women smokers and pregnant smokers. A secondary target population is Aboriginal women smokers of child-bearing age. The Balaang and Binjilaang project targets Aboriginal women living in south-east NSW.	The project will employ culturally safe action research methodologies that engage local Aboriginal communities, elders, and younger women in design, delivery and evaluation of interventions. Partners will collect and correlate data on nicotine dependence and psychological distress among target populations. Qualitative methods will be utilised to identify core components of the interventions most strongly linked to reduction of nicotine dependence. The intervention will be determined to be effective if there are statistically significant changes in nicotine dependence over repeat measures in the three target populations and these are positively correlated to attendance and reduction in psychological distress.	Reduce psychological distress (outcome); and Reduce nicotine dependence and increase quit attempts (impact).
NT Department of Health	Peer lead intervention, which seeks to engage young people with health services that support tobacco cessation and to change their peers' views about smoking. These peer leaders will be part of an integrated service response delivering holistic smoking cessation support, and they will	10 - 18 year olds with resident status in two remote communities – Maningrida and Gunbalanya – Arnhem Land, Top End, NT. This represents a sample size of approximately	The project will provide an in-depth understanding of both the prevalence and nature of youth smoking in the participating communities, and detailed qualitative and quantitative information about the impact of	More accurate estimates of smoking prevalence among the target population; increased number of quit attempts among young people; a shift in norms amongst youth

Innovation Grant Recipient	Project	Target population	Study Design	Key Intended Outcome
	receive accredited training to develop their skills and knowledge.	900 eligible participants.	targeted interventions. The three research questions being addressed are: Does a peer-led tobacco cessation support intervention lead to increased engagement with tobacco cessation services? What works when integrating youth tobacco cessation support into holistic service delivery? How can tobacco supply be restricted for youth under 18 years?	towards non-smoking; and an increased number of smoke free homes and restricted access to tobacco.
Western Australian Centre for Remote and Rural Medicine Ltd	The project will use a women-centred approach to achieve a better understanding of Aboriginal women's barriers to smoking cessation by designing and delivering a relevant, culturally meaningful smoking cessation program for Aboriginal women living in the Hedland and Western Desert communities	Aboriginal women aged from 15 years from the communities serviced by: Wirraka Maya Health Service Aboriginal Corporation (WMHSAC), Port Hedland, Pilbara, WA; and Puntukurnu Aboriginal Medical Service (PAMS), Newman, Pilbara, WA which services Newman, Jigalong, Parnngurr, Punmu and Kunawarritji in the north of WA.	The project will use qualitative and participatory action research methods and will be conducted with cultural sensitivity, in a series of workshops with local Aboriginal women. These workshops will focus on women's health and wellbeing, rather than focusing only on smoking cessation.	Enhance the evidence base on the effectiveness of a women-centred approach to women's self-efficacy and motivation for change. Results will be used to inform strategies and initiatives able to be supported in a primary healthcare setting.

Appendix 7: Table of TIS Program Logic

This table has been provided to ensure the report is accessible for e-readers.

Activities	Inputs	Outputs	Short Term Outcomes	Medium Term Outcomes	Long Term Outcomes
Localised Health Promotion	Regional Grants health promotion. Innovation grants intense services.	Implementation of strategies targeting priority groups including pregnant women and young people. Deliver multi-level, evidence based and locally relevant health promotion for tobacco control. Implementation of community supported strategies.	Increased community/regional involvement and support. Increased leadership and advocacy role of community leaders. Increased understanding of the health impacts of smoking and of quitting pathways. Increase in smoke free homes, workplaces & public spaces. Increased self-efficacy and desire to quit. Increased focus on priority groups. Reduce opportunistic smoking behaviours.	Positive Changes to social norms. Increases in individuals wanting to quit. Increase in number and length of quit attempts. Reductions in amount smoked where cessation not achieved. Reduced exposure to second-hand smoke. Improved quality and relevance to local service of evidence on health promotion. Increased effectiveness of quitting pathways through collaborations and partnerships of various services and organisations.	Reduces gap in prevalence of smoking among Aboriginal and Torres Strait Islander people compared to that among non-Indigenous through: Reducing uptake of smoking and increasing smoking cessation. Reduced exposure to second-hand smoke.
National support for regional grants	National Coordinator. National Best Practice Unit.	Provide evidence and support to funded organisation to focus on outcomes and use of evidence.	Full implementation of the redesigned TIS program outcomes focus. TIS operations guided and supported. Effective approaches adopted through flexible funding and use of evidence		

Activities	Inputs	Outputs	Short Term Outcomes	Medium Term Outcomes	Long Term Outcomes
Access to quit support	Enhanced Quitlines. Quitskills funded. Referrals to medical support. Referring to or operating local counselling (individual & group).	Provide range of opportunities for achieving cessation. Deliver training for supporting people to quit.	Improved access to culturally appropriate support to quit. Collaborations and partnerships built between TIS operations and external support for quitting. Increases in specific skills among those professionals in contact with Aboriginal and Torres Strait Islander people.		
Larger evidence base	Facilitation of local data collections. National Best Practice Unit. Innovation grants results. National evaluation.	Infrastructure in place for collecting, analysing, recording and sharing results.	Improved access to information of what works and what does not, particularly for vulnerable populations. Improved local Aboriginal & Torres Strait Islander community capacity in the collection, analyses and recording of program evaluation data.		

Contextual factors: State and territory tobacco control activities, previous TIS activities, existing service infrastructure, location and population profile variations, regional population coverage, National Tobacco Campaign. Also, program design elements are: Flexible and responsive; Modelling the message; Evidence based; Effective monitoring & evaluation; Outcomes-based; System building; Tobacco action as primary focus; Population health approach; Place-based; Targeted approaches for specific groups; Sharing best practice.

Appendix 8: Data tables for figures

These data tables have been provided to ensure the report is accessible for e-readers.

Figure 10 table. Total number of Aboriginal and Torres Strait Islander referrals to Quitline in 2016 and 2017 by jurisdiction.

State	2016	2017
QLD	2089	2453
NSW/ACT	677	587
SA	263	262
VIC	247	328
TAS	170	205
WA	107	145
NT	45	51

Figure 11 table. Number of referrals each month for Aboriginal and Torres Strait Islander people between January 2016 to December 2016 across each state and territory.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2017	298	300	392	260	317	380	297	330	392	389	388	288
2016	264	299	289	263	385	302	271	305	378	285	309	248

Figure 13 table. Improvement in quality of performance report data over two waves of TIS performance reports (July 2016 and February 2017).

	High quality	Acceptable	Promising	Poor Quality	No data/Unable to rate
Performance Report Data July 2016	3%	35%	31%	16%	15%
Performance Report Data February 2017	10%	44%	29%	9%	8%

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