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Perspective

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Colonial harm in new packaging: Indigenous critiques of the tobacco industry's 'harm reduction' rhetoric

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Abstract

Over the last 75 years, we have learned that commercial tobacco use causes widespread disease and death. However, the commercial Tobacco and Nicotine Industry continues to promote, market, and sell tobacco and nicotine products to protect and expand profit. This reflects their legal obligation to act in shareholders' best interests. While the Tobacco and Nicotine Industry heavily promotes alternative products such as electronic cigarettes and nicotine pouches, for now, these represent a relatively small share of profits compared with combustible cigarette sales. The continued reliance on and expansion of these markets generates addiction, dependence, and a range of harms. These actions represent a modern manifestation of colonization—reproducing control and exploitation that affects people at all levels, particularly Indigenous peoples, whose lands, knowledges, and well-being have long been commodified and targeted. The Tobacco and Nicotine Industry and their collaborators employ misleading strategies, including co-opting terms like 'harm reduction' and making vague promises about a 'smoke-free' or 'noncombustible' future. These tactics distract from the continued promotion and sale of harmful products under the guise of public health and harm reduction. This narrative reframes structural and commercial determinants of health as matters of individual choice and enables the continued production of Tobacco and Nicotine Industry–driven harms. Everyone has the right to health, and it is crucial to have effective tobacco control and resistance programs and policies. Governments have a duty to protect people's health by preventing the creation of new generations addicted to people-harming products. Given the ongoing and disproportionate impact of tobacco and nicotine-related disease and death—particularly for Indigenous peoples—there is an urgent need for structural change to eradicate these harms and dismantle colonial and commercial systems that sustain them.

Keywords: smoking; nicotine; smoking prevention; public policy; tobacco industry

Contribution to Health Promotion

(i) The Tobacco and Nicotine Industry employs misleading strategies, such as coining and appropriating terms such as 'harm reduction'. These tactics are part of ongoing efforts to distract from the continued promotion, sale, and profit of people-harming products.
(ii) For over 75 years, tobacco use has been known to cause disease and death, yet the Tobacco and Nicotine Industry pushes new addictive products such as electronic cigarettes (e-cigarettes), nicotine inhalation products, and nicotine pouches.
(iii) The World Health Organization's FCTC upholds the right to health and calls for strong tobacco control policies.
(iv) Governments must protect current and future generations by preventing nicotine addiction and implementing structural changes to eradicate tobacco and nicotine harms.

INTRODUCTION: WE HAVE KNOWN ABOUT THE HARMS OF COMMERCIAL TOBACCO USE FOR OVER 75 YEARS

When used as directed, commercial or recreational tobacco use generates disease and death (United States Surgeon General's Advisory Committee on Smoking 1964, Institute for Health Metrics and Evaluation 2019). We have known this for over 75 years (United States Surgeon General's Advisory Committee on Smoking 1964). However, the commercial Tobacco and Nicotine Industry, including cigarette manufacturers as well as companies that exclusively produce electronic cigarettes (e-cigarettes), nicotine pouches, and other harmful nicotine products, continues to actively engineer, manipulate, promote, and sell these products for profit (Maddox *et al.* 2022, Friel *et al.* 2023). This reflects the increasing complexity of the market, including companies that sell only e-cigarettes, nicotine pouches, and people-harming products, and their obligations to operate in their shareholders' best interests, prioritizing shareholder profits over health. Their practice of exploiting nicotine addiction continues through a new generation of addictive commercial products, such as electronic cigarettes, nicotine inhalation products, and pouches. This modern manifestation of colonization and subjugation through the appropriation, extraction, and commodification of nicotine and related products occurs across local, regional, national, and international levels (Waa *et al.* 2020a, 2020b, Maddox *et al.* 2022, Piper *et al.* 2022). Throughout this manuscript, we refer to the Tobacco and Nicotine Industry, which includes tobacco companies and newer companies marketing nicotine products, such as e-cigarettes, nicotine inhalation products, pouches, and nontherapeutic nicotine products.

Commercial tobacco exploitation: a colonial tool

There has been increased research, education, and awareness into how racism established the use of commercial tobacco products, resulting in preventable disease and death (Piper *et al.* 2022, Thurber *et al.* 2022, Lee *et al.* 2023). This includes understanding that a plant sacred to many Indigenous peoples and communities was appropriated by European colonizers. The sacred tobacco plant was bastardized, modified, industrialized and commercialized by the tobacco industry, turning it into a 'recreational commodity' with an exploitative profit model (Nez Henderson *et al.* 2022). For Indigenous peoples, this exploitation was threefold: (i) the exploitation of a sacred plant, (ii) the exploitation of Indigenous images and languages, including for product promotion, and (iii) the exploitation of Indigenous peoples through addiction, diseases, and death (Waa *et al.* 2020a, 2020b, Maddox *et al.* 2022, Nez Henderson *et al.* 2022, Piper *et al.* 2022, Truth Initiative 2025).

In concert, colonial policies, in conjunction with the tobacco industry, established and promoted a racist foundation for commercial tobacco and nicotine science (Nez Henderson *et al.* 2022, Lee *et al.* 2023). Racism as an inherent tool of colonization continues to dehumanize the 'colonized' and legitimize the entitlement of settlers and settler colonial states. Colonization systematically embedded the use of commercial tobacco use among many Indigenous populations outside of ceremonial use, actively undermining the sacred relationship with the tobacco plant (Williams and Mohammed 2009, Nez Henderson *et al.* 2022). Commercial tobacco was used in many first encounters by colonizers as a gesture of 'goodwill' or inducement to exploit Indigenous peoples (Colonna *et al.* 2020, Nez Henderson *et al.* 2022). Commercial tobacco was also used as rations in lieu of wages, with many Indigenous communities systematically excluded from the cash economy and the Euro-Western education system (Colonna *et al.* 2020, Nez Henderson *et al.* 2022).

As a tool of colonization, commercial tobacco disrupted traditional cultures and connection to Country, with settlers using its 'desirability' (addiction) to persuade people to give up land and cultural artefacts in exchange for commercial tobacco (Colonna *et al.* 2020, Nez Henderson *et al.* 2022). Its addictive properties meant that it became entrenched within many Indigenous communities and societies as a highly valued commodity, resulting in a range of serious and well-established impacts on Indigenous health and well-being (Colonna *et al.* 2020, Nez Henderson *et al.* 2022).

Colonial processes and systems that actively suppressed Indigenous knowledges, values, behaviors, practices, and ways of knowing, being, and doing were commonly implemented by governments, churches, and institutions (Colonna *et al.* 2020, Nez Henderson *et al.* 2022). For example, the United States of America's federal government passed the Code of Indian Offenses in 1883, prohibiting Indigenous peoples from the right to perform cultural and traditional ceremonial practices, many of which involved the use of ceremonial tobacco, such as Ghost Dance and Sun Dance. In Canada, under the Indian Act of 1885, tobacco use for

ceremonial practices was illegal; however, commercial tobacco use was legal (i.e. *not* illegal) (Nez Henderson *et al.* 2022). These policies actively contributed to the uptake of commercial tobacco among First Nations and Mètis peoples, leading to commercial tobacco products being systematically inserted into a range of ceremonial and everyday practices. Those restrictions on ceremonial tobacco alongside the widespread availability of commercial tobacco products, with its targeted promotion to Indigenous peoples, have actively driven commercial tobacco use, dependence, and addiction (Nez Henderson *et al.* 2022).

TOBACCO CONTROL DISCOURSE AND RACIALIZED LOGICS: THE EURO-WESTERN INFLUENCE TO 'SAVING LIVES' WHILE SELLING DEATH

Tobacco control discourse generally reflects Euro-Western worldviews, including narrow definitions of 'health', 'well-being', 'commercial tobacco', and 'harm reduction' (Lee *et al.* 2023). These frameworks often exclude or misrepresent Indigenous knowledge systems and lived experiences, thereby embedding racialized logics within tobacco control itself—not only within the tobacco industry. This can perpetuate racialized logics and oppress population groups most impacted by the tobacco industry and most targeted by policy gaps and inadequate public health responses. Racialized logics and marginalization can (re)produce and perpetuate inequities and inequalities in health outcomes while continuing to manufacture disease and death (Lee *et al.* 2023), for example, the appropriation of Tupeka Kore ('Tobacco Free') in Aotearoa New Zealand (Waa *et al.* 2020b).

The Tupeka Kore movement is a response to the predatory tactics of the tobacco industry (and Euro-Western ideology) with the goal of ending the exploitation of nicotine addiction. However, faced with an existential threat, the industry has sought to appropriate Tupeka Kore through attempts to shift the movement's focus to smoked tobacco products only, thus carving out a market for alternative nicotine products (ANDs) (such as e-cigarettes, nicotine inhalation products, pouches, and oral nicotine products). This has included appropriation of terms such as 'smoke-free', 'harm reduction', and 'quitting' to promote their ANDs and displaced the original concept of Tupeka Kore (to be free of the tobacco industry and nicotine addiction) (Waa 2024).

Tobacco control institutions and research agendas, when grounded in Euro-Western norms, may inadvertently reproduce similar harm by silencing or sidelining Indigenous-led models of care, knowledges, and policy innovation, to advance tobacco control. There is an urgent need to recognize, address and mitigate racialized logics (Lee *et al.* 2023). Racialized logics frame race as an ideological construct and social phenomenon situated within a racial structure and system to produce differential statuses between racialized social groups, creating a system that affords power and privilege according to an established hierarchy. Racialized logics and racism operate at several intersecting levels, including institutionalized racism, interpersonal racism, and internalized racism (Lee *et al.* 2023). As Indigenous peoples (R.M., M.K., A.W., L.T., S.B., S.M., P.N.H., H.C., E.S.T., C.K., and J.R.), we recognize that such racialized logics and the associated learnings are 'time, place and land' dependent (Moreton-Robinson 2017, Lee *et al.* 2023). Further, the social constructions of race and racism are interconnected, intertwined, and pervasive across all social systems and institutions, including the commercial Tobacco and Nicotine Industry, but also tobacco control policy, science, and the academy itself (Piper *et al.* 2022, Thurber *et al.* 2022, Lee *et al.* 2023). We recognize this dynamic and we understand that critically assessing racism and racialized logics is necessary if society and the academy is to be liberated from oppressive structures based on personal characteristics (Piper *et al.* 2022, Thurber *et al.* 2022, Lee *et al.* 2023), for example, Indigeneity, ethnicity, nationality, sexual orientation, sex, gender, dis/ability, class, and age.

HEALTH: MINOBIMAATISIIWIN—LIVING THE GOOD LIFE

Health does not mean the absence of disease. Health does not just mean physical health. Health is not an individualized commodity. While the definitions of health vary with the diversity and vibrancy of Indigenous peoples, cultures, communities, and nations, they generally encompass a holistic perspective that integrates physical, mental, emotional, and spiritual well-being of the individual and the community (National Aboriginal and Islander Health Organisation 1979, Kahn-John and Koithan 2015, Noisy Hawk 2015, Bourke *et al.* 2018). This echoes the diversity of knowledges, cultures, and connections to Country, with a deep understanding of the interconnectedness of all aspects of life that emphasizes the importance of cultural continuity, spiritual well-being, and the connection to the land, family, community, and kin (National Aboriginal and Islander Health Organisation 1979, United Nations General Assembly 2007, Kahn-John and Koithan 2015, Noisy Hawk 2015, Bourke *et al.* 2018).

Indigenous definitions of health offer valuable insights into health and well-being. This includes helping to better understand the implications of ongoing colonial processes (National Aboriginal and Islander Health Organisation 1979, United Nations General Assembly 2007, Kahn-John and Koithan 2015, Noisy Hawk 2015, Bourke *et al.* 2018). These processes continue to actively undermine Indigenous peoples' and communities' agency, self-determination, and sovereignty, including the ability to be free from nicotine addiction and dependence. This also highlights the inherent and fundamental conflict of interest between the tobacco industry's pursuit of profit and the right to health, including the right to live free from addiction (Waa *et al.* 2020a, 2020b, Piper *et al.* 2022, Lee *et al.* 2023).

Indigenous peoples and communities strive for wellness, self-determination, and sovereignty (World Health Organization 2003, United Nations General Assembly 2007, Maddox *et al.* 2022). The Tobacco and Nicotine Industry pursues its profit goal by exploiting addiction and in so doing actively undermines or removes people's control over their own lives. This inherent and clear conflict between public health and the tobacco industry clarifies why the industry's purported 'transformation' largely consists of increasing production of 'smoke-free', 'reduced risk', 'noncombustible' or 'next-generation' products. Ultimately, the commercial Tobacco and Nicotine Industry continues to generate new cohorts addicted to people-harming products (World Health Organization 2003, United Nations General Assembly 2007, Maddox *et al.* 2022).

COMPLICIT COLONIAL STRUCTURES AND TOBACCO USE PERMITTED

Structural and social pressures to use commercial tobacco have been manufactured through colonization, including the sale and promotion of products (Waa *et al.* 2020a, 2020b, Maddox *et al.* 2022, Tobacco Tactics 2024a). Sales are permitted; widespread retail supply is permitted; highly addictive properties are permitted; youth targeting is permitted (World Health Organization 2003, Colonna *et al.* 2020). The commercial conditions that allow these harms are structural and societal. Therefore, change must come at those levels. Government inaction demonstrates commitment to the colonial project and settler colonial states, where the interests of external organizations and businesses (i.e. industry) are prioritized over the people, Indigenous peoples, and Indigenous leadership. A substantial shift is required. Structural barriers reinforce power imbalances, including inadequate access to the following: cessation supports, culturally safe healthcare, education, policy influence, and economic and cultural sovereignty. These barriers erode agency, self-determination, and sovereignty; exacerbate health harms; foster distrust; and uphold the colonial conditions that enabled commercial tobacco and nicotine use in the first place (Maddox *et al.* 2022, Nez Henderson *et al.* 2022).

We also know that most Indigenous peoples who smoke want to quit or wish they never took up smoking (70% of Aboriginal and Torres Strait Islander peoples want to quit and 78% wish they never took up; 56% of American Indians and Alaska Natives want to quit) (Colonna *et al.* 2020, United States Public Health Service Office of the Surgeon General 2020). Tobacco control strategies such as denormalization and smoking-related sanctions are often implemented with the goal of reducing prevalence. However, these strategies can unintentionally reinforce stigma and discrimination—particularly among marginalized groups already targeted by the Tobacco and Nicotine Industry and underserved by public health systems. This can further isolate them from the very communities from which they typically draw support, solidarity, and a shared sense of identity (Colonna *et al.* 2020). Popular discourse commonly locates the 'problem' (nicotine addiction) with the individual and assigns personal blame (Maddox *et al.* 2024a, 2024b). This highlights the need for structural changes and systemic support, fostering an environment that is free from nicotine dependence and importantly, a future free from commercial Tobacco and Nicotine Industry death and disease (Maddox *et al.* 2022, Lee *et al.* 2023).

'HARM REDUCTION'

Genuine or legitimate 'harm reduction' is a public health approach that, as the name suggests, reduces or mitigates the negative consequences associated with certain behaviors or conditions, rather than focusing solely on eliminating those behaviors (i.e. reduces harm or a net reduction in harm(s), not necessarily reducing use) (Lenton and Single 1998). It reflects that certain behaviors may continue despite efforts to prevent them, such as substance use or sexual practices, and seeks to reduce or minimize the associated harms.

Importantly, harm is not limited to physical health outcomes. Legitimate harm reduction approaches recognize harm in a more holistic sense—encompassing physical, mental, spiritual, social, cultural, economic, legal, and environmental harms now and into the future (National Aboriginal and Islander Health Organisation 1979, Kahn-John and Koithan 2015, Noisy Hawk 2015, Bourke *et al.* 2018). Legitimate harm reduction programs and policies are not shareholder or profit driven, but aim to reduce harms, such as the spread of infectious diseases, prevent overdose deaths, and improve the overall health and well-being of individuals, communities, and future generations (Lenton and Single 1998).

TOBACCO CONTROL AND 'HARM REDUCTION'

Evidence-based tobacco control policy interventions, including legitimate harm reduction efforts, have resulted in meaningful reductions in disease and death from the commercial tobacco epidemic (Colonna *et al.* 2020). This includes Nicotine Replacement Therapy (NRT), stop smoking medications, smoke- and nicotine-free spaces as well as restricting tobacco advertising, promotion, and introducing plain packaging; increasing tobacco tax excises and consequently the price of tobacco products that include legitimate net harm reductions across health, social, spiritual, economic, legal, and environmental harms (World Health Organization 2003). Such measures support public health and people who smoke and/or use e-cigarettes that are ready to quit, without requiring abstinence, meaning that individuals can benefit even if not ready or able to quit entirely. However, progress in addressing health inequities through these types of measures has been slow and incremental (Maddox *et al.* 2022, Ouakrim *et al.* 2023). Furthermore, several major tobacco transnationals have attempted to invest in nicotine containing therapeutic products or position their existing products as therapeutic. For example, Philip Morris International previously owned Vectura (a pharmaceutical company) and Fertin Pharma (a nicotine gum manufacturer), while British American Tobacco in launching its new nicotine pouches has attempted to gain FDA approval (Sy 2023; Tobacco Tactics 2025, 2024b). This direct involvement in both the sale of tobacco and NRT products reflects a conflict of interest and reinforces the paradox of Tobacco and Nicotine Industry-led 'harm reduction'. By profiting from both addiction and its supposed treatment, these corporations perpetuate cycles of dependency, deepen structural inequities, and compromise culturally safe cessation pathways—particularly for Indigenous peoples disproportionately targeted and impacted by commercial tobacco and nicotine harms (Tobacco Tactics 2025).

Despite longstanding recognition of the cultural and social determinants of health, including colonization and racism and the ongoing impacts of commercial tobacco-related death and disease, tobacco control efforts have predominantly targeted individuals and failed to address broader structural inequities (Maddox *et al.* 2022, Ouakrim *et al.* 2023). The detrimental impact of commercial tobacco on health and well-being has been well-documented for decades, and since the nineteenth century, it has been understood that health inequities are deeply rooted in social, not merely biological, factors (Zambrana and Williams 2022). This underscores the need for comprehensive approaches (World Health Organization 2003, Colonna *et al.* 2020) that address social and commercial determinants of health (Colonna *et al.* 2020).

There is no one-size-fits-all approach to reducing and eradicating commercial tobacco-related disease and death. Legitimate 'harm reduction' efforts—whether implemented alone or in combination with supply and demand reduction measures—have been shown to support people in quitting smoking, e-cigarette use, and other forms of nicotine dependence and addiction (World Health Organization 2003, Colonna *et al*. 2020, Maddox *et al*. 2024a, 2024b).). In addition, legitimate 'harm reduction' can include supply and demand reduction measures to prevent second- and third-hand smoke exposure as well as prevent uptake among those who have not smoked or been addicted to nicotine. This can include children and adolescents, adults, and the elderly. This is a critical public health issue that requires an understanding of Indigenous health. This includes considering the social, spiritual, economic, legal, environmental, and physical aspects of health to address this issue effectively; incorporating targeted programs and policies that are specific to the context and free from commercial interests.

TOBACCO INDUSTRY'S APPROPRIATION OF HARM REDUCTION: A PUBLIC HEALTH DILEMMA

Tobacco industry appropriation and/or coining terms are consistent with the industry playbook. For example, the Industry coined the term 'environmental tobacco smoke' and some companies have made nonspecific statements about working toward a 'smoke-free' or 'noncombustible' future, contributing to 'harm reduction' and 'reducing the harms their products cause' (Espiner 2024, Industry Documents Library 2024, Tobacco Tactics 2024a).

However, none have ended commercial tobacco product sales or appear to be on track to meet their own stated goals (Mehegan *et al*. 2024, Maddox *et al*. 2024a, 2024b).

The tobacco industry's strategic engagement and arguable appropriation of 'harm reduction' represents a somewhat conflicted and complex terrain within the realm of *public health* (Espiner 2024).

At first glance, the purported pivot from manufacturing, marketing, distributing, and profiting from an addictive product that drives a global epidemic killing eight (8) million people per year to supposedly pioneering a 'smoke-free world' may be promising (Institute for Health Metrics 2019, Hill *et al*. 2023). Genuine harm reduction has aimed to reduce and minimize the adverse consequences of the commercial tobacco and nicotine epidemic, including social, spiritual, economic, legal, and environmental health harms. However, the tobacco industry's appropriation of harm reduction reframes structural and commercial determinants of health as matters of individual choice, embedding personal responsibility rhetoric within a commercial discourse that protects profits and shifts blame onto people who smoke. This embeds a myriad of moral, ethical, regulatory, public health, and societal challenges (Espiner 2024).

Despite this dilemma, the tobacco industry's embrace and appropriation of 'harm reduction' continues (Waa *et al*. 2020a, 2020b, Espiner 2024, Industry Documents Library 2024, Truth Initiative 2025, Waa 2024). This has included the promotion and marketing of ANDs, such as e-cigarettes, heated tobacco products, and pouches. These products are commonly purported to be 'reduced risk products' and less harmful than combustible tobacco products, leveraging 'harm reduction' rhetoric to appeal to consumers, policymakers, and society (Hill *et al*. 2023, Espiner 2024, Industry Documents Library 2024). This is despite e-cigarettes (commonly marketed as vapes) being aggressively promoted, marketed, and socialized to children, young people, and people who do not smoke. Further, evidence continues to grow reflecting the concerns of these products to (re)normalize commercial tobacco use, serving as gateway products for people who do not smoke, perpetuating and increasing nicotine addiction and dependence among children, youth, and people who do not smoke (Banks *et al*. 2023, Waa 2024). The tobacco industry's tactics, including aggressive marketing, lobbying efforts, manufacturing and sales of combustible tobacco products as well as strategic alliances with 'harm reduction' advocates, undermine the integrity of genuine harm reduction principles. (Truth Initiative 2025, Tobacco Tactics 2024a).

The industry's claims of beneficence might be plausible, if only that same industry was not simultaneously lobbying against almost every evidence-based tobacco control measure introduced, enabling addictive tobacco and nicotine products to remain the leading cause of preventable disease and death around the world (Espiner 2024). Further, the tobacco industry's ongoing history of deception, manipulation, targeting, and profiting from Indigenous peoples and communities' casts doubt on its *commitment* to promoting genuine harm reduction (Waa *et al*. 2020a, 2020b, Espiner 2024, Waa 2024). While harm reduction has played and continues to play a constructive role in reducing the burden of tobacco and nicotine-related harms, the industry's appropriation of this concept introduces a myriad of moral, ethical, regulatory, public health, and societal considerations as they continue to fuel the deaths of 8 million people per year (Waa *et al*. 2020a, 2020b, Espiner 2024, Waa 2024).

Vigilance, critical scrutiny, and evidence-based policymaking are essential to eradicate industry-generated disease and death and ultimately uphold the Human Right to Health (Maddox *et al*. 2022, Maddox *et al*. 2024a, 2024b).

HUMAN RIGHT TO HEALTH: ERADICATING COMMERCIAL TOBACCO AND NICOTINE-RELATED DISEASE AND DEATH

All Indigenous peoples and communities have the right to develop, implement, and access appropriate tobacco reduction programs and policies and uphold the Human Right to Health (World Health Organization 2003, United Nations General Assembly 2007). Indeed, 'all' peoples and communities have a right to health consistent with the World Health Organization's Framework Convention on Tobacco Control (FCTC), an evidence-based treaty that reaffirms the right of all people to the highest standard of health and highlights the need to engage Indigenous peoples in the development, implementation, and evaluation of tobacco control (World Health Organization 2003, United Nations General Assembly 2007). This includes recognizing the critical leadership of Indigenous-led services—such as Aboriginal Community Controlled Health Organisations—which are grounded in Indigenous ways of knowing, being, and doing.

In upholding the Human Right to Health, governments have a responsibility in actively protecting the health of Indigenous peoples and 'all' peoples (World Health Organization 2003, United Nations General Assembly 2007). This includes preventing the creation of new cohorts of people addicted to

people-harming products in a predatory commercial landscape (World Health Organization 2003, United Nations General Assembly 2007). As we witness the cumulative burden of tobacco and nicotine-related death and disease, there are clear obligations to eradicate the completely preventable harms generated by commercial tobacco and nicotine use (Institute for Health Metrics 2019, Banks *et al.* 2023). This does not mean legitimizing and perpetuating new harms or the purported substitution of one harm for another (Lenton and Single 1998, Waa 2024). This is consistent with efforts to end the widespread availability of commercially produced and marketed tobacco, e-cigarette, and nicotine products that exploit addiction and cause harm, in alignment with commitments under the WHO FCTC (World Health Organization 2003). While Article 2.1 of the FCTC explicitly encourages parties to go beyond its provisions to protect public health (World Health Organization 2003), the Tobacco and Nicotine Industry has actively sought to delay, disrupt, and contest regulatory action on newer people-harming products by exploiting perceived gaps in the treaty's language.

The next logical step in tobacco control and commercial tobacco resistance is to urgently place communities in the driver's seat by implementing evidence-based structural changes that fundamentally change the nature and supply of tobacco to eradicate the epidemic and foster a nicotine-free future (Maddox *et al.* 2022, Maddox *et al.* 2024a, 2024b). Examples of structural changes include phasing out the retail availability of commercial tobacco and nicotine products; investing in Indigenous-led health systems and culturally grounded cessation care; enforcing commercial tobacco exclusion policies across all levels of government, research, and health sectors; implementing WHO FCTC Article 5.3 (World Health Organization 2003) protections more rigorously; and removing profit incentives from selling products known to harm or kill. Article 5.3 of the WHO FCTC aims to protect public health policies from commercial and other vested interests of the tobacco industry. Structural change is also required to help address the colonial foundations that sustain tobacco-related inequities—by improving access to quality education, creating meaningful employment opportunities, and ensuring economic and cultural sovereignty for Indigenous peoples.

INDIGENOUS LEADERSHIP AND RELATIONAL FOUNDATIONS

This manuscript was led by Indigenous interests, needs and rights as Indigenous peoples, consistent with UNDRIP, the WHO Framework Convention on Tobacco Control, and ethical practice (World Health Organization 2003, United Nations General Assembly 2007). The conceptualization of the manuscript with Indigenous leadership and engagement includes but is not limited to Indigenous lived experience (R.M., M.K., A.W., L.T., S.B., P.N.H., H.C., E.S.T., C.K., and J.R.). Recognizing relationality and our credentials, grounded in our respective roles, community accountability, and responsibilities, is foundational to this work (Moreton-Robinson 2017). This recognition necessitates an understanding of our connections, biases, and worldviews. Relationality, as a distinct Indigenous social research presupposition, constitutes the epistemic framework that informs and sustains the generation of knowledges that are specific to time, place, and land (Moreton-Robinson 2017). By privileging and adhering to our logics, we develop an understanding of who we are, who we assert ourselves to be, and who asserts us, as well as how we are interconnected. This is a matter of ontological and epistemological significance, where our existence and the way relationality informs our Indigenous social research paradigms are critical to this work (Moreton-Robinson 2017).

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Author contributions

All authors contributed to this work. Their contributions align with the Contributor Roles Taxonomy (CRediT) as follows: Conceptualization: R.M., C.H., A.W., L.T., P.U., P.N.H., C.K., J.R., J.L., E.S.T., S.A.M., S.K.B., and M.K. Methodology: all authors. Investigation: all authors. Formal Analysis: not applicable. Data Curation: not applicable. Writing—Original Draft: all authors. Writing—Review & Editing: all authors. Supervision: all authors. Project Administration: all authors. Funding Acquisition: not applicable. All authors have read and approved the final manuscript.

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