

Identifying and integrating Behaviour Change Techniques into an Indigenous-led group based smoking and vaping cessation program for women during pregnancy and the perinatal period: upholding Indigenous knowledges and rights in research.

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ABSTRACT

Introduction. There is an urgent need for community-led and embedded smoking and vaping cessation programs developed for and by Indigenous people to address the disproportionate tobacco-related harms stemming from colonisation. This paper describes the development of an Indigenous-led program for Aboriginal and Torres Strait Islander women during pregnancy and the perinatal period, drawing on Indigenous knowledges to prioritise and integrate behaviour change techniques.

Methods. A systematic process involving four steps was implemented to uphold Indigenous knowledges, rights and self-determination in program co-creation. First, we identified and prioritised behaviour change techniques that are important and meaningful to Aboriginal and Torres Strait Islander people, and identified effective behaviour change techniques from existing published literature. These steps informed a collective program development process of iterative development, reflection, and feedback to weave behaviour change techniques in the final program.

Results. The behaviour change technique domains prioritised by Aboriginal and Torres Strait Islander people included natural consequences, antecedents, goals and planning, social support and comparison of outcomes. Twenty-four behaviour change techniques across fifteen domains were identified from the peer-reviewed literature. The final program incorporates fifteen behaviour change domains and 60 unique individual behaviour change techniques.

Conclusions. The *Which Way? Women's Group-based Smoking and Vaping Cessation Program* was co-created with Aboriginal and Torres Strait Islander women and community partners, drawing on the knowledges and wisdom of Aboriginal and Torres Strait Islander people and behaviour change techniques. The effectiveness of the program will be tested in a hybrid-Type 1 implementation trial.

Implications. This paper reports a novel co-creation process led by Aboriginal and Torres Strait Islander women in partnership with community to develop a smoking and vaping cessation program for women during the pregnancy and perinatal period. In detailing the development process used, this work upholds Indigenous rights to self-determination as outlined in the World Health Organisation Framework Convention on Tobacco Control. Our transparent reporting upholds Indigenous ethics and provides valuable insights to inform the development of other interventions aimed at supporting Indigenous women and communities in empowering smoke and vape free generations.

Keywords

Cessation, behaviour, Pregnancy—treatment and intervention

INTRODUCTION

There is an urgent need for community-led and embedded smoking and vaping cessation programs developed for and by Indigenous people to address the disproportionate tobacco-related harms stemming from colonisation^{1,2}. Daily smoking rates among Aboriginal and Torres Strait Islander people has reduced significantly over the past few decades³, however, tobacco remains the most prevalent cause of death and disease including the primary cause of premature death among Elders⁴. In 2022, 40% of Aboriginal and Torres Strait Islander women reported smoking during pregnancy⁵. However, research led by the authorship team has recently found that over 90% of Aboriginal and Torres Strait Islander women report changing smoking behaviours including reducing intake and having smoke free periods during pregnancy⁶. Additionally, women who reported using an Aboriginal Health Service were 4.5 times more likely to be smoke-free during pregnancy⁶. Currently, there are limited programs that specifically address barriers and enablers to smoking and vaping cessation among Aboriginal and Torres Strait Islander women during pregnancy and the perinatal period⁷. However, if implemented, these programs have the potential to have significant impact and contribute to smoke and vape free generations.

Indigenous-led programs are recognised globally as the most effective and meaningful way to increase engagement and successful cessation among Indigenous peoples⁸. However, there remains limited Indigenous-led evidence of comprehensive cessation support programs developed for and by Indigenous people⁸. In Australia, recent Indigenous-led, community-based initiatives have been successful in supporting Aboriginal and Torres Strait Islander people to quit and reduce smoking rates⁹⁻¹³. The *Which Way?* program is continuing to develop innovative, Indigenous-led smoking and vaping cessation programs that address community priorities and known barriers in access and uptake^{9,14,15}. Partnering with Aboriginal community organisations and Aboriginal Health Workers, the *Which Way?* program has co-created a smoking and vaping cessation program targeted at the pregnancy and perinatal period with associated training and resources to be embedded in Aboriginal and non-government Health Services. Developed at the request of Aboriginal and Torres Strait Islander women¹⁶, the program is a group-based model of care that draws on cultural and community strengths, underpinned by Indigenous knowledges and ways of doing. The development process moved “beyond co-design” to uphold Indigenous knowledges, rights and self-determination. The comprehensive process undertaken to develop the program was co-authored with community partners and is reported elsewhere¹⁷.

It is well established that the development of interventions to address behaviours is complex and involves multi component approaches. Behaviour change techniques (BCTs) are defined as “*a replicable component of an intervention designed to alter or redirect causal processes that regulate behavior*”¹⁸. BCTs aim to drive behaviour change and have been integrated into other Indigenous programs¹⁹. BCTs have potential to enhance the quality of cessation care offered to Aboriginal and Torres Strait Islander people who want to be smoke and vape free. However, limited evidence exists as to which BCT’s are meaningful to Aboriginal and Torres Strait Islander people and how these can be integrated into the comprehensive design and development of cessation programs.

While the evidence for BCT’s informs “active ingredients”²⁰ for behavioural interventions, it does not direct how these should be integrated into practice. In this paper we report how the

Which Way? program has co-created a smoking and vaping cessation program for Aboriginal and Torres Strait Islander women during pregnancy and the perinatal period, drawing on Indigenous knowledges to prioritise and integrate BCT's across core program components. This process has privileged Indigenous leadership and held time and space for ethical research conduct. The resulting program will be implemented across Australia's New South Wales communities to evaluate effectiveness using a hybrid-Type 1 implementation trial.

METHODS

Positionality

This research centres Indigenous knowledges and our rights to upholding our ways of being and doing through Indigenist methodology²¹ drawn from the standpoint of the individual Aboriginal and Torres Strait Islander research team members and relational research practices with Aboriginal communities²². This work is led by Aboriginal (SM, FC, TLR, JF, MK) and Torres Strait Islander (ZM) women drawing on the relational and reciprocal research led by the lead researcher (MK) over the past decade to develop Indigenous-led smoking and vaping cessation evidence^{17,23}. Our position draws upon our lived experiences as Aboriginal and Torres Strait Islander women, mothers, aunties and grandmothers, alongside our expertise in tobacco control and resistance (SM, JF, MK, JB,KB) and health service delivery (SM, FC, TLR, JF, MK), and embodies a collective and relational approach to this work. The ongoing relationality and interconnectedness between the research team and partnering communities forms the basis for which this work can meaningfully, and intentionally uphold Indigenous ethics and ethical practices, ensuring it is responsive and relevant to Aboriginal and Torres Strait Islander women and their communities.

Governance and ethics

This work was governed and led by Aboriginal and Torres Strait Islander people and communities who informed all aspects of this work from conception to design and implementation. This project was conceived by Aboriginal and Torres Strait Islander women who called for group-based supports to empower smoke and vape free pregnancies¹⁶. This work partnered with Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation and the Aboriginal Health & Medical Research Council (AH&MRC). The project upholds place-based principles of ethics as defined by and for the partnering communities and has been conducted in line with ethical guidelines including National Health and Medical Research Council's Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research²⁴, the Aboriginal Health and Medical Research Council ethical guidelines: Key principles (2020) V2.0²⁵. Ethical approvals were obtained from the AH&MRC Ethics Committee of NSW (2170/23) and the University of Newcastle (H-2023-0432).

Upholding Indigenous knowledges, rights and self-determination in program development

Indigenous knowledges and self-determination are central to the development of meaningful and culturally responsive smoking and vaping cessation programs. Aboriginal Health Workers (AHW) provide non-clinical services such as advocacy, support, liaison, and health promotion in community and hospital settings. Roles include cultural navigation, social and emotional wellbeing support, patient advocacy, health promotion, and case coordination. As

such, they are well placed to provide culturally responsive cessation support to their community. This work, conducted by an Aboriginal and Torres Strait Islander research team partnering with Aboriginal communities and Aboriginal Health Workers, carefully and respectfully upheld systems of ethics and relational research practices to co-create the *Which Way? Women's Group-based program*. The process was “*akin to our traditional weaving practices. The processes were not prescriptive; they did not follow a Western Eurocentric co-design*”¹⁷. Over two years, the team of Aboriginal and Torres Strait Islander women applied a weaving framework to develop the program which included, but was not limited to, the integration of BCTs. The program was then piloted and new program components designed over an additional year. Each piece to the program including but not limited to the BCTs, were woven, revisited, revised, enacted, and refined continually over the three-year period. While we offer details of these methods (see Figure 1), the reader must acknowledge that Indigenous work is not linear. This process held space and time for communities to guide the work in meaningful ways.

Gathering	Building an Indigenous-led evidence base centring Aboriginal and Torres Strait Islander voices, experiences, and needs (<i>previous work reported elsewhere</i>) Yarns with Aboriginal and Torres Strait Islander women to identify key components and development of a group-based program (<i>previous work reported elsewhere</i>) Drawing from existing literature on successful BCTs relevant to smoking cessation to integrate into the program
Drying	Workshops to identify and prioritise BCTs that are important and meaningful to Aboriginal and Torres Strait Islander people
Mellowing	Collective program development with Aboriginal and Torres Strait Islander health workers, and community
Weaving	Weaving community-identified and literature-identified BCTs in the Which Way? Women's Group-Based Program

Figure 1. Weaving research framework applied to the development and integration of BCTs to the program

Building from our previous work^{14,15,16}, we sought to understand how to best develop a group-based cessation program for Aboriginal and Torres Strait Islander women, which included Yarning with community and local maternal health teams. The details of this process have been reported in more detail in a separate manuscript.¹⁷ In recognising the alignment with existing BCTs and key components recommended by community, the research team sought to incorporate community-led BCTs into the program. For this paper, we report the specific processes undertaken using a mixed method approach to identify, prioritise, and integrate BCT's in the *Which Way? Women's Group-Based Program*.

Identifying the existing evidence base.

The research team sought to identify relevant BCTs associated with effective smoking cessation in randomized controlled trials through examination of existing literature. No reviews were identified to provide details specifically for BCTs associated with Indigenous smoking cessation interventions. As such, review relevance was identified based on broad

application to smoking cessation intervention contexts. We therefore drew from the most recent and comprehensive systematic review at the time examining the individual BCTs associated with cessation rates in intervention and comparator groups of smoking cessation trials was identified as most relevant to inform the co-development process²⁹. We used the individual BCTs identified in the Black et al. review to scaffold the initial BCTs for inclusion in the program.

Further, we found no reviews which examined BCTs utilised in group-based settings relative to effective smoking cessation. In returning to the leadership of Aboriginal and Torres Strait Islander women in the process and their call for group-based support, we then conducted a systematic review to identify effective BCTs associated with cessation success in group-based smoking cessation interventions³⁰. This review aimed to identify the individual BCTs and BCTs domains related to effective group-based smoking cessation interventions at 6-month follow-up. Data about effective individual BCTs identified in both systematic reviews were extracted independently by two members of the research team. Data about individual BCTs, rather than effective BCT domains, was prioritised as individual BCTs are more precise in terms of the specific behaviour they target, and the mechanisms through which they influence behaviour change. For the previously published review²⁹, we extracted data for effective individual BCTs within each domain (not controlling for total BCTs), as we deemed this the most straightforward and targeted approach for determining effectiveness by focusing on the precise BCTs that are driving behaviour change.

All BCTs reported as effective for smoking cessation across both reviews were incorporated into the program development.

Identifying and prioritising BCTs that are important and meaningful to Aboriginal and Torres Strait Islander people.

To ensure the program was grounded in Indigenous knowledges and expertise, we sought to identify and prioritise the BCTs that Aboriginal Health Workers felt were most important and meaningful for supporting Aboriginal and Torres Strait Islander women in quitting smoking and vaping, as well as explore how these techniques could be effectively implemented in practice.

To ignite dialogue (that continued over the course of the co-development process) to identify and prioritise BCTs, a half day workshop with 30 participants was facilitated by members of the research team (SM, TR, JF, MK), with key community partners including Aboriginal Health Workers, nurses, midwives, and the management team of a maternal health service held at the local Aboriginal Land Council. During the workshop, participants were presented with a set of cards with individual BCTs on side A and an example of the BCT in action on side B. The cards were created using all individual BCTs from the BCT Taxonomy v1²². The cards outlined various techniques, including goal setting, self-monitoring, and social support, among others, which could be used in health programs. Workshop participants were split into three large groups and were asked “*What BCTs do you think are most important to include in a smoking and vaping cessation program for Aboriginal and Torres Strait Islander women?*” Collaborative yarning²⁶ was used to provide a deeper understanding of the prioritisation of the BCTs selected, and how it could be applied to program development. Photographs,

participant notes, and research team reflections were recorded and summarised by the research team to inform the co-development process.

We did not seek to collect data through formalised western methods, but rather, through visual prompts and collaborative yarning methods (see Bessarab and Ng'andu 2010 for more on this method²⁷). Through collaborative yarning, we were able to synthesise ideas to incorporate into the design of the program. While it is out of the scope of this paper which focuses on the incorporation of community-led BCTs, more specifics on our co-design and weaving process can be found here in our co-design paper²⁸.

Collective program development

The research team synthesized evidence from the preliminary processes to identify BCTs important both in the literature and from Aboriginal and Torres Strait Islander people. Using this foundation, a draft structure and content for the program was developed aligned to the BCT framework. This process took place over an 18-month period, and upheld practices of ethics and relational research approaches. The draft program structure was workshopped with community partners for a full day on their Country, face to face using Collaborative Yarning²⁶. The program was refined during continual cycles of development, revision, feedback and reflection both in person and via online workshops of differing lengths of time from one hour to one day. This process provided the overall structure and logic for the BCTs included in the program.

Weaving BCTs in the Which Way? program activities and resources.

Simultaneous to development and finalisation of the program structure and content, the research team began developing activities and resources to operationalise the identified and prioritised BCTs. This collective process included ongoing workshops among the research team (SM, MK, TR, ZM, JF, and FC) and with community partners both in person and via online workshops of differing lengths of time from one hour to one day. Community partners provided guidance about whether the activities and resources were appropriate and meaningful in their community context. This process occurred iteratively over a 2-year period. Activities and resources were piloted with Aboriginal and Torres Strait Islander women face to face and online as well as Aboriginal health workers which informed revisions and refinement. Each of the group-based sessions were mapped to activities and resources including a participant journal which was created to extend on BCTs covered in the group sessions and to reinforce BCT's that were prioritised by Aboriginal and Torres Strait Islander community partners.

RESULTS

Identifying and prioritising BCTs that are important and meaningful to Aboriginal and Torres Strait Islander people.

Supplementary Table 1 reports the individual BCTs that were rated as most important and meaningful to Aboriginal and Torres Strait Islander women during the first phase planning. The BCT domains that were rated the most important to Aboriginal and Torres Strait Islander community partners included natural consequences, antecedents, goals and planning, social support and comparison of outcomes. The individual BCTs rated as most important to

Aboriginal and Torres Strait Islander community partners included problem solving, social support (emotional), information about health consequences, credible source and self-talk. Other individual BCTs that were chosen by greater than two groups in the workshops (represented by two ticks in Supplementary Table 1), included goal setting (behaviour), feedback on behaviour, social support (unspecified), information about emotional consequences, comparative imagining of future outcomes and pharmacological support. During the workshops, Aboriginal Health Workers defined empowering ways to apply BCTs in practice, for example, they emphasised the importance of building self-confidence and positive self-talk as critical to women's ability to apply the health education components. Through the yarning process, conversations (both formal and informal) lead to the production of knowledge. While community partners did not always use the terminology or framework of BCTs, their discussions still reflected core principles of behaviour change which we were able to capture during the workshops. This way, community partners were able to share their perceptions of *what* a smoking and vaping cessation program should include in a natural and fluent way, so that it is responsive to community needs outside of rigid BCT criteria. For example, 'positive self-talk' was spoken about in a way that emphasised the need to empower women and improve self-esteem. The yarns during the workshop not only identified *which* BCTs to include, but also how and importantly, *why*. This context allowed the research team to develop a more meaningful and responsive program.

Identifying the existing evidence base.

Evidence for effective BCTs for smoking cessation²⁹ and effective BCTs for group-based smoking cessation³⁰ extracted from the two identified relevant reviews are provided in Supplementary Table 1. Twenty individual BCTs were significantly associated with increased intervention effectiveness at 6-months follow-up in the review by Black et al: commitment, feedback on outcome(s) of behaviour, social support (practical), instruction how to perform the behaviour, salience of consequences, information about social and environmental consequences, information about emotional consequences, reduce prompts/cues, behavioural practice/rehearsal, generalisation of target, pros and cons, social reward (behaviour), reward (outcome), reduce negative emotions, restructuring the physical environment, restructuring the social environment, avoidance/reducing, identity associated with changed behaviour, focus on past success, and self-talk. The group-based review identified four individual BCTs associated with smoking cessation outcomes at 6-month follow up: problem solving, information about health consequences, information about social and environmental consequences, and reward (outcome).

Collective program development.

The BCTs identified in the reviews and workshops were deliberately embedded in the program. Additional BCTs which naturally emerged through the development of the program were included in the mapping, as it sought to detail all BCTs that were included in the program. Using the BCTs identified in the preliminary and collective co-development process including the iterative refinement and piloting phases, 42 individual BCTs were identified to be incorporated into the group-based program.

During the piloting phase community partners highlighted the need for the program to be flexible in delivery. The research team workshopped a range of possible approaches and

developed an approach to adaptation of the program without losing BCTs but only reducing frequency covered. As a result, it was decided to structure the program with both session content and a standalone journal to deliver all the relevant BCTs. The final program content, activities and resources mapped to BCTs identified in the earlier phases, are outlined in Supplementary Table 2.

Forty out of the 42 BCTs identified in the literature and by community were embedded into the program. Two BCTs that were identified to be included through the co-design process were not included (feedback on outcome of behaviour and reduce prompts/cues), as these were not always achievable within the duration of the program as they require feedback at later stages. Instead, we focused on self-monitoring and feedback, as this was identified as important by the community. Although, it is anticipated that these will be addressed by health workers when delivering the program. Of the 40 which were included in the program, 39 are embedded in the sessions led by health professionals and 33 are in the journal for the participants to take home. After mapping of additional BCTs, we found a total of 60 BCTs across the Which Way? program.

Weaving BCTs in the Which Way? program activities and resources.

Through an iterative and evolving process, the pilot phase sought to carefully refine and select the final activities and resources to be developed that aligned with Aboriginal and Torres Strait Islander women's collective strength and embodied their ways of sharing, learning and doing. A rigorous amalgamation of what had been recommended to be included in a women's group-based program within existing literature, and the wisdom and knowledges of Aboriginal and Torres Strait Islander women ensured the program would be responsive and relevant to increase uptake of the program. This approach also considered how communities could adapt the program and select from a suite of resources and activities which required a comprehensive method to embed BCTs into multiple content components. This would allow each community to self-determine and adapt sessions, activities and resources as suitable and appropriate to their organisation and community. BCTs were embedded throughout a range of different activities and resources to ensure the content, no matter which way it was woven together by the community, would ensure prioritised and relevant BCTs were being incorporated to support Aboriginal and Torres Strait Islander women on their cessation journey.

Several key elements were identified throughout the process of weaving BCTs within the group-based program. Firstly, community partners placed great emphasis on women benefiting from positive self-talk and reframing themselves during the quitting journey. In line with this direction, a Women's Journal has been created to extend on BCT's covered in the group sessions and reinforces the need to affirm, empower, encourage women and guide the importance of self-care and self-worth. Information about emotional consequences was also deemed important which community partners extended to include stress identification and stress management, emotional support options and support tools for self-care which were incorporated in both the session and journal content.

Acknowledging Aboriginal and Torres Strait Islander women's rights to self-determine the cessation journey that best suits them, the program has been built to be culturally responsive,

as such, this centres Aboriginal and Torres Strait Islander women as the experts and knowledge holders in their cessation journey. Program content has drawn on identified BCTs such as restructuring the social environment and avoidance/reducing exposure to cues for the behaviour. This has been embedded throughout multiple aspects of the program sessions and activities, including the journal. Women participating in the program are able to reflect on their own personal experiences and knowledges to identify challenges and feel empowered to make a behaviour change or quit attempt. Additionally, weaving cultural practices and protocols throughout the program has been critical to ensuring Aboriginal and Torres Strait Islander women feel safe and empowered to draw on their inherent strength as Indigenous women. This included practices such as yarning and social support. Each session commences with a yarn and checking-in between group participants, as well as opportunities embedded throughout the program for sharing experiences and stories about quit attempts, challenges and successes. Social support and affirmation cards have been developed and embedded in the program to increase the opportunity for social support BCTs to be enacted whereby women participating are able to provide support to other women throughout their journey or write messages to re-enforce positive self-talk.

Social and cultural determinants of health have been well-established as being pivotal to the overall health and wellbeing for Aboriginal and Torres Strait Islander peoples wellbeing and empowerment. In this program, activities that incorporate cultural practices and draw on these as a strength in quitting were core components to the development of activities and resources. Community partners and Aboriginal and Torres Strait Islander women identified how the application of BCTs such as “distraction” and “substitution” may be completed in a culturally responsive and relevant way. Cultural practices such as weaving were identified for components of the program that required deep yarning and reflections. It was identified that the incorporation of weaving embeds opportunities for connection and empowerment throughout the group-based work, as well as being a strong technique for women to apply when working through cravings and challenges in their quitting journey. This process of translating the application of cultural practices and frameworks within the program ensured BCTs embedded were dually scientifically sound and rigorous in both Euro-Western and Indigenous contexts, which was identified by Aboriginal and Torres Strait Islander women as increasing uptake of BCTs and actioning a behaviour change.

DISCUSSION

This paper describes a rigorous, Indigenous-led process used to develop the *Which Way? Women's Group-based Smoking and Vaping Cessation Program* which upholds evidence-based BCTs as applied using an Indigenous framework. The strength of Aboriginal and Torres Strait Islander women and communities underpinned every aspect of development through respectfully holding space and time for meaningful partnerships and knowledge generation. By listening to the voices of Aboriginal and Torres Strait Islander women, health workers, and practitioners, we sought to co-create a program that supports women in quitting smoking and vaping in ways that are meaningful and driven by them. Our development process privileged Indigenous and Euro-western knowledges from conceptualisation by using community-identified BCTs and strategies as the foundation of a comprehensive co-creation process that was carried forward to development by a team of Aboriginal and Torres Strait

Islander women. While these practices are rooted in the knowledge of the research team and workshops, we did not rely solely on this, instead we also sought ongoing validation from the community to ensure that their wishes and cultural values were upheld in the design. This integration was critical to ensuring that the resulting program is both scientifically sound and culturally centred while offering flexibility in delivery, acknowledging the diversity of Aboriginal and Torres Strait Islander women and communities.

The activities within the program were developed for and by Aboriginal and Torres Strait Islander women, ensuring they were grounded in cultural practices and wisdom, facilitating ways of sharing, learning and doing. Both the program and Women's Journal covered all BCT domains but not all individual BCTs. Our program was designed to be empowering, as such there were key BCTs that were decided not to be embedded in the final program, particularly those that had negative associations or individualised blame which have previously been reported to be inappropriate in this setting⁸.

BCTs are implemented through methods such as yarning and hands-on activities like weaving. Our development process showed that these cultural practices can not only be engaging but can also provide an effective way to integrate BCTs such as social comparison into health interventions as they organically encourage the sharing of personal stories and experiences related to quitting smoking. The sharing of narratives and stories have been reported to be an effective BCT in other populations and is the foundational BCT for the Australian National Government campaign "Don't Make Smokes Your Story"³³ highlighting the relevance of this approach across tobacco resistance efforts. *Which Way?* scaffolds BCTs to uphold empowerment through quit planning and monitoring which have been reported to be relevant in other cessation programs³⁴ and provide a mechanism to uphold self-determination in the quitting process.

The need to embed social support, health education (including natural consequences) and pharmacological education and support were identified most frequently during the co-creation process with community. Pharmacological support was identified as important by the community, but was previously reported by Aboriginal and Torres Strait Islander women as being a concern during pregnancy³¹. To address this, our program has incorporated the BCT domain in one session and in the resource to address concerns with pharmacological support through education and social support, which has been identified in other research to have promising evidence for potential effectiveness for sustained cessation³⁵. Recent Indigenous-led evidence by this research team found that Aboriginal and Torres Strait Islander people who want to quit do want access to nicotine replacement therapy (NRT), but are rarely provided with appropriate education on how to correctly use NRT¹³. Furthermore, when Aboriginal and Torres Strait Islander people are provided with combination NRT, advised on the correct usage, and offered behavioural support they are able to successfully quit³⁶.

The need and potential impact of Indigenous-led cessation programs has been reported for over a decade⁸. *Which Way? Women's Group-based Smoking and Vaping Cessation Program* drawing on Indigenous and Euro-western expertise in cessation has potential to make significant impact on the health and wellbeing of Aboriginal and Torres Strait Islander women and future generations.

Strengths and Limitations

This work being led by and for Aboriginal and Torres Strait Islander women and communities is a key strength of this work. The alignment between community priorities and the scientific evidence strengthens the *Which Way?* program by ensuring that the selected techniques are not only culturally relevant but also supported by established research. However, several limitations to our intervention development process should also be considered. Firstly, the review of published literature to identify effective BCTs was limited to two recent reviews rather than a review of the broader literature. While the narrower scope of literature review may limit the breadth of evidence considered, both studies were systematic literature reviews, were published recently, and included data from a large number of trials, strengthening the validity and relevance of the BCTs identified. Secondly, our co-design process included women from two regional Aboriginal communities in New South Wales, Australia. While participants in the co-design workshops held at these services included a diverse range of perspectives, they may not fully capture the broader perceptions of Aboriginal and Torres Strait Islander women and their health workers about culturally meaningful smoking cessation BCTs or activities across the country.

Conclusion

Aboriginal and Torres Strait Islander women want support to quit smoking and vaping and requested group-based models to support and empower cessation. The *Which Way? Women's Group-based Smoking and Vaping Cessation Program* was co-created with Aboriginal and Torres Strait Islander women and community partners, drawing on the knowledges and wisdom of Aboriginal and Torres Strait Islander people and behaviour change techniques. Activities and resources enact behaviour change techniques through culturally responsive practices that draw on shared learning, empowerment and self-determination. The final program will be trialled for effectiveness in New South Wales Aboriginal communities over the next two years.

Funding

This work was supported by the National Heart Foundation of Australia Aboriginal and Torres Strait Islander Award [Grant number 106200] MK is supported by a National Health and Medical Research Council Investigator Grant #2032970.

Declaration of Interests

None declared.

Data availability

The data underlying this article cannot be shared publicly due to ethical requirements and the privacy of individuals that participated in the study.

Consent for publication

Not applicable

Acknowledgements

We acknowledge the wisdom and leadership of Aboriginal and Torres Strait Islander women who guided the development of this program. The research team acknowledges partnering organizations including the Aboriginal Health & Medical Research Council NSW, Waminda South Coast Aboriginal Women's Health and Wellbeing Corporation and Birra Li Infant and Maternal Health Service.

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