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An Indigenous qualitative study from Australia

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Do the Yolŋu people of East Arnhem Land experience smoking related stigma associated with local and regional tobacco control strategies?

An Indigenous qualitative study from Australia

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Abstract

In remote Aboriginal communities in East Arnhem Land, Northern Territory of Australia, the Yolŋu people, traditional owners of this remote and isolated region, have a long tradition of *ŋarali'* [tobacco] use, which is commemorated within funeral ceremony, as *manikay* [songlines] and *buŋgul* [dancing]. Today, smoking is very prevalent and a highly normalised social activity among Yolŋu. There are concerns that tobacco control activities aiming to denormalise smoking may lead to stigma in already disadvantaged communities with high smoking prevalence. Interviews were conducted from August 2014 until December 2015 to ascertain whether smokers may have experienced smoking-related stigma through their interactions and engagement with health services and regional tobacco control activities including denormalisation strategy. Informants described their experiences, observations and perceptions of smokefree environments, television and media advertising, and smoking cessation support. We found that while tobacco control denormalisation is not leading to stigma in these communities, some clinical consultations and interactions may have led to feelings of smoking-related shame among Yolŋu health workers who smoked. However, we found that caring, trusting relationships and having the right people communicating the right messages respectfully enabled raising the issue of smoking in clinical consultations without causing shame.

Keywords: Indigenous, smoking, stigma, shame, caring

Introduction

Introduced over 700 years ago by the Macassans into northern Australia (Brady, 2013) to the Yolŋu people (Indigenous land owners of Arnhem Land), ŋarali' [tobacco] has become closely enmeshed in daily activities and Yolŋu funeral ceremony. Celebrated in the ŋarali' manikay [songlines], and buŋgul [dancing] traditions, today, smoking is a highly normalised social activity in remote East Arnhem Land communities. This study explored the lived experiences of Yolŋu informants to determine whether tobacco control denormalisation efforts in the region had produced smoking-related stigma.

Tobacco control denormalisation seeks to change broad, social norms of tobacco smoking, from being 'normal' or 'desirable' to an 'abnormal practice' (California Department of Health Services, 1998, p. 3). In Australia, 'denormalisation of smoking' is a term used in tobacco control to describe efforts that fundamentally erode community acceptance and tolerance for smoking (Scollo & Winstanley, 2018). Historically, the approach had a strong focus on the tobacco industry (Roeseler & Burns, 2010). Denormalisation is an essential component of comprehensive tobacco control strategy, and is achieved by mass media tobacco control campaigns, television advertising, smokefree areas and laws, and supporting access to cessation services. These tactics have been used successfully in many countries to reduce tobacco smoking (Feldman & Bayer, 2011) and in Australia, prevalence has declined to an all-time low of 14% for daily smokers, aged 14 years and over (Greenhalgh, Bayly, & Winstanley, 2018).

In contrast, the proportion of Aboriginal and Torres Strait Islander people who are current daily smokers remains disproportionately high despite a decline from 45% in 2008 to 39% in 2014 (Australian Bureau of Statistics, 2017b). Nationally, Aboriginal and Torres Strait Islander adult smoking prevalence and adolescent initiation is falling, and successful cessation is increasing (Australian Bureau of Statistics, 2017a). However, there has been no significant change in remote areas in Australia, and in East Arnhem Land, smoking prevalence between 68% to 83% in men and 65% to 73% in women has been reported, with little change since the mid-1980s (Clough, MacLaren, Robertson, Ivers, & Conigrave, 2011).

In recent years, tobacco control advocates and public policy makers in some countries began to pursue denormalisation as a discrete policy goal (Feldman & Bayer, 2011), in addition to advertising bans, public smoking restrictions and increased tobacco excise tax. Debate among public health advocates and tobacco control researchers about the ethics associated with the ongoing and targeted use of denormalisation has followed (Bayer, 2010; Bell, Salmon, Bowers, Bell, & McCullough, 2010; Stuber, Galea, & Link, 2008, 2009). Despite the extraordinary success of public health campaigns in dramatically reducing smoking prevalence in industrialised nations such as New Zealand, Canada, the United States, the United Kingdom and Australia, a strong social gradient of tobacco smoking, morbidity and mortality has been reported (Feldman & Bayer, 2011). Evidence shows that the decline in smoking was unevenly distributed, with benefits enjoyed primarily by those at the upper end of the social continuum. Disappointingly, those lower on the gradient continued to smoke at disproportionately higher rates (OECD, 2011).

Cigarettes, no longer associated with glamour, have become a ‘stigma symbol’ (Castaldelli-

Maia, Ventriglio, & Bhugra, 2016) with its users having a corrupted, debased identity and blemished character. Policy-induced stigma (Graham, 2012), in the current social climate where smokers may be openly criticised, and experience isolation and severe embarrassment (Bayer & Stuber, 2006), may represent an unfair burden on those who are already socially disadvantaged.

In his archetypal formulation, theorist Erving Goffman (Goffman, 1963) defined stigma as *"an attribute that is deeply discrediting"* (p.3), reducing people *"from a whole and usual person to a tainted, discounted one"* (p.3). Conceptualised from Goffman's theory, Link and Phelan (Link & Phelan, 2001) propose that the components of stigma are contingent on access to all forms of societal, economic and political power. They posit that the labelling and differentiating of individuals or groups ('us' and 'them'), the creation of negative stereotypes, and the rejection, exclusion, and discrimination against these 'others', has led to status loss, discrimination and unequal outcomes.

In Australia, there is evidence to suggest that those who identify as Aboriginal may be affected by a 'stigma of inferiority' in how they are treated in the health care system (Williams, 1999) and may experience daily, racially based treatment. These impacts have been linked to poor general mental health (Paradies & Cunningham, 2012) and negative consequences among Indigenous Australians (Larson, Gillies, Howard, & Coffin, 2007). Institutional and cultural racism has also been linked to health harms, and through stigma, stereotypes and prejudice, contributes to inhibited access to societal participation, assets and prospects required for health (Williams & Mohammed, 2013; Williams, Priest, & Anderson, 2016).

Within the context of disadvantage and poorer health outcomes, smoking-related stigma may represent a 'double-whammy' for Indigenous Australians. According to Bond, Indigenous Australians have been characterised as "*'unhygienic and contagious', considered 'passive', 'immoral' and 'dysfunctional'*" (Bond, 2007, p. 77). Bond asserts that despite shifts within public health literature, the widely-held assertion of inferiority of Aboriginality still prevails. Williams (Williams, 1999) had earlier proposed that those who experience these negative consequences of stigma are likely to internalise the popular imagery of Aboriginality into their own identity formation, cultivating feelings of helplessness, frustration and failure. Bond posits that the stigmatised identity of 'the smoker' is only one among many possible stigmas that Indigenous Australians must negotiate, within their own communities, as well as the wider society where smokers are increasingly marginalised or considered to be 'deviant' (Bond, Brough, Spurling, & Hayman, 2012).

Tobacco control strategy is an important priority in addressing persistent, worse health outcomes for Indigenous Australians, particularly for those who reside in remote communities where smoking prevalence is so high. However, stigmatisation, as an unintended consequence of tobacco control denormalisation, has not been investigated sufficiently in Indigenous populations. This study explores whether the Yolŋu people of East Arnhem Land experience smoking related stigma from tobacco control denormalisation efforts.

Methods

The study sought to acknowledge and respectfully engage with the Yolŋu peoples of Arnhem

Land as traditional owners and custodians within their homelands and communities of Marthakal, Miwatj and Laynhapuy, where this research was conducted. This approach required an intentional position that valued Indigenous knowledges, experiences and reflections and that privileged the analyses of social, material and spiritual conditions and values of the Yolŋu peoples who participated in this study.

Two Cultural Mentors provided oversight and guidance throughout the research, through language interpretation during qualitative interviews, cultural advice pertaining to the observance of ŋarali' [tobacco] traditional practices and insight during analysis. They helped the first author, who completed all primary data collection, to navigate language, customs and relationships among the Yolŋu.

Informant selection

Initial contact with communities was made through local health services. Meetings with Elders and leaders were held to describe the project aims and request permission to conduct interviews with local people. Following approval by the Elders, the researcher (MT) returned to communities with the Cultural Mentors, and recruited information-rich key informants for the study. The selection process began with the purposeful recruitment of Elders from each community, progressing to snowball enlistment where existing informants recruited family members for interviews.

Interview setting and approach

Interviews were conducted on the veranda and in consult rooms at remote community health clinics (n=15), informants' homes (n=1) and the home of the researcher (n=6). Interviews were conducted in a Yolŋu Matha language and in English, with the Cultural Mentors translating and interpreting during the data collection process. Brief field notes were written immediately after the interviews and these supplemented coding and formed the basis for memo writing. Interviews lasted between 20 minutes and one hour.

Sample size and description

A total of 22 Yolŋu informants were interviewed. Thirteen were employed with local health services. Table 1 shows their demographic characteristics.

[Insert Table 1]

Data Analysis

Data was analysed using the Framework Method (Gale, Heath, Cameron, Rashid, & Redwood, 2013) and involved seven stages. In the first and second stages interview recordings were transcribed by MT, who became familiar with the content and immersed in the data through playback of recordings, working alongside the Cultural Mentors who clarified words and meanings, and offered insight into the Yolŋu worldview. In stage three line-by-line coding of small blocks of text was undertaken using NVivo 10. In stage four, an

analytical framework was developed from *a priori* themes, associated with tobacco control strategies implemented in the region. These included smokefree environments, television and media advertising, and access to smoking cessation support. The framework also included emergent themes derived from open (unrestricted) coding. Memo writing was used to reflect upon and explore the data and to assist in identifying categories and themes, informed by discussions with MH and DT. In stages five and six, transcripts were reviewed again in their entirety, to check indexing and coding decisions made. Informant attributes (such as smoking status, position in community, gender, age) were also reviewed at this stage to determine if this was a relevant component of themes. During the seventh and final stage of analysis, a spreadsheet was used to index codes and categories and to summarise and chart the themes.

Ethics Approval

The study was approved by the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research (HREC Reference Number: 2014-2169). The HREC application was supported by all three of the relevant local Aboriginal health organisations. Copies of the information and consent forms for the study are available on request.

Results

Our study did not find smoking-related stigma as an impact of tobacco control denormalisation among smokers in these remote communities. However, smoking-related shame was experienced by all Health Service employees who were current smokers,

particularly when interacting with colleagues at work, or undertaking their roles in the workplace. Individuals who reported these experiences of shame also seemed reluctant to receive smoking cessation advice from colleagues and/or visiting health professionals. They also reported giving false information about their smoking status if questioned directly about smoking by health professionals. In contrast, where a Health Service employee was a smoker and had an existing relationship of trust with a health professional, smoking cessation advice was accepted without shame or embarrassment. Community members who were smokers did not report the same experiences of shame when engaging with health professionals, although some reluctance to answer direct questions about their smoking (an approach not common in Yolŋu dialogue), was described by some.

No stigma from smokefree advertising, posters and signage

Smokers did not report any shame or stigma when exposed to health promoting messages about smoking cessation, such as television advertisements and posters. Rather, the messages were considered as reminders:

"They [television advertisements] remind me, just a reminder. Just a picture about what smoke is, about when people talking about smoking, it's just a picture, maybe it's just to let you know, when you're going to stop from doing like him, like he's doing it" (Elder, male, current smoker, Community 1).

Informants considered that messages in different forms (posters, television advertisements, smokefree signs, graphic pack warning labels) were useful prompts in helping others to re-

evaluate their smoking. These messages were supported by informants, and they did not lead to any apparent stigma:

Researcher: "What do you think of those things? [Smokefree] signs and pictures?"

Informant: "Anybody can [be] thinking or smoking."

Researcher: "Are those good messages?"

Informant: "Good one, yeah" (Elder, male, ex-smoker, Community 6).

Some community members had put up smokefree signs, and others asked visitors not to smoke near or in their homes. These requests to refrain from smoking near others, particularly around children, were reportedly seen as non-judgemental, non-shaming prompts, and accepted in the same manner as smokefree posters, signs and television advertisements:

Informant: "You know if they come into my house, and if they feel like they want to smoke in that area, then they walk away. You know I tell them".

Researcher: "Do they get upset?"

Informant: "No, no they know [it is] safety for this little girl" (Elder, male, ex-smoker, Community 6).

The importance of agency and exercising choice was highlighted, and nicotine addiction was acknowledged, if somewhat understated. Although messages to quit smoking were

considered as useful prompts by current smokers, these did not always lead to smoking cessation:

"Sending message is good. It is up to the individual person, the choice is theirs, it's good for the message to bring, it's good to stop smoking" (Elder, male, current smoker, Community 1).

"Doctor or nurses tell me, "No good for ŋarali'" and I say to them, "It's my habit. My own feeling, my own life"" (Health Service employee, female, current smoker, Community 6).

Health Service employees, smoking related shame and confidence to give quit smoking advice

Current smokers who were health workers reported feelings of shame and embarrassment about their smoking among colleagues, while at work and in the community:

"Make me sometimes I feel, I'm a health [employee] and still smoke, why? Feel like I'm embarrassed, also feel I'm not a good [employee]. You can still smoke ŋarali', I'm having that education I sneak off, I smoke. You can't see me, I hide" (Health Service employee, female, current smoker, Community 2).

"Yeah, people looking at me, going past me and I'm standing there [outside the health clinic] under the shade smoking. And I heard one woman was saying, talking, this was on the

weekend, [during] Festival Night: "Please everybody, don't stand out on the road smoking when you're wearing your uniform"" (Health Service employee, female, current smoker, Community 2).

Although health workers who smoked expressed reluctance or felt compromised to give advice to clients to quit, they did so believing that as health professionals, they were obligated to offer support. This support included reminders about the importance of protecting others from the harms of second hand smoke:

""You're not allowed to smoke here while we are here." Or sometimes I talk to that old man, they're living in one room, a disabled lady, and I tell that old man, "You're not allowed to smoke in here because that lady [is affected by your smoke]" and she's disabled" (Health Service employee, female, current smoker, Community 6).

Health Service employees who were ex-smokers reported having high confidence in giving advice to quit smoking and in reminding staff and clients about the importance of smokefree environments. They believed strongly that they played an important role in reminding current smokers to adhere to smoking restrictions in clinics, workplaces and community settings:

"Like couple of days ago I went to the hospital visiting and I said, "You girls shouldn't be smoking around here. If you want to smoke ŋarali' just go away, long way, far away. If you girls want to go and sit down, just go past the outpatients' ward and smoke ŋarali' there, not here." Bäyŋu [no] because they didn't want to move from there, they're a bit strong" (Health Service employee, female, ex-smoker, Community 4).

This significant association between the smoking status of health workers and their confidence to talk to others was consistent with all our informants who were ex-smokers. An informant who was a never-smoker described his experience when he was asked to stop at a local store to purchase tobacco while driving a work vehicle, and in uniform. He refused to do so believing that being a Health Service employee should be associated with abstinence from smoking:

"I was driving and D was sitting on the front with the red shirt. We both wear red shirt. [Laughter]. And I got this [work] vehicle: "Ok where we going to drop you?" "We're going to buy cigarette first [laughter]." That's what she was saying to me, and I said, "Hey, we are Health employees, look we got shirt [uniform] here, we got shirt, we don't have to get cigarette while using the red shirt [uniform]" (Health Service employee, male, never-smoker, Community 2).

Informants described feelings of shame, a reluctance to receive smoking cessation advice, and avoidance or false reporting of their smoking status when interacting with health professionals, particularly if there was no previous or existing relationship. One informant dismissed advice from a health professional, feeling that his comments were meant to scare her. She felt that an approach of help would be a much better way to be offered advice:

"Bayŋu [no, not] a doctor or anyone can say to me, "Better you can stop, otherwise you might lose your life." I don't care [what he says]. *Manymak [not good] when they say you will lose your life, better if they could ask if I would like to use patch, it will make me feel*

better" (Health Service employee, female, current smoker, Community 2).

"The person is asking the right question [but] I feel embarrassed sometimes. I can't tell, but I don't really lie, I'm hiding [my smoking]" (Health Service employee, female, current smoker, Community 2).

An ex-smoker reported her view that patients needed non-judgmental help from clinic staff to address smoking cessation and that a definite decision by a smoker to quit, was also key to successful quitting:

"No, she [a current smoker] has to think that somebody has to support her, to let her know that they can't judge her…that she has to go and tell them that, "Now it's my time to quit"" (Health Service employee, female, ex-smoker, Community 2).

The right message from the right person

The ability to respectfully and effectively raise the issue of smoking according to informants, was based on having the right people communicating the right messages in the right way:

"And the best is, X and XX [local Health Service employees] because they've got tight voice and they tell straight to the Yolŋu – Yolŋu to Yolŋu. And the message is [very] strong…because that's the job, what they [are] working for, and what their job [is] for (Health Service employee, male, never smoker, Community 2).

When interviewed, these workers attributed their success in engaging with Yolŋu, with communication that was considered less direct or confrontational, offering information and support in a soft, respectful way:

"Well if you want to be a role model, or a leader, you have to be kind to every, everyone, each one of them, every clan, each bäpurru [clan group]. Happy smile, and if you want to be a leader, you don't have to talk cheeky [be rude] to them, if you want to tell stories about ŋarali' [tobacco], or with angry words. Don't tell them, "Yaka buny'djurr ŋarali'!" [Don't smoke!] No! You have to be kind, soft, respectful, go and sit down and talk with them, in a polite way. If you want to be a leader and tell the message about this ŋarali' [tobacco], you have to be kind. Go and sit down with them, and be smiling. Talk with them, "Look ŋarali' [tobacco], is yaka manymak [not good]." Don't be rough with them, you have to be kind" (Health Service employee, male, never smoker, Community 2).

Another informant described the contrast between receiving smoking cessation advice from a colleague (health professional) about smoking which produced embarrassment, and having someone she knows and trusts, give her advice to quit which did not engender shame:

"One of the workmates ask me, "How many times do you smoke? How many packets a day?" Or that sort of question…made me feel like I feel ashamed, because he's asking questions, and that I'm smoking... [Addressing researcher] But I don't hide anything from you, I trust in you all the time, now I feel comfortable because [you are] challenging [me] from smoking" (Health Service employee, female, current smoker, Community 2).

The idea that a patient needed to feel comfortable and supported to access smoking cessation from health professionals was an important finding. One informant who had experience in guiding and helping Yolŋu to quit smoking in her role with a local Health Service, commented:

"Yes, she needs help, someone who can help her, a person who she feels comfortable with so they can help her go to the doctor and get that support and to quit on smoking" (Health Service employee, female, ex-smoker, Community 6).

Discussion

Although our study found experiences of shame and embarrassment among some Health Service staff, we did not find evidence of smoking-related stigma, as defined by Link and Phelan (Link & Phelan, 2001). The notion that individuals would be excluded and isolated, and experience smoking related stigma, status loss, discrimination and unequal outcomes, as has been found among other populations with high smoking prevalence, is counter to the foundations on which Yolŋu society stands (Christie & Greatorex, 2006). Within Yolŋu society, an individual's connectedness with, and membership of, kinship and social network, is vital to maintaining identity within the collective, where the group is always prioritised before the individual.

In East Arnhem Land, denormalisation approaches to encourage quitting and to warn about

the harms of smoking, remain important among the Yolŋu. These messages and promotion materials are offered in positive terms and do not appear to cause stigma to smokers. Smokefree areas, media campaigns, pack warning labels and offering smoking cessation support are perceived by these informants as being important and contribution to the health and wellbeing of family and clients. Those Yolŋu workers who promote smoking cessation do so from a basis of caring and respectful engagement and this approach fits well with the srong cultural values and expectations explicated by Yolŋu informants.

The absence of smoking-related stigma among our participants may also be a result of the relative isolation of the Yolŋu people from non-Indigenous society. Smoking is highly normalised in these remote communities and smokers are rarely exposed to *"a shared belief that a person ought to behave in a certain way …*" (Stafford & Scott, 1986, p. 80). This relative isolation means that unlike many other Australian smokers, Yolŋu smokers are much less exposed to such widespread, shared beliefs that people should not smoke, and so may be less likely to experience stigma, discrimination or exclusion because of their smoking. However, compared to other participants, Yolŋu health staff who smoked had very close contact with non-Yolŋu health professionals with anti-smoking beliefs and reported some shame in this health care setting.

The impact of a caring, trusting relationship between health professional and patient to prevent smoking-related shame when giving quit smoking advice, was an important finding of our study. This finding is consistent with previous health research that showed distrust was overcome through building relationships of respect, care, commitment and compassion (Bond et al., 2012). Early education research in Arnhem Land (Harris & Kinslow-Harris, 1984) also

identified improved learning by Yolŋu informants was likely to be predicated on a relationship rather than on the knowledge itself: *"Knowledge is, in Yolŋu society, valued because of who gives it, rather than for the objective value of the information"* (Harris & Kinslow-Harris, 1984, p. 97). Having the right people communicating the right messages in the right way, was essential to respectfully and effectively raise the issue of smoking with Yolŋu residents in these remote communities, without generating feelings of shame or stigma.

Efforts to further encourage Health Service employees to make quit attempts and to facilitate access to smoking cessation support for their patients, irrespective of their own smoking status, are a priority in these remote communities. They represent an important intervention strategy (Nicholson, Borland, Davey, Stevens, & Thomas, 2015) and a useful contributor to reducing community smoking rates (Thomas et al., 2015).

Strengths and Limitations

A strength of the study was that MT lived in East Arnhem Land, being based in three remote communities, during the period that data collection was being conducted. This was conducive to a collaborative, community-centred, and culturally appropriate model of inquiry, where advice and guidance was available from the Cultural Mentors, which was a significant strength of the study. The number of study participants was small (n=22), with a large proportion of the sample (n=13) employed locally by health services. The latter cohort were role models and leaders in the communities and clinics, and their contribution to the study was important, being that they were often at the forefront for responding to patient needs,

particularly for smoking cessation. The small number of smokers who were not employed by Health Services, and those who did not mention stigma during smoking cessation and clinical consultations, means that we are reluctant to generalise our findings about shame within the clinic setting beyond this study.

Implications

In our study, the strong cultural values and social interconnectedness within Yolŋu society where smoking is the norm, appear to protect smokers from smoking-related stigma. Further research of stigma in populations with similar cultural emphases and both high smoking prevalence and tobacco control policies to denormalise smoking are warranted. For Health Service workers who smoke and experienced shame and embarrassment at work, having a close and trusting relationship with a health professional was found to mitigate this effect.

Friendly, helpful and judgement-free offers of support to quit smoking were considered important by both those who were giving and those who were receiving smoking cessation advice, and fits within the Yolŋu cultural importance of connectedness, kinship and social network (Christie & Greatorex, 2006, p. 12).

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Declaration of Interests

None to declare.

References

Australian Bureau of Statistics. (2017a). *Aboriginal and Torres Strait Islander Peoples: Smoking Trends, Australia, 1994-2014-15*. Retrieved from Canberra, ACT: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by Subject/4737.0~1994 to 2014-15~Media Release~Aboriginal and Torres Strait Islander smoking down (Media Release)~10000

Australian Bureau of Statistics. (2017b). *National Aboriginal and Torres Strait Islander Social Survey*. Retrieved from Canberra, ACT: http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/08E3E3C7DA59D676CA2580ED0012B307/$File/47140do10.pdf

Bayer, R. (2010). Stigma and the ethics of public health redux: A response to Bell et al. *Soc Sci Med, 70*(6), 800-801. doi:10.1016/j.socscimed.2009.09.061

Bayer, R., & Stuber, J. (2006). Tobacco control, stigma, and public health: rethinking the relations. *American Journal of Public Health, 96*(1), 47-50. doi:10.2105/AJPH.2005

Bell, K., Salmon, A., Bowers, M., Bell, J., & McCullough, L. (2010). Smoking, stigma and tobacco 'denormalization': Further reflections on the use of stigma as a public health tool. A commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue (67: 3). *Soc Sci Med, 70*(6), 795-799; discussion 800-791. doi:10.1016/j.socscimed.2009.09.060

Bond, C. (2007). *"When you're black, they look at you harder": Narrating Aboriginality within Public Health.* (PhD), University of Queensland, Brisbane, QLD.

Bond, C., Brough, M., Spurling, G., & Hayman, N. (2012). 'It had to be my choice' Indigenous smoking cessation and negotiations of risk, resistance and resilience. *Health, Risk & Society, 14*(6), 565-581.

Brady, M. (2013). Drug substances introduced by the Macassans: the mystery of the tobacco pipe. In M. Clark & S. May (Eds.), *Macassan History and Heritage: Journeys, Encounters and Influences* (pp. 141-158). Canberra, ACT: ANU ePress.

California Department of Health Services. (1998). *A Model for Change: the California experience in Tobacco Control*. Retrieved from Sacramento, CAL:

Castaldelli-Maia, J., Ventriglio, A., & Bhugra, D. (2016). Tobacco smoking: From 'glamour' to 'stigma'. A comprehensive review. *Psychiatry and Clinical Neurosciences, 70*, 24-33.

Christie, M., & Greatorex, J. (2006). Yolngu Life in the Northern Territory of Australia: the significance of community and social capital. *Inter-Networking Communities*, 1-13.

Clough, A., MacLaren, D., Robertson, J., Ivers, R., & Conigrave, K. (2011). Can we measure daily tobacco consumption in remote indigenous communities? Comparing self-reported tobacco consumption with community-level estimates in an Arnhem Land study. *Drug Alcohol Rev, 30*(2), 166-172.

Feldman, E., & Bayer, R. (2011). The Triumph and Tragedy of Tobacco Control: A Tale of Nine Nations. *Annual Review of Law and Social Science, 7*(1), 79-100.

Gale, N., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(117), 1-8.

Goffman, E. (1963). *Stigma: notes on the management of spoiled identity*. New York: USA: Simon & Schuster Ltd.

Graham, H. (2012). Smoking, Stigma and Social Class. *Journal of Social Policy, 41*(01), 83-99. doi:10.1017/s004727941100033x

Greenhalgh, E., Bayly, M., & Winstanley, M. (Eds.). (2018). *Prevalence of smoking—adults* Melbourne, VIC: Cancer Council Victoria.

Harris, S., & Kinslow-Harris, J. (1984). *Culture and Learning : Tradition and Education in North-east Arnhem Land*. Canberra: Atlantic Highlands, NJ.

Larson, A., Gillies, M., Howard, P., & Coffin, J. (2007). It's enough to make you sick: the impact of racism on the health of Aboriginal Australians. *Aust N Z J Public Health, 31*, 322-329.

Link, B., & Phelan, J. (2001). Conceptualising Stigma. *Annual Review of Sociology, 27*, 363-385.

Nicholson, A., Borland, R., Davey, M., Stevens, M., & Thomas, D. (2015). Predictors of wanting to quit in a national sample of Aboriginal and Torres Strait Islander smokers. *Med J Aust, 10*, 26-31.

OECD. (2011). *Divided We Stand: Why Inequality Keeps Rising.* . Retrieved from Paris, FR: http://dx.doi.org/10.1787/9789264119536-en

Paradies, Y., & Cunningham, J. (2012). The DRUID study: racism and self-assessed health status in an Indigenous population. *BMC Public Health, 12*(131), 1-12.

Roeseler, A., & Burns, D. (2010). The quarter that changed the world. *Tob Control, 19 Suppl 1*, i3-15. doi:10.1136/tc.2009.030809

Scollo, M., & Winstanley, M. (2018). Tobacco in Australia: Facts and issues Retrieved from http://www.tobaccoinaustralia.org.au/

Stafford, M., & Scott, R. (Eds.). (1986). *Stigma deviance and social control: some conceptual issues*. New York, US: Plenum.

Stuber, J., Galea, S., & Link, B. (2008). Smoking and the emergence of a stigmatized social status. *Soc Sci Med, 67*(3), 420-430. doi:10.1016/j.socscimed.2008.03.010

Stuber, J., Galea, S., & Link, B. (2009). Stigma and Smoking: the consequences of our good intentions. *Social Service Review*, 585-609.

Thomas, D., Davey, M., Panaretto, K., Hunt, J., Stevens, M., & van der Sterren, A. (2015). Smoking among a national sample of Aboriginal and Torres Strait Islander health service staff. *Med J Aust, 202*(10 Suppl), 85-89.

Williams, D. (Ed.) (1999). *Race and health in Kansas: Data, issues and directions*. New York, US: New York Press.

Williams, D., & Mohammed, S. (2013). Racism and Health I: Pathways and Scientific Evidence. *American Behavioral Scientist, 57*(8), 1152-1173.

Williams, D., Priest, N., & Anderson, N. (2016). Understanding Associations between Race, Socioeconomic Status and Health: Patterns and Prospects. *Health Psychol, 35*(4), 1-9.

Table 1 Characteristics of key informants from seven East Arnhem Land remote communities, interviewed from August 2014 – May 2015

Characteristics	Number of Informants
Gender	
Female	9
Male	13
Employee of health service	
Yes	13
No	9
Smoking status	
Smoker	9
Ex-smoker	4
Never-smoker	9
Community of residence	
1	1
2	6
3	6
4	1
5	3
6	3
7	2