PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	How can a coordinated regional smoking cessation initiative be developed and implemented? A program logic model to evaluate the "10,000 Lives" health promotion initiative in Central Queensland, Australia
AUTHORS	Khan, Arifuzzaman; Green, Kalie; Khandaker, Gulam; Lawler, Sheleigh; Gartner, Coral

VERSION 1 – REVIEW

REVIEWER	Juhan Lee Department of Health Education and Behavior, College of Health and Human Performance, University of Florida, United States.
REVIEW RETURNED	04-Oct-2020

GENERAL COMMENTS	Overall: The authors used a program logic model framework to evaluate the smoking cessation initiative, 10,000 Lives in Central Queensland, Australia. Authors reviewed documents and conducted key informant interviews and indicated inputs, outputs and activities such as strategies, materials, interventions and human/financial resources. Overall, it is a well-written paper with thorough descriptions of the smoking cessation program. I believe this is going to be a good baseline paper for those who are interested in implementing cost-effective smoking cessation initiatives in different contexts. Here are my minor comments/suggestions: Introduction: "Queensland has performed as one of the best states in Australia for tobacco control activities in recent years.10 Programs and policies delivered by the Queensland Government include the Quitline service11, anti-smoking mass media campaigns, and smoke-free policies and laws. These have contributed to maintaining a downward trend in the daily smoking rate in Queensland over the last few decades." Would you please provide more detail about the outcomes of those activities? e.g., How many percentages of smoking prevalence declined? "name of the "10,000 Lives" initiative builds on the previously highly successful "10,000 Steps Rockhampton" program, which promoted physical activity in Rockhampton.16,17" I see why the authors indicated this sentence, but it seems a bit irrelevant to the paper. Please consider revising it. "As such it is imperative to consider how to leverage off existing funded programs with small iterative changes and budgets. A low-

	cost and locally initiated program like “10,000 Lives” is one such example, where this principle is being applied, with the aim of improving the health and wellbeing of the community” I agree with this practical reason for program evaluation, particularly since this is a cost-effective smoking cessation program. However, would you please consider providing any other reasons in addition to financial reasons? e.g., you may want to evaluate “10,000 Lives” to consider which part of the strategic plans or partnership plan should be improved (i.e., lesson learned). No research (program evaluation) was done in the smoking cessation program, etc. Methods: “However, this paper focuses on describing the inputs (planning, resources and cost, and partnership), activities and outputs of the initiative.” Could you please provide the rationale for this? e.g., not yet collected? “Aboriginal and/or Torres Strait Islanders.” Readers, including me, may not be familiar with this population group. Was there a reason to indicate this population here? e.g., health disparities in smoking cessation? “The proportion of the determinants for poor health, i.e., ‘low-income households’, ‘early exit from school’, ‘unemployment’ and ‘mental health issue’ is higher in CQ than the whole of Queensland and Australia.23” You may want to consider citing this paper to indicate as socioeconomic and health-related disadvantage index: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6547249/ Results: “For example, plans were formulated to give more attention to specific geographical areas (e.g., Gladstone and Woorabinda) and populations (e.g., mine workers and Aboriginal and Torres Strait Islander people).” Again, you may want to provide why those geographical areas and populations to be targeted? e.g., socio-economically disadvantages areas and groups? “The local Primary Health Network (PHN) actively collaboratored with “10,000 Lives” initiative by distributing information to General Practitioners (GPs)” “Local sports clubs and radio staions also partnered with the initiative on health promotion activities” Well-explained with the partnerships above. Would you please briefly provide more details about health promotion activities with those groups? There is also a typo in “staions” “brief intervention via a standardised ‘Smoking Cessation Clinical Pathway (SCCP)’ form among patients who smoke” Would you please provide more details about SCCP? https://metrosouth.health.qld.gov.au/innovationcentral/project/smoking-cessation-clinical-pathway#:~:text=The%20Smoking%20Cessation%20Clinical%20Pathway,intervention%20and%20follow%20up%20assistance.

	"These included; conducting events on the local radio station ('Triple M'), posting messages on Facebook pages ("10,000 Lives" , CQHHS and 'Triple M' Facebook pages), local newspapers (The Morning Bulletin and Gladstone Observer) and in the daily news and weekly bulletin of CQHHS and e-newsletters for GPs, and electronic billboard display in the center of the main city of the CQ region (i.e. Rockhampton CBD)" Could you please provide any of those examples? e.g., images or screenshot of Facebook/e-newsletter page? That would help readers understand the materials. "Outputs" section This is not a strong suggestion, but that would be helpful to use any visualization for these outputs. "10,000 Lives" made such a good achievement, but indicating numbers in the text or table may be less effective delivery for readers. Would you please consider presenting them with a visualization tool? e.g., graphs or infographics. Table / Figures: In Table 2(b) in the numbers column, e.g., 133(7) might be confusing. We are aware of this is # of people contacted (# of people support), but this may be clearer when indicated in the different columns. e.g., Numbers Champions and partners Contacted Identified as a Champion / Actively supported Clinical Staffs 133 7 (5.26%) Community Staff 26 2 (7.69%) … The percentage was calculated by the following formula: # of champions / # of contacted Discussion: "The regular communication and motivation to the stakeholders (clinical and community champions) helped the SPO to identify the opportunities (e.g., arrange training and workshop on smoking cessation) and tackle the barriers of smoking cessation work for them." You already provided the examples in (e.g., …), but would you please provide more examples and elaboration on how these works and anything expected/unexpected during this process? In this way, readers may learn more about the details about the process. My overall impression of the 2nd paragraph was just reiterating results. e.g., "People from multiple sectors including Health and Community Services and state and local government were invited to attend the inaugural summit which ultimately facilitated the initiative to build the partnerships and identify champions. Partnerships were built with various government and non-government organisations so that the coverage of workplace based smoking cessation programs were increased and the smoke-free workplace policies implemented." Would you please provide more examples or elaboration about the result? What did you learn and what would be the implication for the future process? "The 10,000 "Lives" initiative was built on the success of a previous health promotion campaign "10,000 Steps Rockhampton" in this region.16,17 The Rockhampton area was choosen for "10,000

	Steps Rockhampton" program because of the high prevalence of obesity.16" Now I see the authors' point of why authors indicated the "10,000 Steps" program in the introduction. e.g., similarities between 10,000 steps Rockhampton and 10,000 Lives. e.g., technology use. Would you please provide more description or how to connect between "10,000 steps" and "10,000 lives" program in the introduction? "Creating autonomus motivation in people who smoke, often explained by the 'SelfDetermination Theory',34 is effective for promoting smoking cessation. 35" As we know, it is always good to have a solid theoretical background. However, this self-determination theory was firstly introduced in the discussion section. I think it may be more appropriate to explain this concept at the beginning of the manuscript. Would you please briefly mention this (related to 10,000 steps/lives program) in the introduction section? "However, the implementation of the program was sometimes challenging, such as increasing clinician participation in deliverying brief advice and quitline referrals. Some stakeholders expected "10,000 Lives" to directly deliver smoking cessation services. However, this was beyond the scope and resources of the program." I see the authors' point here, but would you please give more elaboration of this, instead of "this is beyond the scope of the program". For example, you may want to be aware of the potential challenging point, and mention it as "future program or future research are needed x, y, z…" "However, the findings of process evaluation using a logic model of those program were not found after serachin in relevant websites" This seems more likely to be a rationale for this study. Would you please move this (or mention this) in the introduction section? "The strategies for achieving the goal of the "10,000 Lives" initiative reflect ecological models of health promotion' which explain the multiple levels of influence on health behaviour. 39 The initiative put substantial efforts to increase the use of interventions of smoking cessation programs by involving the service providers in the community (e.g., clinicians, NGO personnel) such this is a 'downstream' approach. For example, the "10,000 Lives" initiative encouraged clinicians to deliver brief interventions with their patients and refer them to Quitline, and other relevant smoking cessation programs. The use of local radio, which involved sports stars discussing smoking cessation and posting messages on Facebook pages are examples of 'midstream' strategies. While the advocacy of state level policies and programs (e.g., smoke-free hospitals) are 'upstream' strategies. Thus the "10,000 Lives" program fits the multi-level population based health promotion model of McKinlay" This seems also to fit in the introduction section. Would you please consider revising this to the introduction section with more examples and elaboration of "McKinlay model" (e.g., downstream, upstream, and midstream) Overall, it is well-designed smoking cessation initiative and a well-written manuscript for program evaluation. I believe this is going to be a good publication with some minor revision (e.g., more examples, elaborations and relocate introduction/discussion). I

	sincerely appreciate having me review this manuscript.

REVIEWER	Adriana Ratier-Cruz University of West England UK
REVIEW RETURNED	26-Oct-2020

GENERAL COMMENTS	Dear Authors, Thank you for sharing your work and well done for your '10,000 lives' initiative. You have done some amazing work! Regarding your paper, I have reviewed it and made some suggestions, as per below: Introduction Section (Pages 5 & 6) 1. As the aim of your study was to address a regional problem in Queensland, I'd be inclined to offer your (international) readers a brief description of where Queensland is in relation to Australia (northeast) and its regions. 2. Provide up to date information on the national and state average smoking rates. I would also include the highest (Central West - 20%) and the lowest (Sunshine Coast - 9%) HHSs smoking rate across Queensland and compare them to the rates in Central Queensland (14%). 3. Include regional morbidity and mortality data on smoking in addition to or as oppose to the national data. 4. Discuss specific groups of smokers in the region e.g. indigenous groups, expectant mothers, youth and any other hard-to-reach groups (your target groups). Talk about social and health inequalities experienced by them and why it is important to address smoking within these groups. Include smoking prevalence rates for them and evidence of initiatives which contributed to address smoking within these groups. 5. On page 5, Lines 29-33 – Discuss the tobacco control measures in Queensland e.g. quit line, campaigns and legislation by telling us - how and why these measures have been successful there and not in other parts of Queensland such as Central Queensland. Include any other positive outcomes achieved by these measures such as reduced morbidity and mortality (if applicable), as this is ultimately the aim of your project 10,000 lives. Hence, these measures being included in your strategy to reduce smoking in Central Queensland. 6. On page 5, lines 56-58 - You stated - "the strategic goals to address smoking health inequalities in Central Queensland were translated into the 10,000 lives initiative". However, the authors should briefly introduce their assumptions regarding why and how the use of existing resources (tobacco control measures), successful local evidence (10,000 steps) and planned work framework (logic model) would contribute for these strategic goals to be achieved. 7. On page 6, Lines 3-4 – You informed that the name "10,000 lives" was inspired by a highly successful initiative "10,000 Steps Rockhampton". I would move this information to the Methods

	Section under Study Design and explain (besides the name) which other aspects of the Steps programme were adapted to your project and how. And, in the Discussion Section, I would elaborate on any comparisons between the two programmes and anything that has emerged or been observed from using similar methodology in your project. Methods Section (Pages 6-8) 1. On page 6 – lines 34-36 - I'd explain in more details what 'logic model' is, why it was the chosen approach for the project, how it can contribute to achieve the objectives and how it will be evaluated. Include some evidence that can show the suitability of the model for the development of projects similar to yours. 2. On pages 6 & 7 – under Target Population, I'd discuss the psychosocial factors for smoking in the region, with focus on your target group and include any relevant demographic characteristics of smokers living in Central Queensland. 3. I understand your project involved a range of stakeholders. You should also include information about them, their involvement and recruitment under this section. Describe who they are, their professional roles, how they were involved and what their role in the project was. 4. Also, under this section you should mention the various settings where the project took place and describe the tools used in the project. Results Section (Pages 8-12) 1. My understanding is that the aim of your project was to develop a referral pathway into the existing smoking cessation services by (i) training health professionals on delivering smoking cessation brief intervention and (ii) driving health promotion messages via the local authorities and local media. But, how has this been integrated within their roles? And what is the evidence that the initiatives created opportunities for smoking cessation? 2. You also mentioned training and events - but these were not described in detail. What was the focus of these training programmes (e.g. Smoking awareness, smoking cessation, smokefree policies, health promotion and etc.)? 3. Under planning - I'd suggest to summarise the information about the proposal and describe point (iii) on page 6 (lines 54-55) – about the evidence based approaches you used. 4. I would suggest to structure this section in line with the methodology you used e.g. Logic Model. Use clear labels such as Inputs, Activities and Outputs. Provide a brief description for these labels before presenting the data. For instance, I'd structure resources into categories such as human, financial, organisational and etc. Activities into tools, events, products and so on.

	5. Also, explain the difference between brief and intensive smoking cessation support so that readers know what your programme was trying to achieve. Discussion Section (Pages 12-14) 1. On page 13, line 51 - needs reference for the claim – "leading to increased autonomous motivation to quit smoking." 2. I appreciate that the outcomes of the project will be presented in a separate report. However, your project has short, medium and long term outcomes and it would be important to share at least some of these outcomes in this report so that your readers can understand what has been achieved and whether or not the project has been cost-effective at this point. I believed these are some of your achievements: • Formed a tobacco control alliance with health professionals, local authorities, communities and media in CQ. • Disseminated knowledge of smoking cessation brief intervention amongst health professionals via training programmes. • Distributed information, promotional materials and etc. to raise the profile of smokefree policies and smoking cessation practices in CQ. • Carried out events and campaigns to increase smoking awareness amongst the large and small communities in the region. Minor reviews Avoid repetitions Double check your references/ claims. Explain abbreviations- CQPHU, NGOs, NRTs, Avoid brand names – Smokelyser is a brand name. The product is usually known as carbon monoxide breath monitor or breath co monitor. Best wishes, Adriana Ratier-Cruz

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Dr. Juhan Lee, University of Florida
Comments to the Author:
Overall:
The authors used a program logic model framework to evaluate the smoking cessation initiative, 10,000 Lives in Central Queensland, Australia. Authors reviewed documents and conducted key informant interviews and indicated inputs, outputs and activities such as strategies, materials, interventions and human/financial resources.
Overall, it is a well-written paper with thorough descriptions of the smoking cessation program. I believe this is going to be a good baseline paper for those who are interested in implementing cost-effective smoking cessation initiatives in different contexts. Here are my minor comments/suggestions:

Introduction:
"Queensland has performed as one of the best states in Australia for tobacco control activities in recent years.10 Programs and policies delivered by the Queensland Government include the Quitline service11, anti-smoking mass media campaigns, and smoke-free policies and laws. These have

contributed to maintaining a downward trend in the daily smoking rate in Queensland over the last few decades."
Would you please provide more detail about the outcomes of those activities? e.g., How many percentages of smoking prevalence declined?
Response: Included as "*The daily smoking rate in Queensland declined from 17.9% in 2002 to 10.3% in 2020.*[11]"

"name of the "10,000 Lives" initiative builds on the previously highly successful "10,000 Steps Rockhampton" program, which promoted physical activity in Rockhampton.16,17"
I see why the authors indicated this sentence, but it seems a bit irrelevant to the paper. Please consider revising it.

Response: Revised combined in response to another comment made later on. "*The popularity of "10,000 Steps Rockhampton" helped branding "10,000 Lives" and increasing recognition of the program among the partners and the community. Besides, the lesson learned from the process evaluation of "10,000 Steps Rockhampton" assisted us to develop a working model for achieving the goals of the "10,000 Lives"initiative.* [17,18]*."*

"As such it is imperative to consider how to leverage off existing funded programs with small iterative changes and budgets. A low-cost and locally initiated program like "10,000 Lives" is one such example, where this principle is being applied, with the aim of improving the health and wellbeing of the community"
I agree with this practical reason for program evaluation, particularly since this is a cost-effective smoking cessation program. However, would you please consider providing any other reasons in addition to financial reasons?
e.g., you may want to evaluate "10,000 Lives" to consider which part of the strategic plans or partnership plan should be improved (i.e., lesson learned). No research (program evaluation) was done in the smoking cessation program, etc.

Response: Revised as *"Completing a process evaluation of "10,000 Lives" was undertaken so that others can benefit from the shared learning experience, and to identify elements that were implemented well and which were less successful and could be improved. Process evaluations of the national campaign for smoking cessation in Australia are documented rigorously.*[20-24] *Some targeted smoking cessation campaigns have been evaluated for their impact and outcomes.*[25,26] *However, we could not find any similar evaluations of smoking cessation programs that used a logic model in the scientific literature."*

Methods:
"However, this paper focuses on describing the inputs (planning, resources and cost, and partnership), activities and outputs of the initiative."
Could you please provide the rationale for this? e.g., not yet collected?
Response: We are also evaluating the impact of 10,000 Lives but did not include in this paper. We have added a sentence by mentioning this at the end of discussion part- "*The stakeholder's perspective and the impact of "10,000 Lives" are currently evaluated through analysis of the stakeholder-survey data and changes in the numbers and rate of referrals, program participation and interactions to Quitline and the result will be reported through separate peer-reviewed publications.*"

"Aboriginal and/or Torres Strait Islanders."
Readers, including me, may not be familiar with this population group. Was there a reason to indicate this population here? e.g., health disparities in smoking cessation?
Response: Yes, this group has higher smoking prevalence than the general population, which is mentioned in the manuscript describing target population. "*Approximately six per cent of the population are Aboriginal and/or Torres Strait Islanders (Australian Indigenous people).*[7] *The rate of smoking is higher among these population groups compared to the overall population due to the legacy of colonisation.*[29]"

“The proportion of the determinants for poor health, i.e., ‘low-income households’, ‘early exit from school’, ‘unemployment’ and ‘mental health issue’ is higher in CQ than the whole of Queensland and Australia.23”
You may want to consider citing this paper to indicate as socioeconomic and health-related disadvantage index:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6547249/
Response: Included and revised as “*Compared to the whole state of Queensland, CQ has a higher burden of the social determinants of poor health, including low-income households, early exit from school, unemployment and mental health issues. These socio-demographic factors contribute to the higher prevalence of smoking in this region.* [30]”

Results:
“For example, plans were formulated to give more attention to specific geographical areas (e.g., Gladstone and Woorabinda) and populations (e.g., mine workers and Aboriginal and Torres Strait Islander people).”
Again, you may want to provide why those geographical areas and populations to be targeted? e.g., socio-economically disadvantages areas and groups?
Response: Yes, revised as “*For example, plans were formulated to give more attention to specific geographical areas (e.g., Gladstone and Woorabinda) and populations (e.g., mine workers and people of Indigenous origin) since the higher rate of smoking were observed among these population”.*

“The local Primary Health Network (PHN) actively collaboratored with “10,000 Lives” initiative by distributing information to General Practitioners (GPs)”
“Local sports clubs and radio staions also partnered with the initiative on health promotion activities”
Well-explained with the partnerships above. Would you please briefly provide more details about health promotion activities with those groups?
There is also a typo in “staions”
Response: Revised. “*The local Primary Health Network actively collaboratored with “10,000 Lives” initiative by promoting the initiative’s interventions (e.g., referral to Quitline, smoking cessation advice to patients who smoke) to General Practitioners (GPs). Local sports clubs and radio staions also supported the initiative to promote the available smoking cessation interventions to their audience.”*

“brief intervention via a standardised ‘Smoking Cessation Clinical Pathway (SCCP)’ form among patients who smoke”
Would you please provide more details about SCCP?
https://metrosouth.health.qld.gov.au/innovationcentral/project/smoking-cessation-clinical-pathway#:~:text=The%20Smoking%20Cessation%20Clinical%20Pathway,intervention%20and%20follow%20up%20assistance.

Response: Included and cited by a recently published study regarding use of SCCP. *“SCCP is an evidence-based decision support tool for screening smoking status and delivering a brief intervention to the hospitalised patient for smoking cessation.*[42] *Besides, community champions were encouraged to promote the Quitline program and other smoking cessation support (e.g., My QuitBuddy app) among people who smoke.”*

“These included; conducting events on the local radio station (‘Triple M’), posting messages on Facebook pages (“10,000 Lives” , CQHHS and ‘Triple M’ Facebook pages), local newspapers (The Morning Bulletin and Gladstone Observer) and in the daily news and weekly bulletin of CQHHS and e-newsletters for GPs, and electronic billboard display in the center of the main city of the CQ region (i.e. Rockhampton CBD)”
Could you please provide any of those examples? e.g., images or screenshot of Facebook/e-newsletter page? That would help readers understand the materials.
Response: Included as figure 3.

“Outputs” section

This is not a strong suggestion, but that would be helpful to use any visualization for these outputs. "10,000 Lives" made such a good achievement but indicating numbers in the text or table may be less effective delivery for readers. Would you please consider presenting them with a visualization tool? e.g., graphs or infographics.
Response: Thanks for your suggestion. The number of figures in this article is exceeded already hence we needed to replace the Figure 3 based on your previous comment.

Table / Figures:
In Table 2(b) in the numbers column, e.g., 133(7) might be confusing.
We are aware of this is # of people contacted (# of people support), but this may be clearer when indicated in the different columns.
e.g.,

	Numbers		
Champions and partners / Actively supported		Contacted	Identified as a Champion
Clinical Staffs	133	7 (5.26%)	
Community Staff	26	2 (7.69%)	

…
The percentage was calculated by the following formula: # of champions / # of contacted

Response: We have revised the **Table 2 b** according to this suggestion.

Discussion:
"The regular communication and motivation to the stakeholders (clinical and community champions) helped the SPO to identify the opportunities (e.g., arrange training and workshop on smoking cessation) and tackle the barriers of smoking cessation work for them."
You already provided the examples in (e.g., …), but would you please provide more examples and elaboration on how these works and anything expected/unexpected during this process? In this way, readers may learn more about the details about the process.
Response: Added a sentence "*For example, if any champion talked about any organisational challenge to perform or promot smoking cessation, the SPO took initiative to escalate the issue to his/her supervisor and discussed to resolve the issue.While not all opportunities and barriers were able to be successfully resolved, a reasonable proportion (~32 %) led to successful outcomes (Table 2(b)).*"

My overall impression of the 2nd paragraph was just reiterating results.
e.g., "People from multiple sectors including Health and Community Services and state and local government were invited to attend the inaugural summit which ultimately facilitated the initiative to build the partnerships and identify champions. Partnerships were built with various government and non-government organisations so that the coverage of workplace based smoking cessation programs were increased and the smoke-free workplace policies implemented."
Would you please provide more examples or elaboration about the result? What did you learn and what would be the implication for the future process?

Response: Revised the paragraph*. "Participation of the people from multiple sectors including Health and Community Services and state and local government in the inaugural summits ultimately facilitated the initiative to build the partnerships and identify champions. Partnerships with various government and non-government organisations opened and enhanced the oppourtunities to increase the coverage of workplace based smoking cessation intervention (e.g., smoke-free pollicies, referrals to Quitline). Partnership with Quitline Queensland assisted the initiative to promote their intensive Quit support program among the partering organisations (e.g., Hospitals, Councils, NGOs). Besides, the regular communication and motivation to the stakeholders (clinical and community champions) helped the SPO to identify the opportunities (e.g., arrange training and workshop on smoking cessation) and tackle the barriers of smoking cessation work for them For example, if any champion talked about any organisational challenge to perform or promot smoking cessation, the SPO took initiative to escalate the issue to his/her supervisor and discussed to resolve the issue.While not all opportunities and barriers were able to be successfully resolved, a reasonable proportion (~32 %) led to successful outcomes (Table 2(b)). These integral strategies of building partnerships and communication became useful to build a clinical and a community taskforce of smoking cessation in CQ which leveraged the*

existing smoking cessation program and policies available in the region. This approach is an exemplar of running a health promotion campaign in a resource constrained environment."

"The 10,000 "Lives" initiative was built on the success of a previous health promotion campaign "10,000 Steps Rockhampton" in this region.16,17 The Rockhampton area was choosen for "10,000 Steps Rockhampton" program because of the high prevalence of obesity.16"
Now I see the authors' point of why authors indicated the "10,000 Steps" program in the introduction. e.g., similarities between 10,000 steps Rockhampton and 10,000 Lives. e.g., technology use.
Would you please provide more description or how to connect between "10,000 steps" and "10,000 lives" program in the introduction?
Response: Revised the paragraph in the introduction as "*The popularity of "10,000 Steps Rockhampton" helped branding "10,000 Lives" and increasing recognition of the program among the partners and the community. Besides, the lesson learned from the process evaluation of "10,000 Steps Rockhampton" assisted us to develop a working model for achieving the goals of the "10,000 Lives"initiative.* [17,18].

"Creating autonomous motivation in people who smoke, often explained by the 'Self-determination Theory',34 is effective for promoting smoking cessation. 35"
As we know, it is always good to have a solid theoretical background. However, this self-determination theory was firstly introduced in the discussion section. I think it may be more appropriate to explain this concept at the beginning of the manuscript. Would you please briefly mention this (related to 10,000 steps/lives program) in the introduction section?
Response: Thank you for your suggestion. But we think this would interrupt the flow of the introduction to include this information .

"However, the implementation of the program was sometimes challenging, such as increasing clinician participation in deliverying brief advice and quitline referrals. Some stakeholders expected "10,000 Lives" to directly deliver smoking cessation services. However, this was beyond the scope and resources of the program."
I see the authors' point here, but would you please give more elaboration of this, instead of "this is beyond the scope of the program". For example, you may want to be aware of the potential challenging point, and mention it as "future program or future research are needed x, y, z…"

Response: Included as *"Future program planning may need to think about how cost-effective and tailored services can be incorporated in the smoking initiative like "10,000 Lives"."*

"However, the findings of process evaluation using a logic model of those program were not found after searching in relevant websites"
This seems more likely to be a rationale for this study. Would you please move this (or mention this) in the introduction section?
Response: Shifted and revised the last paragraph of Introductions as "*Completing a process evaluation of health promotion programs, such as "10,000 Lives" is important so that others can benefit from the shared learning experience. Process evaluations of the national campaign for smoking cessation in Australia are documented rigorously.*[20-24] *Some targeted smoking cessation campaigns have been evaluated for their impact and outcomes.*[25,26] *However, we failed to recognise any process evaluation of such smoking cessation program using a logic model and documented or published in scientific journals.* .

"The strategies for achieving the goal of the "10,000 Lives" initiative reflect ecological models of health promotion' which explain the multiple levels of influence on health behaviour. 39 The initiative put substantial efforts to increase the use of interventions of smoking cessation programs by involving the service providers in the community (e.g., clinicians, NGO personnel) such this is a 'downstream' approach. For example, the "10,000 Lives" initiative encouraged clinicians to deliver brief interventions with their patients and refer them to Quitline, and other relevant smoking cessation programs. The use of local radio, which involved sports stars discussing smoking cessation and posting messages on Facebook pages are examples of 'midstream' strategies. While the advocacy of

state level policies and programs (e.g., smoke-free hospitals) are 'upstream' strategies. Thus the "10,000 Lives" program fits the multi-level population based health promotion model of McKinlay" This seems also to fit in the introduction section. Would you please consider revising this to the introduction section with more examples and elaboration of "McKinlay model" (e.g., downstream, upstream, and midstream)
Response: Thank you for your suggestion. We considered moving this information to the introduction, however decided it fits better in the original location where we discuss the planning, strategies and activities of "10,000 Lives" in discussion section.

Overall, it is well-designed smoking cessation initiative and a well-written manuscript for program evaluation. I believe this is going to be a good publication with some minor revision (e.g., more examples, elaborations and relocate introduction/discussion). I sincerely appreciate having me review this manuscript.

Response: Thank you very much.

Reviewer: 2
Dr. A Ratier-Cruz, Springfield University Hospital Comments to the Author:
Dear Authors,

Thank you for sharing your work and well done for your '10,000 lives' initiative. You have done some amazing work!

Regarding your paper, I have reviewed it and made some suggestions, as per below:

Introduction Section (Pages 5 & 6)

1. As the aim of your study was to address a regional problem in Queensland, I'd be inclined to offer your (international) readers a brief description of where Queensland is in relation to Australia (northeast) and its regions.
Response: Included in the introduction as *"In Queensland, the northeast state of Australia, top leading causes of deaths occurred from the diseases (e.g., Lung cancer, COPD, Coronary heart diseases) those have strong link with smoking.[3] In 2016, 12% of the adult population were daily smokers in Australia,[4] whereas 14.5% of adults in Queensland,[5] and 16.7% of adults in Central Queensland (the central regional district of Queensland) smoked daily.[6]*

2. Provide up to date information on the national and state average smoking rates. I would also include the highest (Central West - 20%) and the lowest (Sunshine Coast - 9%) HHSs smoking rate across Queensland and compare them to the rates in Central Queensland (14%).
Response: "10,000 Lives" was introduced to tackle the higher rates of smoking in 2016. Hence, we provided 2016 smoking statistics in the background. However, we included some regional statistics (highest and lowest in 2016) in introduction section as *"Central Queensland (CQ) had the fourth-highest smoking prevalence among all 15 hospital and health services catchment regions in Queensland; South West (inner regional area) had the highest (21.6%) and the Sunshine Coast (close to the capital city, Brisbane) had the lowest rate (10.3%).[7] "*

3. Include regional morbidity and mortality data on smoking in addition to or as oppose to the national data.
Response: Unfortunately Australian Disease Burden study did not include morbidity and mortality data due to smoking at state or regional level however, we have extracted relevant information from recently published Chief health officer report of Queensland health and included in the introduction as *""In Queensland, the northeast state of Australia, leading causes of deaths are lung cancer, COPD, coronary heart diseases, which have a strong link with tobacco smoking.[3]"*

4. Discuss specific groups of smokers in the region e.g. indigenous groups, expectant mothers, youth and any other hard-to-reach groups (your target groups). Talk about social and health inequalities experienced by them and why it is important to address smoking within these groups.

Include smoking prevalence rates for them and evidence of initiatives which contributed to address smoking within these groups.

Response: We included briefly in introduction *"Priority populations for smoking cessation assistance identified within CQ include pregnant women (17.0% smoking prevalence),[9] Aboriginal and/or Torres Strait Islander peoples (Australia's Indigenous people groups),[5] and people living in some local government areas within CQ, such as Gladstone 19.1% and Rockhampton 17.7% smoking prevalence.[7,8]".* Further described in target population section "*In 2017, the population of the CQ region was ~220,000 people (4.5% of the Queensland population and 0.9% of the Australia population).[28] There were 54,722 families (74,201 households) in 2017; the median age was 34.9 years; sixty-five per cent of the population were aged between 15–64 years.[29] Approximately six per cent of the population are Aboriginal and/or Torres Strait Islanders (Australian Indigenous people).[8] The rate of smoking is higher among these population groups compared to the overall population due to the legacy of colonisation.30 The rate of homelessness was 41.0 per 10,000 persons. The median total personal income per year was $35,017 Australian dollars (AUD), with 50.2% having the highest level of schooling of Year 11 or 12 (or equivalent). In CQ, 25.7% of the population were in the most disadvantaged quintile and 10.1% of the population were in the least disadvantaged quintile, whereas in Queensland, 20% of the population were in most disadvantaged quintile and 20.0% in the least disadvantaged quintile in 2017.[8] Compared to the whole state of Queensland, CQ has a higher burden of the social determinants of poor health, including low-income households, early exit from school, unemployment and mental health issues. These socio-demographic factors contribute to the higher prevalence of smoking in this region.[31] According to a state-wide survey in the year preceding the launching of "10,000 Lives" an estimated ~28,000 adults who smoke resided in CQ.[7] The daily smoking prevalence was highest (17.4%) in the 30-44 years age group. Also, the prevalence was high (18.5%) among the most disadvantaged quintile.[7]"*

5. On page 5, Lines 29-33 – Discuss the tobacco control measures in Queensland e.g. quit line, campaigns and legislation by telling us - how and why these measures have been successful there and not in other parts of Queensland such as Central Queensland. Include any other positive outcomes achieved by these measures such as reduced morbidity and mortality (if applicable), as this is ultimately the aim of your project 10,000 lives. Hence, these measures being included in your strategy to reduce smoking in Central Queensland.

Response: Line 33-38 described about the contributors of declining trend of smoking in Queensland. However, we do not have adequate information why a regional district like Central Queensland did not have such declining trend of smoking but added a line "*This might be due to a higher baseline smoking prevalence and sub-optimal use of available interventions (e.g., Quitline) by the regional and rural people who smoke (Quitline monthly data, 2014-2019).*" at the end of the paragraph.

6. On page 5, lines 56-58 - You stated - "the strategic goals to address smoking health inequalities in Central Queensland were translated into the 10,000 lives initiative". However, the authors should briefly introduce their assumptions regarding why and how the use of existing resources (tobacco control measures), successful local evidence (10,000 steps) and planned work framework (logic model) would contribute for these strategic goals to be achieved.

Response: This is the background of introduction of "10,000 Lives" initiative hence we stated in the introduction however the explanation was elaborately discussed in the Discussion section based on the study findings and explained by the known theoretical frameworks. "*The strategies for achieving*

the goal of the "10,000 Lives" initiative reflect ecological models of health promotion' which explain the multiple levels of influence on health behaviour. [49] The initiative put substantial efforts to increase the use of interventions of smoking cessation programs by involving the service providers in the community (e.g., clinicians, NGO personnel) such this is a 'downstream' approach. For example, the "10,000 Lives" initiative encouraged clinicians to deliver brief interventions with their patients and refer them to Quitline, and other relevant smoking cessation programs. The use of local radio, which involved sports stars discussing smoking cessation and posting messages on Facebook pages are examples of 'midstream' strategies. While the advocacy of state level policies and programs (e.g., smoke-free hospitals) are 'upstream' strategies. Thus the "10,000 Lives" program fits the multi-level population based health promotion model of McKinlay.[50]

7. On page 6, Lines 3-4 – You informed that the name "10,000 lives" was inspired by a highly successful initiative "10,000 Steps Rockhampton". I would move this information to the Methods Section under Study Design and explain (besides the name) which other aspects of the Steps programme were adapted to your project and how. And, in the Discussion Section, I would elaborate on any comparisons between the two programmes and anything that has emerged or been observed from using similar methodology in your project.

Response: We have included this information in the introduction to tell the background of introduction of "10,000 Lives". We have elaborated a bit more in the introduction as ". *The popularity of "10,000 Steps Rockhampton" helped branding "10,000 Lives" and increasing recognition of the program among the partners and the community. Besides, the lesson learned from the process evaluation of "10,000 Steps Rockhampton" assisted us to develop a working model for achieving the goals of the "10,000 Lives"initiative. [18,19].*

Besides, we avoided this to include in method section since our study method is independent to the program design of "10,000 Lives".

Comparisons between the two programmes were discussed in Discussion section as "*The 10,000 "Lives" initiative was built on the success of a previous health promotion campaign "10,000 Steps Rockhampton" in this region.[18,19] The Rockhampton area was choosen for "10,000 Steps Rockhampton" program because of the high prevalence of obesity.18 Again, "10,000 Lives" initiative was launched in CQ to address the higher prevalence of smoking in this region. The "10,000 Lives" utilised the program strategies (e.g., media campaign, partnerships with clinicians, focusing on priority populations) that were also used in the "10,000 Steps Rockhampton" program.[18] Other similarities include the use of of technology to measure exhaled carbon monoxide in "10,000 Lives" and pedometers in "10,000 Steps Rockhampton" to measure activity levels. The use of the carbon monoxide breath monitorSmokelyzer provided a teaching moment to discuss the health impacts of smoking by demonstrating the person's exposure to one of the toxins in cigarette smoke, leading to increased autonomous-motivation to quit smoking . Creating autonomous motivation in people who smoke, often explained by the 'Self-Determination Theory',[45] is effective for promoting smoking cessation. [46]"*

Methods Section (Pages 6-8)

1. On page 6 – lines 34-36 - I'd explain in more details what 'logic model' is, why it was the chosen approach for the project, how it can contribute to achieve the objectives and how it will be evaluated. Include some evidence that can show the suitability of the model for the development of projects similar to yours.
Response: Revised as *"The evaluation framework was discussed among stakeholders who attended the "10,000 Lives" summit in Rockhampton, Australia, in November 2018. We have chosen this model because this has guided understanding the program input for "10,000 Lives" but also the program evaluation, where process, impact and outcome assessment can be clearly delineated (Figure 1).*

2. On pages 6 & 7 – under Target Population, I'd discuss the psychosocial factors for smoking in the region, with focus on your target group and include any relevant demographic characteristics of smokers living in Central Queensland.
Response: We rearranged the sentences to improve the coherence. "*In 2017, the population of the CQ region was ~220,000 people (4.5% of the Queensland population and 0.9% of the Australia population).[28] There were 54,722 families (74,201 households) in 2017; the median age was 34.9 years; sixty-five per cent of the population were aged between 15–64 years.[29] Approximately six per cent of the population are Aboriginal and/or Torres Strait Islanders (Australian Indigenous people).[8] The rate of smoking is higher among these population groups compared to the overall population due to the legacy of colonisation.30 The rate of homelessness was 41.0 per 10,000 persons. The median total personal income per year was $35,017 Australian dollars (AUD), with 50.2% having the highest level of schooling of Year 11 or 12 (or equivalent). In CQ, 25.7% of the population were in the most disadvantaged quintile and 10.1% of the population were in the least disadvantaged quintile, whereas in Queensland, 20% of the population were in most disadvantaged quintile and 20.0% in the least disadvantaged quintile in 2017.[8] Compared to the whole state of Queensland, CQ has a higher burden of the social determinants of poor health, including low-income households, early exit from school, unemployment and mental health issues. These socio-demographic factors contribute to the higher prevalence of smoking in this region.[31] According to a state-wide survey in the year preceding the launching of "10,000 Lives" an estimated ~28,000 adults who smoke resided in CQ.[7] The daily smoking prevalence was highest (17.4%) in the 30-44 years age group. Also, the prevalence was high (18.5%) among the most disadvantaged quintile.[7]".*

3. I understand your project involved a range of stakeholders. You should also include information about them, their involvement and recruitment under this section. Describe who they are, their professional roles, how they were involved and what their role in the project was.
Response: We think 'Partnerships' section described about different stakeholders. "*Developing partnerships and involving stakeholders in the implementation of "10,000 Lives" was a key strategy of the initiative. A strategic partnership was made with the Queensland Quitline[13] for enhancing the promotion of their existing intensive Quit support program which was available to rural, regional and remote communities with a higher than average smoking prevalence and accessing a monthly report to track Quitline registrations and participation status for smokers in CQ. Extensive in-kind support was provided by the Board and Chief Executive of CQHHS by arranging the project fund, and the Preventive Health Branch of Queensland Health by giving strategic advice and advocacy for implementing the smoke-free policies. Partnerships were built with different units and programs within CQHHS (e.g., Oral health, Mental health, 'CQ Youth Connect'), community organisations (e.g., Rotary[36]), a foundation for youth mental health called 'Headspace',[37] a targeted brief intervention training program for Aboriginal and/or Torres Strait Islanders named 'B.strong',[38] a health promotion initiative for Aboriginal and/or Torres Strait Islander people called 'Deadly Choices',[39] local councils (city council and local government staff) and a non-government organisation (NGO) supporting and developing businesses and projects in CQ called "Capricorn Enterprise"[40] to promote and support smoking cessation activities for their staff and client population (patient, youth, community and Indigenous people who smoke). The project collaborated with the University of Queensland for academic support for the program evaluation. Partnerships were developed with "Cancer Council Queensland"[41] for conducting training and workshops for the local clinicians, social workers and volunteers who were interested in supporting the initiative. The local Primary Health Network actively collaborated with "10,000 Lives" initiative by by promoting the initiative's interventions (e.g., referral to Quitline, smoking cessation advice to patients who smoke) to General Practitioners (GPs). Local sports clubs and radio stations also supported the initiative to promote the available smoking cessation interventions to their audience.*

Unfortunately, word limit restrictions preclude us from providing additional detailed information in this manuscript. In response to last part of this comment, more about role and experience of the stakeholders will be reported in separate publication as mentioned "The immediate and short- term impacts of the "10,000 Lives" initiative assessed via a stakeholder survey and analysis of Quitline data will be reported in detail elsewhere. However, we found good responses from the stakeholders in sharing their experience, role and recommendation for the continuation of the initiative."

4. Also, under this section you should mention the various settings where the project took place and describe the tools used in the project.

Response: We intended to describe the methodology (i.e., how we unwrapped the inputs, activities and outputs of 10,000 Lives) of our study in the Method section The setting, tools etc of the "10,000 Lives" project included in as inputs of the project and presented in result section and discussed these in discussion section.

Results Section (Pages 8-12)

1. My understanding is that the aim of your project was to develop a referral pathway into the existing smoking cessation services by (i) training health professionals on delivering smoking cessation brief intervention and (ii) driving health promotion messages via the local authorities and local media. But, how has this been integrated within their roles? And what is the evidence that the initiatives created opportunities for smoking cessation?

Response: Yes, you are right. The aim of the "10,000 Lives" described in Planning sections as "*1. Establish a 10,000 Lives Taskforce: The taskforce will form the backbone of the project and through collective impact with the support of a wide range of community stakeholders large scale social change will be achieved. ("Collective impact" is a structured and disciplined approach to bringing cross-sector organisations together to focus on a common agenda that result in long-lasting improvement.).*

2. Establish a team of clinical champions to engage key stakeholders e.g. G.P.'s and provide health promotion activities, intervention and education to the broader community".

. The integration process is described in *Activities* section *("1. Organising tobacco summits to develop partnerships with clinicians, GPs, social workers, local council and industry staff, and local politicians.*
2. Establishing a clinical and community organisation taskforce for smoking cessation to identify clinical and community organisation personnel to become a champion for smoking cessation. CQHHS clinicians were encouraged to conduct inpatient hospital and health care facility-based documentation and brief intervention via a standardised 'Smoking Cessation Clinical Pathway (SCCP)' form among patients who smoke, and to refer them to Quitline for accessing the intensive Quit support program. The SCCP is an evidence-based decision support tool for screening smoking status and delivering a brief intervention to patients for smoking cessation.42 Community champions were encouraged to promote the Quitline program and other smoking cessation support (e.g., My QuitBuddy app) among to people who smoke.
3. Promoting smoking cessation through emails, newsletters, local radio, social media pages (i.e., Facebook), digital billboard and ground signage, and exhibiting in various community expos and health-related events. The SPO explored various communication pathways to promote the available smoking cessation support, particularly the Quitline program. These included; conducting events on the local radio station ('Triple M'), posting messages on Facebook pages ("10,000 Lives" , CQHHS and 'Triple M' Facebook pages), local newspapers (The Morning Bulletin and Gladstone Observer) and in the daily news and weekly bulletin of CQHHS and e-newsletters for GPs, and electronic billboard display in the center of the main city of the CQ region (i.e. Rockhampton CBD) (Figure 3).

4. Advocating for smoke-free policies and programs that could support smokers to quit. For example, the initiative established the ground signage and delivered tear off flyers promoting Smoke-free Healthcare in each of the hospital and community health campuses of CQHHS.
5. Implementing mini-projects to give extra attention to priority populations. For example, a film competition on 'smoke-free teens' was organised to deliver a youth-centric smoking cessation message designed by youth for youth, and a workshop was conducted by the SPO to introduce carbon monoxide breath monitorswith Gumma Gundoo Indigenous Maternal & Infant Care Outreach team [43] to increase awareness of the adverse effects of antenatal smoking on mother and baby amongst Aboriginal and Torres Strait Islander pregnant women.

How the initiative can impact on smoking cessation is shown in Evaluation framework (Figure 1) and discussed in Discussion section as "*The strategies for achieving the goal of the "10,000 Lives" initiative reflect ecological models of health promotion' which explain the multiple levels of influence on health behaviour.49 The initiative put substantial efforts to increase the use of interventions of smoking cessation programs by involving the service providers in the community (e.g., clinicians, NGO personnel) such this is a 'downstream' approach. For example, the "10,000 Lives" initiative encouraged clinicians to deliver brief interventions with their patients and refer them to Quitline, and other relevant smoking cessation programs. The use of local radio, which involved sports stars discussing smoking cessation and posting messages on Facebook pages are examples of 'midstream' strategies. While the advocacy of state level policies and programs (e.g., smoke-free hospitals) are 'upstream' strategies. Thus the "10,000 Lives" program fits the multi-level population based health promotion model of McKinlay.[50]"*

2. You also mentioned training and events - but these were not described in detail. What was the focus of these training programmes (e.g. Smoking awareness, smoking cessation, smokefree policies, health promotion and etc.)?
Response: We mentioned the training agenda in the output section (e.g. *…a three-day training course on nicotine addiction and smoking cessation, which was completed by six clinicians. Forty Aboriginal and/or Torres Strait Islander volunteers were trained in performing Brief Intervention for smoking cessation conducted by the Menzies School of Health Research (B.strong).* Also we have added the examples of events in activities section *as "Promoting smoking cessation through emails, newsletters, local radio, social media pages (i.e., Facebook), digital billboard and ground signage, and exhibiting in various community expos and health-related events. The SPO explored various communication pathways to promote the available smoking cessation support, particularly the Quitline program. These included; conducting events on the local radio station ('Triple M'), posting messages on Facebook pages ("10,000 Lives" , CQHHS and 'Triple M' Facebook pages), local newspapers (The Morning Bulletin and Gladstone Observer) and in the daily news and weekly bulletin of CQHHS and e-newsletters for GPs, and electronic billboard display in the center of the main city of the CQ region (i.e. Rockhampton CBD) (Figure 3)".*

3. Under planning - I'd suggest to summarise the information about the proposal and describe point (iii) on page 6 (lines 54-55) – about the evidence based approaches you used.

Response: Example added to clarify *"iii) Evidence-based approach of integrating knowledge from research evidence into implementation (e.g., evidence review of effective smoking cessations and partnership with academic institute for process evaluation,…)"*

4. I would suggest to structure this section in line with the methodology you used e.g. Logic Model. Use clear labels such as Inputs, Activities and Outputs. Provide a brief description for these labels before presenting the data. For instance, I'd structure resources into categories such as human, financial, organisational and etc. Activities into tools, events, products and so on.

Response: We have revised in accordance with the reviewer suggestion and added the following to the Headlines- Input: Planning, Input: Resources and Costs, Input: Partnerships, Activities and Outputs. The text was revised at the beginning of the Results section to reflect this. "*Table 2 lists the key findings about the inputs (planning, resources and cost, and partnerships), activities and outputs of the "10,000 Lives" initiative in first 26 months after it's launch. Below, we described the result according to the findings from different parts of the logic model framework (i.e., Inputs, Activities and Outputs).*

5. Also, explain the difference between brief and intensive smoking cessation support so that readers know what your programme was trying to achieve.

Response: "Brief intervention" is a generic term for smoking cessation advice and referral that is embedded opportunistically into clinical practice. We have added a footnote defining this term for thos unfamiliar with it. The Intensive quit support program is a specific program offered by Queensland Quitline and is described in Resources and Costs section (page 9, 49-56) as "*Also, the initiative utilised the existing resources available for smoking cessation in CQ which included combination of 12-weeks-free NRTs and telephone counselling via the Queensland Quitline's Intensive Quit support program,..".*

Discussion Section (Pages 12-14)

1. On page 13, line 51 - needs reference for the claim – "leading to increased autonomous motivation to quit smoking."

Response: Inserted

2. I appreciate that the outcomes of the project will be presented in a separate report. However, your project has short, medium and long term outcomes and it would be important to share at least some of these outcomes in this report so that your readers can understand what has been achieved and whether or not the project has been cost-effective at this point. I believed these are some of your achievements:

- Formed a tobacco control alliance with health professionals, local authorities, communities and media in CQ.
- Disseminated knowledge of smoking cessation brief intervention amongst health professionals via training programmes.
- Distributed information, promotional materials and etc. to raise the profile of smokefree policies and smoking cessation practices in CQ.
- Carried out events and campaigns to increase smoking awareness amongst the large and small communities in the region.

Response: Thank you for your great advice. Besides mentioning some of the bulleted points in the output section we included them in the discussion as section as "…*Achievements of the "10,000 Lives" program include the formation of a tobacco control alliance with health professionals, local authorities, communities and the media in CQ, dissemination of knowledge to health professionals on how to deliver brief interventions, distributed promotional material that raised the profile of smokefree policies and smoking cessation support available in CQ, and conducted events and local campaigns to increase awareness of smoking cessation among the general community and specific priority*

populations. The immediate and short- term impacts of the "10,000 Lives" initiative assessed via a stakeholder survey and analysis of Quitline data will be reported in detail elsewhere. However, we found good responses from the stakeholders in sharing their experience, role and recommendation for the continuation of the initiative. Our analysis of Quitline data indicated a significant positive impact of the introduction of "10,000 Lives" in CQ on referrals calls and use of Quitline services in comparison to a comparable control group."

Minor reviews

Avoid repetitions
Double check your references/ claims.
Explain abbreviations- CQPHU, NGOs, NRTs, Avoid brand names – Smokelyser is a brand name. The product is usually known as carbon monoxide breath monitor or breath co monitor.

Response: Checked and revised accordingly.
Best wishes,

Adriana Ratier-Cruz

Reviewer: 1
Competing interests of Reviewer: None declared

Reviewer: 2
Competing interests of Reviewer: None

VERSION 2 – REVIEW

REVIEWER	Juhan Lee University of Florida, USA
REVIEW RETURNED	04-Feb-2021

GENERAL COMMENTS	Authors addressed my comments thoroughly. Nice job!

REVIEWER	Adriana Ratier-Cruz SWLSGT NHS Mental Health Trust England - UK
REVIEW RETURNED	06-Mar-2021

GENERAL COMMENTS	Dear Authors, Thank you for resubmitting the manuscript and accepting the suggested changes/amendments. My apologies if I am mistaken but I could not find the smoking prevalence rate within Aboriginal and Torres Strait Islander groups in the report. Other than that, I would like to congratulate you on this great work and wish you continued success in future projects/publications. All the best. Adriana